

# Commission on Patient Safety and Quality Assurance

## Minutes of 6<sup>th</sup> meeting

14 June 2007

### Summary of Action Points

	Action	By whom	Deadline
1	A scoping document to be prepared outlining the research requirements for sub-groups 2 & 3	Luke Mulligan in conjunction with Hilary Coates (sub-group 2) and Aidan Clancy (sub-group 3)	Next meeting
2	In the event of members' non attendance at plenary session, observations on minutes to be forwarded to secretariat in advance of meeting.	Commission members	
3	Subgroup reports to be produced  Circulate	Chair (or deputy chair) of each subgroup  Secretariat	ASAP

#### Commission Members in attendance:

Chair: Dr. Deirdre Madden, Senior Lecturer in Law, University College Cork  
Dr. Richard Brennan, General Practitioner, Kilkenny  
Mr. Tim Delaney, Head of Pharmacy, AMNCH  
Ms. Edwina Dunne, Head of Quality & Risk, HSE  
Ms. Mary Duff, Director of Nursing, St. Vincent's Hospital  
Mr Paul Fox, Process Engineering Manager, Bausch and Lomb, Waterford  
Mr Tiberius Pereira, Patient/Carer Representative, Dublin  
Dr. Gabriel Scally, Regional Director of Public Health, NHS  
Mr Dermot Smyth, Assistant Secretary, Department of Health and Children

#### Secretariat:

Mr. Luke Mulligan, Department of Health and Children  
Ms. Susan Reilly, Department of Health and Children  
Mr Aidan Clancy, Department of Health and Children  
Ms. Elaine Tallon, Department of Health and Children  
Ms. Ailish Corr, Department of Health and Children

#### Introductions

The Chair opened the meeting and thanked those in attendance.

#### Agenda Item 1 – Apologies

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Dr. Eibhlín Connolly, Deputy Chief Medical Officer, Dept of Health and Children  
Dr. Tracey Cooper, CEO, Health Information and Quality Authority  
Dr. Mary Hynes, Director of Quality and Risk, National Hospitals Office, HSE  
Ms. Margaret Murphy, Patient/Carer representative, Cork City  
Dr. Alf Nicholson, Consultant Paediatrician, Our Lady of Lourdes Hospital  
Dr. Ailis Quinlan, Clinical Indemnity Scheme

## **Agenda Item 2 - Minutes of Previous Meeting / matters arising**

The minutes of the last meeting were agreed. The Chair requested that any comments on the minutes as circulated should be sent to the secretariat and that minutes would be approved at each meeting for publication on the website.

### **Action points from minutes**

Action Point 1 – It was noted that all research and administrative resources were now in place. The proposed working structure for the three sub-groups was outlined. The Department of Health and Children will provide research resources on Governance of Regulatory Bodies in the autumn in time to report with the other sub-groups.

Mr. Mulligan will provide overall co-ordination function for the Commission with researchers reporting on a regular basis to him and submission of all draft documents through him. He will liaise with the Chairs of the sub-groups as required.

There was a short discussion about the possibility of moving the issue of adverse event reporting to sub-group 1. The consensus was to leave the remit of the groups as originally defined for now.

Action Point 2 – As there was no consensus on any alternative dates suggested for the July meeting, it was agreed that the meeting will take place on 5 July as previously scheduled. The Commission will also meet with Mrs. Rebecca O'Malley on that date to discuss the issue of adverse event disclosure to patients.

It was suggested by the Chair that it may be necessary to meet more frequently from the autumn in order to meet the deadline set for the group. It was also suggested that sub-groups might like to convene their own meetings on separate dates in order to achieve their objectives over the coming months. This will be facilitated by the secretariat.

Action Point 3 – The Chair noted that subgroup reports had been completed and circulated.

## **Agenda Item 3 – Correspondence**

Members were advised that a replacement had been sourced for Prof. Fergal Malone. Professor Muiris FitzGerald, Physician, has been appointed by the Minister and the Commission looks forward to working with him.

## **Agenda Item 4 - Subgroups**

The Chairs of sub-group 1 & 3 presented a verbal report from the earlier subgroup meetings. Sub-group 2 did not meet on this occasion due to non-availability of members. Sub-group 1 presented a scoping document on the work of the group. It was agreed that that all relevant documentation should be circulated prior to the subgroup meetings. A written report from each subgroup will be prepared by the Chair of each subgroup and circulated via the Secretariat.

**Agenda Item 5 – Presentation by Gabriel Scally – “Getting the right professional and getting them to do the right thing: credentialing and privileging”** (presentation to be circulated)

The main tenet of Dr. Scally’s presentation was that it was incumbent on organisations not to facilitate the admission of rogue practitioners into the system. The importance of having the right people delivering the service was stressed.

The following points were made:

- The processes used in recruiting doctors to key posts needs to be improved – those making recruitment decisions are sometimes unaware of major problems with a doctor’s previous performance - the risk of hiring based on references was highlighted;
- The process of recruiting personnel based on a written curriculum vitae generated by the applicant, self appointed referees, review of an application and an interview conducted by a panel is unsatisfactory;
- Credentialing of medical staff would help avoid serious recruitment mistakes - credentialing involves reviewing the qualifications and track record of doctors and other professional staff;
- Credentialing is an important element of the risk management process in the US. One of the important elements in credentialing in that jurisdiction is the National Practitioner Data Bank which includes details of practitioner’s qualifications, disciplinary actions or litigation against them. Notification is mandatory;
- Individuals have the right to review their own record and can challenge the data held about them on the Data Bank;
- Some concerns were expressed around issues of fair procedure etc;
- 'Privileging' relates to the procedures which individual practitioners were allowed to undertake following employment or the medical conditions that they may take responsibility for treating;
- In the UK ‘Alert Notices’ are issued where serious concerns are raised about a practitioner. This is a formal way by which an employer can make other bodies aware that a healthcare professional may pose a threat to patients or staff. On an informal basis ‘grey letters’ (perhaps phone calls) were used. They are intended as a means of alerting prospective employers to check the applicant's employment record and take up references in advance of appointment.
- It was suggested that this could have a profound effect on an individual medical professional’s livelihood;
- The question was raised about the need for ‘alert notices’ where credentialing and privileging were in place;

- Also in the UK, a ‘Smart Card’ was in existence for Non Consultant Hospital Doctors, which was secure, streamlined and reliable, giving details of immunisation status and work record. This has also been introduced into medical schools.

**Agenda Item 6 – Presentation by Paul Fox – “Quality Assurance systems used in the pharmaceutical and medical device industries” – to be circulated**

The main tenet of Mr. Fox’s presentation was the importance of building and maintaining good quality systems.

The following points were noted:

- Quality system based on 8 universal principles – based on customer requirement, output based on customer satisfaction;
- All quality models have four major factors:  
*Management responsibilities i.e. incumbent on management to provide leadership;*  
*Resources – people i.e. continuous training and equipment – equipment must be fit for purpose;*  
*Manufacturing Operations i.e. have procedures for everything you do; and*  
*Evaluation Activities i.e. complaint handling, internal audits.*
- Who is responsible for halting/resuming operations, recording non conformities, investigating and taking remedial action – remedial action often involves retraining;
- Preventative action involves predicting what could go wrong: corrective action involves identifying actions to fix the problem;
- It was noted that while the terminology may be different between manufacturing industry and traditional healthcare, the content and tools for providing a quality service were similar.

**Any other Business**

None

**Next meeting**

Thursday 5 July 2007 – Conrad Hotel, Earlsfort Terrace, Dublin 2  
Dr. Tracey Cooper will give a presentation.

Signed \_\_\_\_\_

Date \_\_\_\_\_

Dr Deirdre Madden

Chairperson

Commission on Patient Safety and Quality Assurance