

**Minutes** of the meeting of the Safe Surgery NZ Advisory Group

Held on 14 September 2017, at the Health Quality & Safety Commission, Wellington

Present: Prof Ian Civil – Chair (Auckland DHB)

Rosaleen Robertson (Southern Cross Hospitals and NZPSHA)

Caroline Gunn (Consumer representative)

Prof Justin Roake (Canterbury DHB)

Dr Mike Stitely (Royal Australian and NZ College of O&G)

Bob Henderson (Airline pilot, psychologist)

Dr Will Perry (Registrar Medical Officer)

David Peploe, substitute for Dr Peter Jansen (ACC)

HQSC team: Gary Tonkin, Gillian Bohm, Owen Ashwell, Maree Meehan-Berge (minute taker)

Guests: From the Commission: Richard Hamblin HQE Director – for item 8

 and, Jenny Hill, Specialist, Patient Deterioration Programme – for item 10

Apologies: Dr Leona Wilson (ANZCA, CCDHB)

Miranda Pope (Canterbury DHB, Perioperative Nurses College NZNO)

Dr Peter Jansen (ACC)

Dr Nigel Willis (CCDHB)

The meeting commenced at 9:30am.

1. **Welcome and apologies**

The Chair welcomed the group and apologies were accepted. The Chair advised the group that the RACS representative, Mr Nigel Willis, has tendered his resignation from the group. The Chair will discuss a replacement with the RACS management team.

1. **Minutes and actions from meeting held on 18 May 2017**

The actions list was considered. All items have been progressed or completed.

**Action:** the approved 18 May meeting minutes will be placed on the Commission website.

1. **Progress report**

The safe surgery monthly report to the end of August 2017 was received and discussed. More detail was provided about the first year of safe surgery QSM results. These were presented as a time series, with supporting descriptions of progress to date. These were used to facilitate discussions with surgeons at the RACS Conference on 17 and 18 August and with theatre nurses at the PNC Conference on 19-21 October. The national summary information was presented in poster format, and detailed DHB results were provided in handouts that surgeons and nurses took away with them to discuss with local teams.

The national summary data demonstrates continuing improvement in results across all three measures. More DHBs achieved the data collection target, more DHBs considered all elements of the surgical safety checklist and more DHBs achieved higher engagement around the checklist. The Sign Out results show a wide range of variation still, with data collection an ongoing issue for some DHBs. Sign Out results also show a number of low uptake and engagement results.

Members of the advisory group want to better understand the performance of high and low scoring DHB surgical teams. The programme team is to develop a set of questions to facilitate these discussions and report back to the advisory group. The questions will develop a better understanding of the quality of audit, a better understanding of the variation in both uptake and engagement results.

**Action:** the programme team will develop a set of questions to facilitate a better understanding of high and low performing QSM results.

The advisory group would also like a letter to go to DHB Surgical Directors around the time the QSM results are next released (July to September results are released in December). The letter will summarise progress so far, describe the variation in results that is beginning to become evident, and ask teams to consider their next focus and actions relating to the teamwork and communication programme.

**Action:** the programme team will send a letter to Surgical Directors with the next QSM results release.

The Safe Surgery NZ landing page on the website has been updated with nine videos demonstrating the interventions and interviews of surgical team members experience of the interventions. These positive examples of a team’s engagement with the surgical safety checklist can be viewed by the public.

1. **Serious Adverse Events 2017 results and trends**

The 2016/17 surgical never events data was tabled. The data includes wrong patient, wrong side/site, wrong procedure and retained objects. The advisory group reviewed the events and recommended some amendments, in particular the removal of technical errors from the report data. The amended table and graph is attached.



The amended number of events (10 in total) is marginally lower than any of the previous four years, and significantly lower than 2015/16 results. This may be the start of a downward trend, but will require continuing observation. Investigation of the actual impact of the teamwork and communication programme on these results will also require further study.

With the new adverse events policy in place from 1 July 2017, events will now be referred to as ‘always report’ events. The programme team will continue to present this information to the group annually.

**Action:** the programme team will present the ‘always report’ event data annually.

1. **Regional workshops, February 2018**

Regional workshops are now planned for February 2018. The focus for the workshop series will be reinforcing the quality of engagement with the checklist and the further establishment of briefing, and then debriefing, in all theatres in all DHBs, and private surgical hospitals as much as possible. Evidencing the impact of the programme to date will be a key part of each workshop. The introduction of briefing is seen as key to positive behavioural change in operating theatre teams and we will invite teams to share their experience of using briefing. The Sign Out component of the checklist will be considered as a possible ‘group workshop’ topic.

The group discussed a range of possible speakers who could present on teamwork and communication, including high profile sports and business teams. The programme team will consider and progress these options. The MORSim programme team will be invited to the workshops and provided with time to present. RACS has been invited to present on the Operating With Respect programme. This will reinforce the interdependencies between the three programmes. If research funding is approved, University of Otago, Wellington researcher Dr Jason Gurney, is very interested in discussing the research project on post-operative mortality inequities between Māori and non-Māori, with surgical teams.

**Action:** the programme team will progress the regional workshop planning.

1. **Article of interest**

An Annals of Surgery paper, *Perception of Safety of Surgical Practice Among Operating Room Personnel From Surgery Data Is Associated With All-cause 30-day Postoperative Death Rate in South Carolina* (Molina, et al) was discussed. The article highlights that for every 1 point increase in the hospital-level (adjusted) mean score for respect, clinical leadership, and assertiveness among all survey respondents, there were associated decreases in the hospital-level 30-day postoperative death rate after inpatient surgery. Higher hospital-level mean scores for the statement “I would feel safe being treated here as a patient” were associated with significantly lower 30-day postoperative death rates.

The authors and journal are prestigious and the findings confirm and support the safe surgery programme approach.

1. **MORSim update**

The Chair, also a member of the MORSim team, updated the group on recent progress. The cohort one DHBs are progressing well. Enthusiasm is very high in a few DHBs and the MORSim team are increasing training opportunities in these teams, sometimes running simulation in two theatres simultaneously. The MORSim team has made multiple rounds of visits to each participating DHB, working towards decreasing input as the DHB builds competency. Small DHBs may require ongoing support from the training team, primarily due to resourcing issues.

The teamwork and communication benefits associated with the simulation exercises reinforce the safe surgery interventions. This programme has a five-year life-span and is seen as key to the sustainability of the Commission programme.

Training for the second cohort of five DHBs will start at the end of 2017. All five second cohort DHBs are signed up and committed to the MORSim programme.

The second tranche of ACC funding, affecting the final 10 DHBs, will be decided before the end of 2017.

1. **Sepsis coding change**

Edition eight of the International Statistical Classification of Diseases and Related Health Problems (ICD) included amendments to the sepsis coding definitions. Sepsis unspecified, has been divided into four codes – two relating to Systemic Inflammatory Response Syndrome (SIRS) diagnoses, one to septic shock and one remaining as sepsis unspecified. The Health Quality and Evaluation team has investigated the impact of the inclusion of the additional conditions in order to make a recommendation to the advisory group, for the ongoing measurement of sepsis rates. After discussion, the advisory group agreed to continue to include code A41.9 (Sepsis, unspecified), start including codes R57.2 (Sepsis Shock) and R65.1 (SIRS of infectious origin with acute organ failure), but exclude R65.0 (SIRS of infectious origin without acute organ failure).

The advisory group requested ongoing updates on both the sepsis rates and the VTE rates.

The Health Quality and Evaluation team confirmed they are open to reporting VTE rates as acute admissions and elective admissions separately. The elective admissions cohort will provide a benchmark for the private surgical sector.

**Action:** the programme team will schedule an update on both outcome measures for the first full meeting of 2018.

**Action:** the health quality and evaluation team investigate reporting VTE rates as acute admissions and elective admissions separately.

1. **Safe Surgery evaluation & Surgical safety culture survey reports dissemination**

The advisory group received, for information only, the final Safe Surgery Evaluation Report and the final 2017 Surgical Safety Culture Survey. These are available to the sector and public through the Commission website.

The repeat of the culture survey means we now have time sequence data, with comparison between the two data points now possible. Comparing the two survey results shows that the programme has made a difference to surgical teams’ perception of patient safety. The demonstrated difference can then be translated into improved outcomes (2017 Molina, et al) such as a decreased hospital-level 30-day postoperative death rate after inpatient surgery. It is estimated that surgical safety culture change (most culture change) has a five to 10 year change cycle. Therefore, the second survey (two years only) suggests the surgical teams have made early and strong progress.

The NZMJ had previously published a perspective piece on the first culture survey report, so a follow up article will likely be of interest to the Journal editor and the sector. The Commission’s Principal Advisor Publications will be approached to support the development of the article, including interviewing the programme Chair/Clinical Lead.

**Action:** the Chair will approach the NZMJ editor about a follow up perspective piece on the second surgical safety culture survey.

**Action:** the programme team will approach the Principal Advisor Publication to write the perspective piece.

**Action:** the programme team will offer the perspective piece about the surgical safety culture survey to the relevant professional colleges, for their newsletters.

1. **Patient deterioration programme update**

The patient deterioration programme specialist, Jenny Hill, provided an update on the programme. This five-year national programme began in July 2016. It aims to reduce harm from failures to recognise or respond to acute physical deterioration for all adult inpatients (excluding maternity) by July 2021.

Currently, the programme team is working with hospitals (DHBs and private surgical) to prepare for and implement improvements to their recognition and response systems for adult patients. The focus is on getting the clinical, local measurement and governance components of the system in place. Acting on patients, families and whānau concerns, discussing patients’ preferences for care early, and making shared decisions about the goals of an episode of care can improve communication, provide better experiences for all involved and ensure appropriate responses to acute deterioration.

The Health Quality and Evaluation team are developing an atlas of variation about patient deterioration, including failure to rescue data, days alive out of hospital, mortality rates, and accident and emergency statistics. The data will improve the quality of questions the national and local teams are able to develop.

1. **Terms of reference review**

The Safe Surgery NZ Advisory Group terms of reference was considered by the group. The only changes requested related to the members’ titles and roles. Once these changes are made the final version will be recirculated, for information only.

**Action:** the programme team will amend the terms of reference and provide the final version to the advisory group, for information only.

The RMO representative on the advisory group is now a qualified consultant and discussion moved to a replacement. The Chair will progress finding a replacement RMO by seeking a recommendation from colleagues.

**Action:** the advisory group Chair will work with the programme team to progress replacing the outgoing RMO representative.

1. **Other business; wrap up**

The next meeting, on 23 November will be the first of the advisory group teleconference meetings. The group discussed how these meetings will be most effective, particularly around development of the agenda, and papers.

**Action:** the programme team will ensure the teleconference meeting agenda clearly identifies key questions and papers highlight where a decision is required from the advisory group.

The meeting finished at 2.30pm.

Next meeting; 23 November 2017

Teleconference meeting

Programme team and Clinical Lead meet at Health Quality and Safety Commission offices