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Supplementary Submission G

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Letter of Support from Anne Daniels for a Patient Safety Commission for Aotearoa New Zealand

Korero Mai – A Polished Narrative on Paper, a Missed Opportunity!

Letter of Support from Anne Daniels, Registered Nurse and NZNO President, for a Patient Safety Commission for Aotearoa New Zealand to the Health Select Committee.

N.B. This is a professional position but does not currently represent the position of NZNO.

Tena koutou katoa.

He mihi nui ki a koutou.

Our current regulation standards state that patient safety must be the highest priority in the provision of health care by health professionals however the current state of the public New Zealand health system does not support this priority. One example of the lack of focus and action on patient safety within the public health system is the failure to fully implement and integrate the Kōrero Mai strategy within te Whatu Ora, let alone any other health sector.

Kōrero Mai is a strategy that is meant to address communication issues which are at the heart of the majority of complaints from people using public hospital services. It was to be fully implemented by 2021. The strategy is based on 'Ryan's Rule' which encourages communication with the healthcare team to support patient safety and well-being. The 3-step process supports patients, families and carers to raise concerns if a patient's health condition is getting worse or not improving as well as expected.

The three steps are as follows:

(1) speak with a doctor or nurse

(2) ask to speak with the nurse in charge of the shift or the doctor on duty

(3) request a Ryan's Rule clinical review by phoning …….

Ryan's Rule is similar to the broad tenets of Martha's Rule – which has been tested in 143 sites in England, but there are some key differences. NHS staff at these pilot sites were also empowered to activate Martha's Rule, to seek an independent review for the patient from outside their current treating team. Nearly 10% of Martha's Rule activations have been staff-led, suggesting that NHS staff are not always able to raise concerns through the usual escalation pathways.

Implementing Martha's Rule across the NHS in England or the UK presented a major change, requiring a significant investment of resources by the NHS as the already stretched rapid response teams were expected to bear the brunt of providing a 24/7 safety net.

In Australia, alternative pathways of response are already being devised to suit the needs of each service. Experience suggests that the response needs to be rapid, and nurse- or doctor-led, but not necessarily activating the full rapid response team. There is also a need for organisational cultural change - not just a technical change - for this to succeed.

Kōrero Mai is a strategy to prevent avoidable harm or death. However, pilot studies in New Zealand have identified a reluctance of patients and/or their families to escalate concerns, due to the idea of nursing staff being 'busy' or 'not wanting to disturb' nurses. The current context of nurse and doctor strikes protesting severe understaffing and unsafe workloads, and court cases that have been taken by NZNO to obtain an appropriate response by te Whatu Ora regarding nursing staff's repeated reported unsafe staffing concerns, reflect the experience of patients and/or their family's observations.

In a context where there is pervasive unsafe staffing within public hospitals, less time is spent at the bedside with patients, increasing the likelihood of patient acuity changes or concerns going unnoticed, except by the patient or their families. This is why the strategy of Kōrero Mai must fully resourced, socialised, implemented consistently, evaluated and reported transparently so that te Whatu Ora can be accountable for ongoing improvement using quality processes.

Over the last six months I have been presenting on Violence and Abuse in the health work environment, where healthcare workers are five times more likely than any other worker to experience violence and/or abuse in the workplace. Increasing violence and abuse is associated with long wait times, increasing patient and family anxiety and concern. Included in the presentation is the issue of the power imbalance between healthcare workers and patients/families which have led to concerns not being heard in a context where nurses and other healthcare workers are 'too busy', leading to prioritisation of who gets care and who doesn't.

A recent example of this scenario is the experience of Jane Brunts' family (see The Hui for link), where the concerns of Jane's partner were not heard, and Jane collapsed and died in as ED wait room. Jane's partner was seen as aggressive when he tried to escalate his concerns and security was called. He was not aware of the Kōrero Mai system.

I reviewed many DHB websites to understand how Kōrero Mai appears to the public. There was no consistency in the Korero Mai processes across the DHBs. Some approaches increased barriers to raising concerns. At each regional presentation I also asked NZNO members if they knew about the Korero Mai strategy and whether they had seen the posters. Few members knew of the strategy or had seen the poster. While this is not a scientific approach to understand the scope of integration of Korero Mai into practice, the response from members around the country was consistent. Few knew about Kōrero Mai, suggesting that a big opportunity for change in improving patient safety has been missed.

An analysis of complaints to the Health and Disability Commissioner involving district health boards (DHBs) for the period 1 July 2016 to 30 June 2017 states: 'When all issues raised in complaints were considered, concerns about a failure to communicate effectively with the consumer were the most prevalent…' 1

There is a lack of cohesion between organisations responsible for patient safety. Further a lack of authority and legislative ability of any organisation that purports to improve patient safety to enact measurable or effective change is a major barrier to change. Incident reporting processes within te Whatu Ora, the Health and Disability Commissioner functions, occur after the fact i.e. they do not

stop potential patient harm as it occurs. Kōrero Mai has the potential to do just that, if it was fully implemented and resourced. The fact that it has not been fully implemented, and poorly socialised amongst patients, families and health care staff, is reflective of the growing message from the New Zealand public that patient safety is not being taken seriously enough.

Systemic failings continue to enable avoidable harm, while polished narratives obscure the stark reality faced by patients and health workers alike. Our health system must transform from one that reacts after harm occurs to one that actively prevents it.

The establishment of an independent Patient Safety Commission (PSC), underpinned by the principles and values inherent within our founding document, te Tiriti o Waitangi, represents a vital safeguard for Aotearoa. This role would focus on systemic risks, ensure early identification of medical harm, drive improvements in safety standards and processes**, and amplify the voices of patients, staff, and whānau, especially in decisions that impact them directly.**

Establishing a Patient Safety Commission is a necessary and overdue reform to restore public trust, drive systemic change, and elevate the patient voice at the highest level. We cannot continue to allow the patient and family voice to be silenced and ignored. A dedicated, legislated, and independent Patient Safety Commissioner is urgently needed to protect the public, prevent harm, and ensure system-wide learning and accountability to those we care for and must be heard through systems such as Kōrero Mai.

Thank you for listening to my voice, as a practising Registered Nurse of over 45 years, and an occasional patient within the public health system.

Anne Daniels

Registered Nurse.