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Elective Services Pathway Programme Outcomes Work Stream Lead
ACC

Tēnā koe Nina

Re: Elective Services Pathway Programme

The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on ACC's proposed elective services pathway programme.

NZNO has consulted its members and staff in the preparation of this submission, in particular our professional nursing, industrial, policy, research and legal advisers, Te Runanga, Regional Council and Board members and members of our specialist Colleges and Sections – in particular the Perioperative Nurses College and the Private Hospitals Sector Group.

NZNO is supportive of measures that will improve patient care and quality. NZNO note a number of areas where the proposed indicators could be improved and list these under their respective indicators below. We also encourage ACC to continuously review their services to ensure the original Woodhouse Principles of community responsibility, comprehensive entitlement, complete rehabilitation, real compensation and administrative efficiency continue to underpin the work of ACC.

Quality indicator 2:

In private hospital environs they do not have readmissions. Patients instead go to other providers. NZNO are concerned that complications from surgery initially undertaken in private hospitals will not be captured in this data. If, for example, the patient was to receive subsequent services in a DHB the indicator would not capture complications that emanated from the initial surgery.

Quality indicator 3:

Many cases arrive at a hospital the day of surgery, but this does not mean all cases. The denominator "total number of elective surgery patients that are admitted on the day of

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surgery" needs to change to "total number of elective surgery patients booked/scheduled for surgery".

Quality indicator 6:

NZNO members note no ACC patients are cancelled due to scheduling issues in private settings, but they are cancelled due to the clinical status of the patient, e.g. not fasted, clinically unwell, poor communication. The indicator needs to capture this issue.

Quality indicator 7:

As this indicator has not yet been developed by the Health Quality and Safety Commission, NZNO and the Perioperative Nurses College (NZNO) request consultation on the indicator regarding surgical team engagement and compliance with the three evidence based components.

Quality indicator 10

NZNO would like to point out that indicator 10 refers to the '5 movements' of hand hygiene. The correct terminology is the 5 moments of hand hygiene. This needs to be corrected throughout the document.

Quality indicator 11:

NZNO recommend removing "diagnosis by the surgeon or attending physician" under the Superficial Inclusion Criteria. The other two classifications do not rely on the surgeon to diagnose infection: it is done via clinical methods. It might pose a risk for patients if the surgeon is not available, or will not declare an area infected – if it is to be recorded as an adverse outcome, people may not wish to declare an infection. It is possible that other providers can declare the wound infected e.g. GP, district nurse, Nurse Practitioner, wound specialist nurses, surgical nursing staff etc.

NZNO also note that indicator 11 'Measures the reduction in orthopedic wound infection rates for a given hospital' assumes a reduction in wound infection rates. The indicator should measure orthopaedic wound infection rates, to capture both increases and reductions.

Quality indicator 13:

The denominator for indicator 13 measures the number of inpatient bed days in the quarter (calculated on the midnight consensus method). The denominator "bed – midnight census" does not account does not take into account the turn-over of inpatient beds in a 24 hour period i.e. churn and throughput. There is only one patient in the bed at midnight, but there could have been three patients in the bed during the day which is occurring increasingly frequently. There is a need to use actual numbers of patients as the denominator. Churn or high patient turnover can contribute to infection rates and this needs to be accounted for in staffing numbers. Aiken et al (2002) clearly indicates that in hospitals with high patient to nurse ratios, surgical patients experience higher risk-adjusted 30-day mortality and failure to rescue rates.

Quality indicator 14:

NZNO members report issues for health consumers who have had cover declined and who lack an advocate to assist them. The more health literate the health consumer is the better chance they have of accessing surgery. Patient satisfaction indicators have not

captured the patient experience going through the ACC process and elective surgical pathway. NZNO recommend the addition of indicators relating to ACC processes.

ACC has also indicated that if a facility conducts patient reported experience measure (PREM) data, ACC would look to collect those results. Individual facilities may have specific areas of interest they may be focusing / requesting patient feedback on. PREM data may be facility sensitive. It is unclear how ACC would use PREM data when the level and type of data will differ between facilities.

NZNO would like to see more emphasis on measuring patient quality of life (QOL) indicators through a planned approach. For example indicator 11 provides detailed criteria on the infection status and diagnostic codes, but no indicators on how a surgical site infection affects the patient quality of life. QOL data should sit alongside all clinical data and process data whereby keeping the patient the central focus.

There is nothing in the quality indicators specific to Māori. This is contrary to the recognition given to the Tiriti o Waitangi in ACC's Statement of Intent 2015-19 and its stated aim "to support the Crown in its Treaty of Waitangi relationships and deliver our services in ways that enable equitable outcomes for Māori" (ACC, 2015, p29). It is difficult to see how ACC can improve equity for Māori (who are over represented in high risk industries) without specific quality indicators. Although the leading causes of morbidity and mortality among Māori are chronic diseases, Māori suicide rates are nearly twice as high as non-Māori, Māori adults were more likely than non-Māori adults to suffer adverse health effects as the victims of violence, Māori rates of hospitalisation as the result of assault or attempted homicide were also significantly higher than those for non-Māori, Māori children aged 0–14 years had an unintentional injury mortality rate three-and-a-half times that of non-Māori children in the same age group in 2010–12, and Māori adults aged 15–64 years had an unintentional injury mortality rate more than one-and-a-half times that for non-Māori adults in the same age group (Ministry of Health, 2015). Given these disparities and the fact that Māori should therefore be more likely to present for elective surgery, a measure specific to Māori health outcomes is appropriate. It is essential that proactive measures are undertaken to improve Māori health outcomes. NZNO strongly recommend the inclusion of a measure to ensure Māori have equitable access to elective surgery.

Further, as Māori health professionals, Te Rūnanga draws your attention to Article 24.2 of the United Nations Declaration on the Rights of Indigenous Peoples which states that '*Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realisation of this right'* (United Nations, 2008).

While we acknowledge ACC (2008) guideline *Te tūroro Māori me o mahi The Māori patient in your practice: Guidelines on Māori cultural competencies for providers*, it is extremely disappointing that we see little evidence of this excellent work in the ACC's quality indicators. This is not acceptable or just, given te Tiriti o Waitangi is the foundation document in Aotearoa New Zealand's bicultural heritage. We would strongly recommend that ACC would have a Māori specific quality indicator to ensure that Māori have equitable access to culturally appropriate elective surgery services.

Te Rūnanga welcome the opportunity to have further involvement in the review of the quality indicators.

NZNO thanks ACC for the opportunity to comment on the elective services pathway programme.

Nāku noa, nā

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References

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NEW ZEALAND NURSES ORGANISATION (NZNO)

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 46,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces Te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse.*