Waitematā
District Health Board

Best Care for Everyone

DHB Board Office
15 Shea Terrace
Takapuna, Auckland 0622
Private Bag 93-503, Takapuna
North Shore City 0740
Telephone: 09 486 8900
Facsimile: 09 486 8924
www.waitematadhb.govt.nz

18 February 2020

[redacted]

Dear [redacted]

Re: OIA request - Communications in relation to informed consent in 2018 and 2019

Thank you for your Official Information Act request received 17 December 2019 seeking information from Waitematā District Health Board (DHB) about communications in relation to informed consent in 2018 and 2019.

In addition to your original request (questions 1 to 6) you contacted us on 18 December 2019 to add another question (see question 7).

Before responding to your request, it may be helpful to provide the following context.

Since issues were raised in 2013, Waitematā DHB has undertaken a systemic review of our informed consent processes, confirming that they meet legislative requirements and Medical Council benchmarks. However, there is still some work to do around ensuring that there is national consistency around informed consent.

Our position on RMOs (Resident Medical Officers) has not changed since 2014, as outlined in the consent policy and again in the joint letter from our Chief Executive Officer (CEO) and Board Chair to the Director-General of Health in December 2019 (provided in our earlier response).

Waitematā DHB's view is that, within the context of a teaching hospital environment, there is generally no requirement to obtain specific consent to the participation of a RMO, who is employed as a member of the clinical team providing care.

However, as the letter states, if a RMO is to undertake a procedure under the supervision of a Senior Medical Officer (SMO) which the RMO is not yet qualified to do on their own, so far as reasonably practicable, the patient's consent to the RMO's participation should be obtained.

We expect that an RMO should introduce themselves to the patient and explain their role. If the registrar is asked directly about their training level/competence, they should respond honestly and appropriately. The overall process of consent for a procedure should notify the patient of the potential for appropriately supervised training to occur during their procedure.

Our 2018 (current) consent form states:

> ***I agree that:***
>
> *I understand that my...care is occurring in a teaching hospital and there may be healthcare students (medical, nursing) present. I understand they will be appropriately supervised but at any time I can ask for them not to be present.*
>
> *I understand that no assurance can be given that a particular clinician will be performing my... procedure but that the clinician will be suitably qualified, and if in training, will be appropriately supervised by a senior clinician.*

We do not expect that a separate written consent needs to be completed by the patient for any training of an RMO to be permitted. However, we have undertaken to make changes to improve the wording on the consent form to ensure further clarity. Professor Ron Paterson is advising us on this and the first draft of changes is currently being reviewed by the Informed Consent Steering Group.

Our Institute of Innovation and Improvement (i3) has undertaken a number of workstreams around clinical education and improving ways to deliver information to patients and whānau about the patient journey through the treatment and consent process.

A key part of our review has included working with Waitematā DHB's Consumer Council, which is made up of lay people from across the North Shore, Waitakere and Rodney areas. The council is a valuable way for the community and consumers to have input into healthcare planning, quality improvement and maintaining the delivery of high-quality, safe and accessible services.

We have taken the issue of consent and the form to the Consumer Council on two separate occasions in 2019 – once with our Director of Patient Experience leading, and once with our immediate past Chief of Surgery as the lead. Valuable feedback was gained on a range of elements in the whole process.

Waitematā DHB has robust policies and processes for informed patient consent and has continued to work to refine these over recent years. We expect our staff to meet legislative and regulatory requirements for informed consent as well as any national guidelines, such as those for medical students.

We take any concerns raised by our staff seriously. We have acted on these, as is shown in the repeated responses to the theatre nurse's concerns since 2013.

We remain focussed on continuously improving the quality, safety and experience of care for our patients and their whānau.

In response to your full request, we can provide the following information:

RNZ requests WDHB provide the following information in full:
[Please provide all information in fully searchable form, with NHI numbers or other patient identifiers redacted to guard privacy.]

1. **Any and all communications, including emails (but excluding purely administrative emails), about informed consent or lack thereof, for the period all of 2018 and all of 2019, to or from or between:**
   a. **Stephanie Doe** **Attachment 1**
   b. **Dr Meia Schmidt-Uili** **Attachment 2**

c.	**Cath Cronin**	**Attachment 3**
d.	**Jocelyn Peach**	**Attachment 4 & Attachment 4a**
e.	**Jonathan Christiansen**	**Attachment 5**
f.	**Judy McGregor, Board Chair**	**Attachment 6**
g.	**Dale Bramley**	**Attachment 7**

We have provided internal emails to, from or between the people listed, where those people are named as either the sender or primary recipient of an email in date order for 2018 and 2019 where the main purpose of the email is addressing issues related directly to informed consent. We have excluded purely administrative emails.

Attachment 4a provides context around an email giving feedback about an informed consent theatre education session. This was the first of two sessions. While some of the feedback in the email appears to criticise certain aspects of the session, a Survey Monkey report shows a balance of more positive and constructive comments. The feedback on this first session allowed the team to reframe the follow-up session to better meet the needs of clinical staff. This second training session, attended by 70 people, received almost universally positive feedback, as outlined in the Survey Monkey report, included in this attachment.

Also attached are agendas and minutes of the Informed Consent Steering Group meeting where either or both Cath Cronin or Jonathan Christiansen were in attendance:

Informed Consent Steering Group agendas for 2019	**Attachment 8**
Informed Consent Steering Group minutes for 2019	**Attachment 9**

2. **Please include any and all communications including emails (but excluding purely administrative emails), from or to or between the above and the theatre nurse (name redacted from your request for privacy reasons) for those periods and on that subject.**

a.	**Stephanie Doe**	**Attachment 10** (relevant mails are included in other attachments in this response. A letter to the theatre nurse was supplied in the previous OIA)
b.	**Dr Meia Schmidt-Uili**	**none**
c.	**Cath Cronin**	**Attachment 11***
d.	**Jocelyn Peach**	**Attachment 12**
e.	**Dr Jonathan Christiansen**	**none**
f.	**Judy McGregor, Board Chair**	**none**
g.	**Dale Bramley**	**none**

We have provided emails to, from or between the people listed and the theatre nurse where the theatre nurse is either the sender or primary recipient of an email in date order for 2018 and 2019 related directly to informed consent. Emails that are purely administrative have been excluded.

To protect the nurse's privacy we have withheld other information relating to matters she has raised regarding her employment. This information is withheld under Section 9(2)(a) of the Act to protect the nurse's privacy and under S9(2)(b)(ii) in order to protect the confidentiality of the employment relationship and because we believe making them available would be likely to damage the public interest in ensuring that matters relating to employment relationships can be dealt with confidentially.

*With regards to page 3 of Attachment 11, please note that the full study day on 21 May for SMOs referred to in that email was not in fact scheduled and, therefore, did not occur. We have confirmed that the reference to Dr John Tait working with MidCentral DHB is incorrect as this did not occur.

3. **Please include any request by Dr Christiansen to Cath Cronin, or any other Waitematā DHB manager, to review cases involving informed consent or lack thereof.**

Dr Christiansen did not ask Cath Cronin or any other Waitematā DHB manager to review cases involving informed consent. We are, therefore, declining this element of your request under 18(d) of the Act on the grounds that the information requested does not exist.

However, Cath Cronin asked Dr Christiansen to provide expert advice in 2019 and we are providing a copy of this email communication - **Attachment 13**.

4. **Please provide the main report done at the time of any notifications on this subject made by any nurse/s or other health practitioner to their manager or others in leadership, for this period.**

Our response to your earlier OIA request received on 3 December, 2019 outlined that we are only able to undertake a formal review of cases where patient NHI numbers or sufficient identifying details are available (see question 3, page 9 & 10). We reviewed cases where these details were provided and found that only one case was inconsistent with our policy on consent. We provided a summary of that case to you.

   a. **All and any Riskpros done by any nurse/s or other health practitioner/s where the main subject is informed consent or lack thereof, or is the outcome of informed consent or lack thereof, including any and all Riskpros that notes any negative medical outcome.**

As per our previous response, referred to above, we are withholding the records relating to that case under section 9(2)(a) of the OIA in order to protect the patient's privacy. We provided a summary of the case with our previous response and ask that you refer to it.

5. **Please detail any and all transfers to Auckland Hospital of maternity patients for highly specialised treatment in full or in part as a result of, or linked to, Waitematā DHB use of students or first or second-year health practitioners in procedures involving those patients.**

No maternity patients have been transferred to Auckland Hospital for highly specialised treatment in full or in part as a result of, or linked to, Waitematā DHB's use of students or first or second-year health practitioners in procedures involving those patients.

6. **Minutes and outcomes of any meeting in the period July-Dec 2019 that covered informed consent or lack thereof in any way, between New Zealand Nurses Organisation (NZNO) or NZNO agent or delegate and Karen Hellesoe and/or Cath Cronin and/or Dale Bramley and/or Jonathan Christiansen.**

During this time period, there was one 30-minute meeting on 8 July, 2019 attended by Jonathan Christiansen, Cath Cronin (who left the organisation in August 2019), the theatre nurse and an NZNO delegate. The purpose of this meeting was to review specific cases around the supervision of medical students in theatre. While no notes or minutes were taken, the intended outcome was that Cath Cronin would continue to meet regularly with the theatre nurse and NZNO.

However, all further meetings were subsequently declined by the theatre nurse and NZNO as their preference at that time was to meet with the Chair of our Board before continuing with these informal meetings.

Two meetings that took place between Karen Hellesoe and an NZNO representative during this time period relate to private employment matters regarding the theatre nurse. The minutes and outcomes of these meetings are withheld under section 9(2)(a) to protect the privacy of the theatre nurse. We are also declining this aspect of your request under section 9(2)(ba)(ii) on the grounds that the records are subject to the obligation of confidence between Waitematā DHB as employer and the theatre nurse as employee and making them available would be likely to damage the public interest in ensuring that matters relating to employment relationships can be dealt with confidentially.

On 18 December, you contacted us to request the following additional information:

7. **Release any and all communications including email attachments, between Dale Bramley and Memo Musa in 2019, that refer to informed consent at Waitematā DHB.**

We have no record of any such communications. This part of your request is, therefore, declined under section 18(e) of the Act on the grounds that the information does not exist.

As you will have noted, we have withheld information on various grounds under sections 9(2)(a) and 9(2)(b)(ii) of the Act and have refused some parts of your request under section 18(e) on the grounds that the information does not exist.

You have the right to seek an independent review of any of the decisions taken in providing this response by contacting the Office of the Ombudsman via www.ombudsman.parliament.nz.

I trust that this information is helpful.

Waitematā DHB supports the open disclosure of information to assist community understanding of how we are delivering publicly funded healthcare. This may include the proactive publication of an anonymised version of this response on our website from 10 working days after the response is released.

If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider your views.

Yours sincerely

Dr Jonathan Christiansen
Chief Medical Officer
Waitematā District Health Board

Attachment 1

Denise Poole (WDHB)

Subject: FW: Actions following up informed consent concerns

From: Stephanie Doe (WDHB)
Sent: Tuesday, 15 January 2019 1:22 p.m.
To: Lyn Wardlaw (WDHB); Diana Ackerman (WDHB); Meia Schmidt-Uili (WDHB)
Cc: Debbie Eastwood (WDHB)
Subject: Actions following up informed consent concerns

Hi everyone
Just following on from our meeting with [redacted] late last year... here are the list of agreed actions and timeframes.
Could you please send me through a quick update or confirm that all is on track?
Thanks
Steph

Action	Status	Due Date	Responsibility	Comments
Provide all RMOs with a hard copy of the Informed Consent policy and ensure that the requirements are understood. All RMOs sign a letter acknowledging this.	Completed	19/12/2018	Diana Ackerman	Completed.
Organise a meeting between [redacted] DA, AB and LW. Stephanie will facilitate this – but date to be confirmed, as Adele is on annual leave this week.	Yes	Jan-19	Stephanie Doe	Meeting scheduled for 22 Jan.
Meia to meet with Diana to review the cases where concerns have been identified.	Yes	19/12/2018	Meia Schmidt-Uili	
Meet with Debbie Eastwood and Mike Rodgers to discuss the development of the informed consent training module and the opportunity to modify and implement this across all surgical specialities.	Yes	Jan-19	Lyn Wardlaw	Met with MR – initially weary of reviewing the consent form, however will keep an open mind

Ensure that there is a clear and agreed process in place for the nursing team to escalate specific concerns about clinical practice, supervision or consent in theatre.	Yes	Jan-19	Lyn Wardlaw	Ulrike to raise with O&G Nursing theatre team to agree processes
Meet with nursing team who work in the obstetrics and gynaecology theatres to discuss how they can support the consistent implementation of the informed consent policy and how they can escalate concerns.	Yes	Jan-19	Lyn Wardlaw	As above
Complete the review of the consent form and present the recommendations to theatre leadership group.	Yes	20/02/2019	Lyn Wardlaw	
Develop an orientation and training package on informed consent. This will include information on the DHB policy, the consent form, documentation expectations and legislative requirements.	Yes	28/02/2019	Stephanie Doe	Development work to commence 21 Jan.
Commence auditing of informed consent.	Yes	Apr-19	Lyn Wardlaw	

Denise Poole (WDHB)

From: Meia Schmidt-Uili (WDHB)
Sent: Wednesday, 19 December 2018 12:28 p.m.
To: Stephanie Doe (WDHB); Cath Cronin (WDHB)
Cc: Diana Ackerman (WDHB)
Subject: RMOs and Informed Consent Policy

Hi Steph,

he signed inform consent forms are in your office. They include the registrars and SHOs. The Chief Resident will FU with the 3 who were on leave or away.

The incident on the 10th December has been attended to appropriately in this session.

Thank you Di for doing this at such short notice – we really appreciate it.

Cheers
Meia

From: Stephanie Doe (WDHB)
Sent: Tuesday, 18 December 2018 4:34 p.m.
To: Cath Cronin (WDHB)
Cc: Meia Schmidt-Uili (WDHB)
Subject: Letter to [redacted] (Draft v2).docx

Hi Cath
Jpdated letter for your review... also, we have attached the form for RMOs to sign.
Diana will be attending handover at 8am to complete this (all RMOs who are not on leave attend this meeting)
If all looks ok – I will send the letter to [redacted] first thing tomorrow
Thanks
Steph

Stephanie Doe I **General Manager**
Child, Women & Family Service I Waitemata DHB
m: 021 246 2718
www.waitematadhb.govt.nz

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Child, Women& Family Services
Waitakere Hospital
55-75 Lincoln Road, Henderson
Private Bag 93-115, Henderson
Auckland 0650
Telephone: 09 838 1846
Facsimile: 09 838 1789

19 December 2018

[redacted]

Dear [redacted]

Thank you for meeting with Dr Meia Schmidt-Uili, Lyn Wardlaw, Jocelyn Peach and me yesterday. I appreciate you taking the time to meet with us. From our discussions I am aware that you have raised these issues for a number of years. I know that this has been a frustrating process for you and I apologise for the time delay. I am committed to working on addressing and resolving these issues with you. I have committed to Cath Cronin that we will achieve a sustainable way of working.

As we discussed, I have summarised the actions taken to date and the plan that we have in place below.

We initially met on 16 October 2018 where you outlined concerns about the way in which informed consent was being managed in theatre and, specifically, within the obstetrics and gynaecology theatre in which you work. You also expressed concerns about the oversight and supervision of junior medical staff working in the obstetrics and gynaecology theatres. At the meeting we agreed:

- You would send a list of patient NHIs that demonstrated your concerns
- Meia and I would meet with Dr Diana Ackerman (clinical director gynaecology) and Dr Helen Allen (acting clinical director obstetrics) to discuss your concerns
- Lyn and I would meet with Debbie Eastwood to discuss the broader theatre issues
- I would arrange a follow up meeting

On 17 October 2018 you sent me the list of patient's NHI numbers. I forwarded these through to Meia on 18 October 2018.

On 18 October 2018 I advised Cath Cronin, Debbie Eastwood and Dr Mike Rodgers that we had met and of your concerns.

On 23 October 2018 Lyn and I met with Debbie Eastwood to discuss your concerns about the way in which consent was being managed in theatre. At this meeting it was agreed that Lyn would undertake a review of the consent form to ensure that it was aligned with the Waitemata DHB informed consent policy and was auditable. This review is currently underway. Lyn will present the findings of the review and her recommendations at the February 2019 theatre leadership group meeting.

On 8 November 2018 Stephanie and Meia met with Helen Allen to discuss your concerns. Unfortunately Diana Ackerman was unable to attend, as she needed to cover an acute duty at short notice. Helen advised that she was aware of your concerns about the oversight of junior medical staff and had addressed a specific issue that had been escalated to her. Specifically, she had

reiterated the requirement for appropriate supervision and oversight and requested that the lead training supervisor follow up individually with the registrar involved. It was good to get your feedback yesterday that there has been an improvement in the level of oversight and supervision that is being provided. Helen also stated that she felt there was an opportunity to improve the information being provided to women before they have an elective caesarean and that she had asked the midwife co-ordinator quality undertake a review.

As Diana was unable to attend the meeting, Meia talked with her separately about our discussions to date and the issues you had raised.

On 12 November 2018 we met to provide an update on actions taken to date and the plan in place. We also talked about the review of the patient information that Helen had requested and asked if you would like to be involved in this. Later that day I linked you in with the midwife co-ordinator quality who was leading the review. I understand from our discussion yesterday that you have met with Dee. We agreed that we would meet again the week before Christmas (yesterday's meeting) and that I would organise this.

Further to the above, Diana has advised that she has talked with you directly about your concerns. Following this she has suggested that Dr Adele Barr (who has just taken on the role of lead training supervisor) and she meet with you. Since then, Diana has written to Adele to advise her of your concerns. She has also met with the chief registrar.

Meia has also requested that Diana send a copy of the informed consent policy out to the team and highlight the informed consent requirements, including documentation. However, as discussed, and outlined below, we will be developing an informed consent orientation module for all staff (both new and existing).

There are a number of further actions that are underway and/or planned. These are listed in the table below:

Action	Responsibility	Timeframe
Immediate action as per Director Hospital Services All RMOs working in Obstetrics and Gynaecology will be required to receive a hardcopy of the consent policy and will meet with Diana Ackerman (clinical director gynaecology) to ensure that the policy is clearly understood by the RMO. The RMO then signs a letter acknowledging this. This will be completed at handover (attach template of form for RMOs).	Diana Ackerman	19 Dec 2018
Organise a meeting between [redacted] Diana, Adele and Lyn. Stephanie will facilitate this – but date to be confirmed, as Adele is on annual leave this week.	Stephanie Doe	Jan 2019
Meia to meet with Diana to review the cases identified.	Meia Schmidt Uili	19 Dec 2018
Meet with Debbie Eastwood and Mike Rodgers to discuss the development of the informed consent training module and the opportunity to modify and implement this across all surgical specialities.	Lyn Wardlaw	Jan 2019

Action	Responsibility	Timeframe
Ensure that there is a clear and agreed process in place for the nursing team to escalate specific concerns about clinical practice, supervision or consent in theatre.	Lyn Wardlaw, Clinical Nurse Director Ulrike Gerstenberger (starts 7 January) and Adele Barr	Jan 2019
Meet with nursing team who work in the obstetrics and gynaecology theatres to discuss how they can support the consistent implementation of the informed consent policy and how they can escalate concerns.	Lyn Wardlaw and Ulrike Gerstenberger	Jan 2019
Complete the review of the consent form and present the recommendations to theatre leadership group.	Lyn Wardlaw and Ulrike Gerstenberger	20 Feb 2019
Develop an orientation and training package on informed consent. This will include information on the DHB policy, the consent form, documentation expectations and legislative requirements.	Diana Ackerman	28 Feb 2019
Commence auditing of informed consent.	Lyn Wardlaw	Apr 2019

As discussed yesterday, in addition to the specific actions listed above the Women's Health service has a number of work streams underway. These include: exploring the implementation of a new medical leadership structure (currently under consultation), strengthening clinical governance and mortality and morbidity processes in Gynaecology, reviewing junior and senior medical rosters and developing and reporting on agreed clinical outcome measures.

Cath has shown me the three incidents that you flagged with her yesterday. I will respond to each:

14 December 2018 – vaginal examination about to be performed by a junior doctor without patient consent
This is not acceptable practice. Thank you for addressing this directly with the registrar at the time, which resulted in the examination not occurring. Diana is ensuring that all junior medical staff are aware of and will adhere to the Waitemata DHB informed consent policy.

24 September 2018– elective caesarean list on 29 August 2018
This incident was investigated by Helen Allen. The issues were addressed directly with registrar by Dr Alex Ivancevic (who was the lead training supervisor at the time). Helen also initiated a review of the patient information that is provided to women before they have an elective caesarean.

10 December 2018 – junior doctor performing an EVAC
This incident has been escalated to Diana Ackerman. Meia has a scheduled follow up meeting with her 19 December to discuss this case. Meia will ask Diana to provide feedback to you directly regarding the outcome of the review and the actions taken.

Thank you again for meeting with us yesterday. Meia and I will be closely monitoring the plan to ensure the timeframes are achieved. We will also be providing regular updates to Cath until these issues are fully resolved.

Please feel free to contact me any time on 021 246 2718.

Kind regards

Stephanie Doe
General Manager
Child, Women and Family

Cc: Cath Cronin, Director Hospital Services
[redacted] NZNO
Lyn Wardlaw, Operations Manager
Meia Schmidt-Uili, Division Head
Michael Rodgers, Chief of Surgery

Denise Poole (WDHB)

From: Diana Ackerman (WDHB)
Sent: Friday, 20 December 2019 13:39
To: Denise Poole (WDHB)
Subject: FW: Informed consent in theatre

From: Diana Ackerman (WDHB)
Sent: Wednesday, 19 December 2018 2:37 p.m.
To: Meia Schmidt-Uili (WDHB)
Cc: Stephanie Doe (WDHB)
Subject: RE: Informed consent in theatre

Dear Meia,
Adele has been on leave so I have not heard from her.
did speak to the team today and reviewed the Informed Consent policy and specific issues related to O&G.
The SHOs and all registrars present signed the document that they were aware of the policy.
I gave these documents to Meia.
[redacted] has now also signed the document.
[redacted] are off today. [redacted] with chase this up and inform them of the need for explicit consent.
I suggested they document this in the notes.

The team requested an update to the consent form to align with the policy. I understand that Lyn Wardlow is working on this.
Best regards,
Diana

From: Meia Schmidt-Uili (WDHB)
Sent: Tuesday, 18 December 2018 11:21 a.m.
To: Diana Ackerman (WDHB)
Cc: Stephanie Doe (WDHB)
Subject: RE: Informed consent in theatre

Hi Di – Have you spoken with Adele and has she agreed to meet with [redacted] in January?
If this is confirmed then Stephanie can send a letter to [redacted] today stating that – thanks Meia

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From: Diana Ackerman (WDHB)
Sent: Friday, 14 December 2018 2:44 p.m.
To: Adele Barr (WDHB)
Subject: Informed consent in theater

Dear Adele.
I am writing to you in your new role as lead training supervisor. I have already had a chat with [redacted] in her role as chief registrar, about this.
There have been a couple of issues in theatre where staff has expressed concerns about whether informed consent had been appropriately obtained.

(I thought that the consent for treatment would have covered this. There are 2 sections (as you are well aware) that state that trainees will be involved and another that says there is no guarantee who will do your procedure. I thought that covered us)

It turns out that there is additional policy about informed consent.

This is outlined in the document attached.

The specific issue is part 2.1, page 12 and is under "Core Principles."

Basically, if the person doing the procedure could not ordinarily do the procedure on their own, the patient needs to specifically say this is ok. The consent should then be documented in the clinical notes. This applies to SHOs doing EVACs. I suspect it also would apply to first year regs doing c-sections? (though assisted by SMO) . Suspect it would also apply to SMOs learning TLH from laparoscopists.

I will need to disseminate this to the larger team but wanted to loop you in. [redacted] the theatre nurse, is working on this a bit with Steph and Meia. I was hoping you could help as well.
Do you have additional thoughts about this?

Regards,
Diana

From: Meia Schmidt-Uili (WDHB)
Sent: Friday, 14 December 2018 12:46 p.m.
To: Diana Ackerman (WDHB)
Cc: Stephanie Doe (WDHB)
Subject: Policy as discussed.

http://staffnet/QualityDocs/Quality%20Documentation/O1%20Clinical%20Practices/[P]%20Informed%20Consent%20Aug18.pdf

Thanks for sending this out today to the SMO & RMOs with particular references to the teaching.

Many thanks

Meia

Attachment 3

Denise Poole (WDHB)

From: Cath Cronin (WDHB)
Sent: Tuesday, 19 March 2019 18:08
To: Michael Rodgers (WDHB)
Cc: Stephanie Doe (WDHB)
Subject: Re: Other points on the consent

Thank mike

Helpful context. We will incorporate this in the response.

On 19/03/2019, at 11:07 AM, Michael Rodgers (WDHB) <Michael.Rodgers@waitematadhb.govt.nz> wrote:

1. The initial issues raised 5 years (approx) ago were with regard to Medical Students performing intimate examinations under anaesthesia. This was dealt with at the time by reference to the University (who have produced a paper on medical students and consent) and education of all staff. Essentially no intimate examination under anaesthetic is to be performed by a student without writtent permission by the patient.
2. It was deemed that verbal consent for involvement of students in patient care (in a general sense) of any professional group was required, but in addition we added that information to the consent form.
3. Subsequently issues have been raised about RMOs and their involvement in surgical procedures. We have clarified that RMOs are in fact qualified doctors, not students, although part of their role is training in that specialty. In general if an RMO is adequately supervised, adequately experienced (for whatever role they are doing) and they are part of the team looking after the patient then specific written consent is not required for their involvement. We do expect that the primary operator will have introduced themselves to the patient prior to the procedure if at all possible (emergencies not withstanding) and explained their role.
4. Another point of concern that has been raised is that, in the opinion of the nursing staff present, the RMO (registrar or house officer) is not adequately experienced and/or adequately supervised. We would strongly encourage that this is brought up in the briefing or debriefing or otherwise brought to the attention of the responsible SMO. It is then the SMOs responsibility to make the call on experience and supervision level of RMOs during the procedure. If the nursing staff are still concerned then the ACCN needs to be involved with further communication through to the Clinical Nurse Director, CD of the relevant service and/or Chief of Surgery as appropriate. It is much more likely that communication and intervention at an early stage will be effective rather than after the fact.

Michael Rodgers FRACS
Chief of Surgery
Waitemata District Health Board

Denise Poole (WDHB)

From: Michael Rodgers (WDHB)
Sent: Tuesday, 26 March 2019 12:46
To: Andrew Brant (WDHB); Amanda Mark (WDHB); Cath Cronin (WDHB); Sandra Mechen (WDHB)
Cc: Jonathan Christiansen (WDHB); Stephanie Doe (WDHB); Debbie Eastwood (WDHB); Kathy Briant (WDHB)
Subject: RE: Consent issues - CONFIDENTIAL

I would be very reluctant to review again unless there is a specific question. We spent 2 years doing this recently.

M

From: Andrew Brant (WDHB)
Sent: Tuesday, 26 March 2019 12:25 p.m.
To: Amanda Mark (WDHB); Cath Cronin (WDHB); Michael Rodgers (WDHB); Sandra Mechen (WDHB)
Cc: Jonathan Christiansen (WDHB); Stephanie Doe (WDHB); Debbie Eastwood (WDHB); Kathy Briant (WDHB)
Subject: RE: Consent issues - CONFIDENTIAL

Agred looks good, and I would take out second part of sentence that Amanda is questioning

Please remind me - have we undertaken to review the consent form, if so this will need wide consultation if changes are recommended

Cheers
Andrew

Dr Andrew Brant
Chief Medical Officer
Waitemata District Health Board
P: 442.7203
M: 021 825 916
F: 486.8924

Waitemata
District Health Board
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From: Amanda Mark (WDHB)
Sent: Tuesday, 26 March 2019 12:15 p.m.
To: Cath Cronin (WDHB); Andrew Brant (WDHB); Michael Rodgers (WDHB); Sandra Mechen (WDHB)
Cc: Jonathan Christiansen (WDHB); Stephanie Doe (WDHB); Debbie Eastwood (WDHB); Kathy Briant (WDHB)
Subject: RE: Consent issues - CONFIDENTIAL

Hi Cath

This looks good. I've made a few edits – see attached.

Regards Amanda

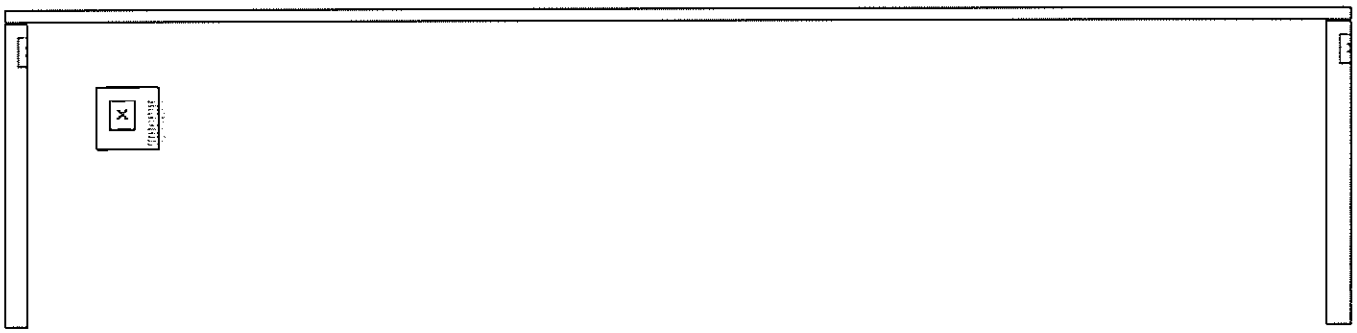
Denise Poole (WDHB)

From: Michael Rodgers (WDHB)
Sent: Friday, 12 April 2019 12:00
To: Cath Cronin (WDHB)
Subject: FW: MCNZ draft revised statement on information, choice of treatment and informed consent

Relevant to our recent response to [redacted] et al. I will read in detail but at this point it is a draft.

M

From: Medical Council of New Zealand [mailto:mcnz@mcnz.org.nz]
Sent: Friday, 12 April 2019 11:00 a.m.
To: Michael Rodgers (WDHB)
Subject: MCNZ draft revised statement on information, choice of treatment and informed consent



12 April 2019

Medical Council of New Zealand's draft revised statement on *Information, choice of treatment and informed consent*

Tēnā koutou

The Medical Council of New Zealand (Council) is reviewing its existing statement on *Information, choice of treatment and informed consent*, and is seeking your input.

The draft revised statement (the draft) retains most of what is in the existing statement with some changes for readability and to ensure it is more patient-centred. There is greater emphasis on involving the patient's family/whānau/caregivers in discussions about the patient's care and treatment.

Several new paragraphs have been added to provide guidance on:

- Instances where the doctor delegates the provision of treatment or advice to another doctor.
- The time pressures and resource constraints that doctors face, and the impact this has when giving patients information and supporting them to make a decision.
- Factors to consider when the clinical presentation of an anaesthetised patient is such that it warrants further investigation or intervention which the patient has not consented for.
- Obtaining the patient's consent if an observer attends the consultation.

You will find links at the bottom of this email to the consultation document, Council's draft updated statement on Information, choice of treatment and informed consent (Appendix 1) that we are consulting about, and the existing March 2011 statement (Appendix 2).

This consultation paper has been widely circulated to the profession and to other relevant stakeholders. We welcome your responses to some or all of the questions in the consultation paper (attached below), or by

forwarding your feedback in a separate document. If there are any other comments you would like Council to consider, please include them with your response. Submissions and suggestions may be sent to:

Kanny Ooi
Senior Policy Adviser and Researcher
Medical Council of New Zealand
PO Box 10509
The Terrace
Wellington 6143

or by email to kooi@mcnz.org.nz.

We look forward to receiving your comments by **31 May 2019.**

Nāku noa

Curtis Walker
Chair
Medical Council of New Zealand

Links:

- Consultation paper
- Appendix 1: Updated draft informed consent statement
- Appendix 2: Existing March 2011 statement on informed consent

Denise Poole (WDHB)

From: Cath Cronin (WDHB)
Sent: Tuesday, 14 May 2019 15:47
To: Kathy Briant (WDHB)
Cc: Penny Andrew (WDHB)
Subject: informed consent

Follow Up Flag: Follow up
Due By: Wednesday, 15 May 2019 16:00
Flag Status: Completed

Categories: Meetings to be set up

Hi

Please set up a meeting with [redacted] and Ulrike to discuss informed consent, culture and next steps

Within 2 weeks.

Please send invite to [redacted] and [redacted] to a monthly meeting with me – six months and we can review.

Penny – had a good meeting with [redacted] and [redacted] I would like to bring in i3 project lead soon to also meet with [redacted] and [redacted] on the alternate monthly cycle to me so they get fortnightly updates. I would brief the PM and have first meeting with them all.

Kathy – do we have the group that met last week on monthly meeting cycle for next 6 months?

Thanks cath

Cath Cronin I Director Hospital Services I RN
Waitemata District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

Denise Poole (WDHB)

From: Cath Cronin (WDHB)
Sent: Thursday, 20 June 2019 07:33
To: Lisa Sue (WDHB)
Cc: Penny Andrew (WDHB); Kathy Briant (WDHB)
Subject: FW: Informed consent - minutes / themes
Attachments: 2019-06-12 Minutes - NZNO.docx; 2019-06-13 Minutes - Steering Group.docx; Themes.docx

Follow Up Flag: Follow up
Flag Status: Completed

Categories: Meetings to be set up

Thanks – great start on complex issue.

Would you please review the questions from [redacted] and add to the themes.

We need a due date added to the minutes with actions allocated to specific people. There are some direct action missing but I will have a another look when you update my tracked changes. Once the next version is done we will circulate to steering group first and then to [redacted] and [redacted]

I need a timeline/summary of all meetings held with who attended.

Happy to meet with you to discuss further.

Thanks cath

Cath Cronin I Director Hospital Services I RN
Waitematā District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Lisa Sue (WDHB)
Sent: Friday, 14 June 2019 3:02 p.m.
To: Cath Cronin (WDHB); Penny Andrew (WDHB)
Subject: Informed consent - minutes / themes

Hi Cath and Penny,

Apologies in the delay sending the minutes across. Please could you advise if I have missed anything before these are circulated.

I think it would be beneficial to give more structure to our upcoming discussions, so I have attempted to group our discussions to date into some common themes to be addressed. Hopefully this will give some direction for the work streams after further clarification.

Please let me know if there is anything I have missed.

Kind regards,

Lisa.

Lisa Sue
Project Manager | Institute for Innovation and Improvement
Conference Room 1, Lower Ground Floor, North Shore Hospital Site, Takapuna, Auckland 0740
Waitematā District Health Board
Private Bag 93503, Takapuna 0740
Mobile: 021 195 3378
Email: Lisa.Sue@waitematadhb.govt.nz
www.waitematadhb.govt.nz
www.i3.waitematadhb.govt.nz

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Informed Consent & Supervision

12 June 2019, 08:00 to 09:00

Waitemata District Health Board
Best Care for Everyone

Attendees: [redacted] Cath Cronin, Jonathan Christiansen, Kate Gilmour, [redacted] Lisa Sue, and Ulrike Gerstenberger ***Apologies:*** Penny Andrew

Minutes	
1.	**Supervision** 1. Clarifying what is meant by a health professional in training. Discussed from a medical perspective: • Medical students are unregistered and governed by the university regarding requirements of supervision. • PGY1, an exception – is an unregistered health professional which the Medical Council governs supervision requirements. PGY2 can practice independently, but require oversight for overall learning not performance. • All other doctors are qualified, registered health practitioners. Training towards vocational scope means supervision requirements are bespoke to the individual. 2. Some colleges have tighter supervision frameworks i.e. Anaesthesia, requiring evidence of competency for a task. 3. The challenge is the difficulty of standardisation when the context of experience and the complexity of the patient are variable. 4. Gave example how to encourage transparency by communicating to nurses on the consent form - stating supervisor and trainee involved in procedure.
2.	**Informed Consent** 1. Good example of how informed consent process is introduced to the patient at ADHB – Oncology. 2. Education material needs to bridge the gap of knowledge for those who have qualified overseas in order to preserve the history of the Cartwright Inquiry.

Actions		**Owner**
1.	Further work on role clarification regarding supervision for all student groups.	Steering group
2.	Discussion to address the burden of learners to each individual patient. Hospital is at a point where numbers of students are increasing. The education committee is reviewing how the DHB accommodates students – a critical group for workforce planning so high support required. ~~it can no longer absorb more students (across all disciplines).~~	Steering group
3.	Further work required on the process of introducing informed consent to the patient.	Working group
4.	Education plan to consider: Including videos (ideal huddle, conversation with patient), case studies (exemplar of process done well, exemplar of breaches)	Working group

Comment [CC(1]: Do we have this outlined in a document or do we need to write one

Comment [CC(2]: We need named people to lead each workstream. Please add dut date column

Informed Consent Policy & Consent Form

13 June 2019, 14:30 to 15:30

Waitemata District Health Board
Best Care for Everyone

Attendees: Amanda Mark, Ara Cho, Cath Cronin, Deborah Davis, Jonathan Christiansen, Kate Gilmour, Lisa Sue, Michael Rodgers, Morgan Edwards, Penny Andrew, and Ulrike Gerstenberger ***Apologies:*** Carlene Lawes, Diana Ackerman, and George Gorringe

Minutes		
1.	Agreement the consent policy~~form~~ is endorsed for use and does not require any change. ~~should be a universal consent form; Due to the sensitivity of Gynaecology, an additional form may be required i.e. supporting guidelines, process flowchart of handling sensitive procedures. This could be something included in CeDS.~~	
2.	Due to the uniqueness of Gynaecology in regards to vaginal examinations, an additional form is required.	
~~2.~~3.	Discussed the rationale behind removing tick boxes on the consent form and acknowledged concerns raised ~~by~~ [redacted] on the audit difficulties. It was highlighted that there are other means to audit informed consent i.e. with patient experience surveys therefore group consensus to leave bullet points as is.	
~~3.~~4.	Current gap in the process ~~documentation~~ is the guidance on education/training/ teaching.	
Actions		**Owner**
1.	Informed consent policy endorsed – no change. Design a comms strategy to resocialise with all surgical staff in the first instance.	
2.	Design gynae consent form. Review ADHB process – would be good to align for staff who work in both DHBs	
~~1.~~3.	To explore if there are professional documents providing guidance on informed consent for other students from their professional body/training organization. (nursing, anaesthetic technician). Similar to university clarity on medical students.	Nursing: KG/UG Anaesthetic technician: TBC
~~2.~~4.	To arrange a meeting to discuss supervision.	CC
~~3.~~5.	Further discussions required on the informed consent process. • To address the approach to take when discussing with the patient, i.e. who will be present; culture/gender/numbers present/roles. • To address process of informed consent documentation – i.e. verbal consent. • Further clarification required on consent for staff partially involved in procedure – i.e. doing suture, intubation. • ~~Clarification of reps in theatre.~~	Steering group
~~4.~~6.	A workstream will focus on formal theatre etiquette guidelines.	UG
7.	Clarification of reps in theatre and develop policy/guideline	CC/UG
~~5.~~8.	Ongoing education piece to include case scenarios with discussions on expected practice. Draft schedule to commence education and roll our for 12 months.	Working group

Comment [LS(1]: Would Morgan be suited to explore this?

Themes		Further clarification required / Current issues

Informed consent	Communication process	To clarify:
		• Approach to informing patients who will be in theatre.
		  ○ Further discussions required on gender, students (types/numbers), role clarification, culture?
		• Approach to ensure sufficient time for patient to make an informed decision.
		  ○ Elective patients start discussion at FSA; Challenge around sufficient time in acute cases.
		  ○ All final consent is asked in pre-operative care, is this appropriate?
		• Approach to communicate with theatre staff when consent was given for a particular student to observe.
		  ○ Is the huddle appropriate? Patients arrive to pre-op in staggered intervals – ~~therefore team may not have asked for consent before huddle.~~ Student is responsible to approach patient prior to arriving in pre-op (ideally) and must seek consent before patient is in theatre/sedation given.
		• Approach for any theatre staff member to escalate concerns regarding the patient's consent.
		  ○ What happens when a staff member does not feel confident to speak up ~~trust their direct line~~?
		  ○ Debrief huddles are not consistently held due to theatres running late.
		• Approach to communicate with theatre staff the number of students expected in theatre.
		  ○ Usually only 2 nursing students per rotation, they are buddied up with a qualified nurse - Easy to communicate this in huddle.
		  ○ Senior Registrars and Consultants have do not have access to Medical Student Rosters; therefore they rely on Medical student to communicate that they are expected in theatre. Current expectation for students to be present at the huddle, but not always the case (i.e. held up doing rounds).
		  ○ Perspective that Trainee Anaesthetic technicians are not 'students' – they are qualified. However are buddied up with an Anaesthetic technician.

	Documentation process	**When patient is conscious and competent:**
		• Clarification required on documentation for student observers. Does this need to be included in consent form / patient notes?
		• Clarification on documenting consent decision and discussion in clinical records (as per Policy pg. 7).
		  ○ Current staff understanding on expectation is inconsistent.
		  ○ Some document verbal consent in clinical records.
		  ○ Some document on the consent form.
		  ○ Some do not document verbal consent at all, only document where written consent is required.
		When patient is under anaesthesia and consent required for procedure not consented:
		• What is the DHB's position on the Treatment without Consent Form?
		• Treatment without Consent Form – Not adopted into practice; lack of awareness of form; not available on controlled documents website.
		Feedback on Treatment without Consent form
		Registrar feedback that this form would be useful if available as a retrospective record of decision making i.e. for dementia patients / mental health patients.
		Consultant feedback that this form is irrelevant in Gynaecology as most patients will be conscious for initial consent and in the current consent form there is a statement that covers in event of emergency. In emergencies, there is no time to fill out

Comment [CC(1]: This is different issue -acute is acute.

Comment [CC(2]: What does this mean?

		this form. *Nurse feedback that usually consultants will attempt to involve family/next of kin in decision making, if not available – then they will seek another clinician's opinion.*
	Theatre etiquette	Clarify process for: • Change in staff in theatre – who may not have been consented by patient (End of shifts, covering breaks) • Entering theatre when is patient under anaesthesia and not introduced/mentioned to patient • Entering theatre to follow up with consultant/registrar about another case • Reps in theatre – not employed by DHB, not a part of patient's therapeutic outcomes on all occasions. Need to seek specific approval to be in theatre during the case. • Process to audit that informed consent took place i.e. patient survey

Supervision	Training / Learning	• To clarify when teaching is part of the optimal provision of care for that patient or is additional to normal clinical requirements (where specific patient consent is not required vs. explicit consent requirements)
		  ○ When opportunities arise to do sutures, intubation etc.
		• **Medical Students:** Although there is an expectation for medical students to be present at the huddles, senior registrars and consultants have no transparency of their roster and who is expected for each list.
		• **Medical registrars:**
		  ○ In O& G, registered health professionals need to be signed off on a procedure before they can carry out procedure without supervision. A list of procedures each registrar is signed off is not transparent to the theatre team.
		  ○ If the registrar is signed off on a procedure it does not take into account their competency in complex cases.
		• What is the governance for supervision of other student's i.e. nursing, anaesthetic technicians, paramedics?

	Communication process	To clarify: • Approach so that all theatre staff are informed the health professional carrying out procedure independently is competent ○ Credentialing list? Challenge is that the complexity of the patient and the experience of the registered health professional are variable. • How to embed a culture where a registered health professional recognises their clinical limits and seeks guidance from their supervisor as needed?
	Increasing volume ~~Burden~~ of learners/students	• Discussion to address the increasing demand~~burden~~ of learners to each individual patient. Hospital is at a point where it needs to review how we support and train students ~~can no longer absorb more students~~ (across all disciplines).

Theme 1: Informed Consent

Waitemata DHB Informed Consent Policy, updated August 2018

Policy	Supporting Comments	Current practice / Clarification required
1.2 What is Informed consent, pg. 5 Informed consent is **not** the process of filling out forms, but rather the exchange of information so that the person can make an informed decision about the healthcare options, including the option of refusing health care~~the service~~.		Elective cases: Information and discussion occurs in the clinic appointment. In both acute and elective cases, asking for consent takes place in pre-operative care.
1.6 Documentation of Consent or Written Consent, pg.7 Documentation of the consent discussion and decision is to be made in the clinical record, including as appropriate: - Notes of information provided - Specific issues of concern/ and or wishes of the patient - Important questions asked by the patient and answers given/who was present - Who gave consent	Perioperative form has a check list in place to ensure patient has given surgical and anaesthetic consent Anaesthetic nurse confirms consent with patient; will not take patient into operating theatre without confirmation of consent given	Written consent process are well in place I.e. consent form and use of medical student PV stickers in the patient's notes. **Inconsistency in the understanding of documenting consent in clinical records when verbal consent obtained.** Some comments: - Lack of awareness to document - Not necessary to document verbal consent as it is an assumed trust between patient and doctor - Based on the context of clinics: for sensitive examinations - If audited, would find verbal consent it is not consistently documented - It is not practical to document all verbal consents. The consent form signed is considered sufficient. - Insufficient space in the consent form to document conversation Consent of student observing is not documented in notes
1.9 How should information be given? pg. 8 Sufficient time should be allowed for the patient to read the written information and discuss this and any verbal information with whomever he/she wishes.	As per Medical Council: "With more complex treatments, you must ensure the patient is given sufficient time to reflect and consider the options before making a decision on the treatment they wish to pursue"	To be clarified: Consent is asked in pre-operative care for O&G cases; Are there other options to ask the patient earlier? (i.e. In a less stressful situation) What is the situation in acute circumstances? To discuss how much information/delivery of conversation regarding who is in theatre.

2.0 Teaching and Observers. Pg. 12 Consent for involvement in teaching applies not only to interventional procedures but also to observation of them.	Consent for observers not just those conducting procedure	Observers who have not introduced themselves to the patient are able to enter operating theatre. - What is the process in place to manage staff changes (end of shifts, breaks) - What is the process in place to managed those not under the care of patient to enter for staff communication purposes?

Specifically on the Consent Form

Consent Form	Current practice	Clarification required
2.7 Consent for all Students in Theatre/Operating Room/Procedure room. Pg. 15 In theatres/OR/PR, Supervising consultants and registrars must inform patients that a student is assisting or observing part of the anaesthetic team or surgical team and that any practical task undertaken by a student will be directly and closely supervised. Verbal consent must be obtained. The consent and the student role should be documented on the consent form by the Registered Health Professional responsible. The consent should be obtained before premedication is given.	Currently there is no space to specifically document verbal consent of the student / trainee involved on the consent form. Current practice, if done, is that it is written in the front, top section of Surgery/Other Procedures in the space provided after ***Agree that the following procedure be performed for me / my child/ person in respect of whom I am welfare guardian or attorney under an enduring power of attorney...***	What is the guidance around verbal consent for nursing students, anaesthetic trainees?

Denise Poole (WDHB)

From: Lisa Sue (WDHB)
Sent: Thursday, 15 August 2019 12:38
To: Penny Andrew (WDHB); Cath Cronin (WDHB); Jonathan Christiansen (WDHB); Diana Ackerman (WDHB); Michael Rodgers (WDHB); Amanda Mark (WDHB); Kate Gilmour (WDHB); Ulrike Gerstenberger (WDHB)
Cc: David Price (WDHB)
Subject: Consumer Council - informed consent feedback
Attachments: Consumer Council Feedback- consent process and form.pdf

Dear All,

David kindly invited me to attend the agenda for informed consent with the Consumer Council yesterday. I have tried my best to summarise what was discussed in the slides attached. (David, please let us know if there was anything I have missed).

My overall impression from the Consumer Council is that further work is required on the Agreement to Treatment / Consent Form, of which Dale (on behalf of Judy) has expressed this to me. Our next steering group meeting is 4 September, I will add this as an agenda idea for further discussion.

Kind regards,
Lisa.

Lisa Sue
Project Manager | Institute for Innovation and Improvement
Conference Room 1, Lower Ground Floor, North Shore Hospital Site, Takapuna, Auckland 0740
Waitematā District Health Board
Private Bag 93503, Takapuna 0740
Mobile: 021 195 3378
Email: Lisa.Sue@waitematadhb.govt.nz
www.waitematadhb.govt.nz
www.i3.waitematadhb.govt.nz

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Consumer Council Feedback
Informed consent

14 August 2019

Consumer Council

- A workshop was held with the Consumer Council
- 13 members were divided into small groups to review the Agreement To Treatment / Consent Form
- The groups were asked to think about:
  - What would you expect from the consent process?
  - What are your thoughts on the content within the form?

Expectations from the consent process

- To be in plain English – easy to read and understand
- All information in one place or 100% information made available
- Content on form non specific to the procedure (i.e. students, body parts, blood components) should be information given to the patient to think about in advance – where possible
- Format of the form should be accessible for all (i.e. languages, those with health disabilities)

Thoughts on the form (1 of 5)

Could this form be available in other languages?

Could be more accessible for those with health disabilities i.e. video option (with sign language) or a brail version

Waitemata District Health Board

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Waitemata DHB Wide

[*PLACE PATIENT LABEL HERE*]

First Name: _____ Gender: _____

Surname: _____ Ph: _____

Address: _____

Date of Birth: _____ NHI#: _____

Ward/Clinic: _____ Consultant: _____

Agreement to Treatment / Consent

INTERPRETER REQUIRED: Yes ☐ No ☐ LANGUAGE: _____

SURGERY / OTHER PROCEDURE(S)

I, _____ (name of patient / parent or guardian / welfare guardian or attorney under enduring power of attorney)

Agree that the following procedure be performed for me / my child / person in respect of whom I am welfare guardian or attorney under an enduring power of attorney

_____

_____

_____

_____ If relevant specify side (*circle one*): Right / Left

I have discussed this with:

Name _____ Designation _____ Signature _____

They have explained to me the reason for this procedure, the alternatives, and the possible risks.

Risks of the procedure include (but are not limited to):_____

_____

Thoughts on the form (2 of 5)

Perception that **all** aspects must be agreed to. Format doesn't indicate options for refusal
"Feels like a waiver"
There is a need to change the agree section format.

Group discussed when the form is first introduced to the patient.
Where risk isn't high (i.e. non acute presentation), the non procedure specific content should be introduced earlier, to allow more time for consideration – as overwhelming to make big decisions just prior to surgery.

I agree that:

- I have had adequate opportunity to ask questions and I have received all the information that I require.
- I understand that during this procedure images or pictures relevant to my / the patient's care may be captured and incorporated into my / the patient's clinical record.
- I understand that in the event of an emergency, and as determined by my / the patient's medical team at the time, there may be other procedures undertaken to save my / the patient's life or prevent harm.
- I understand that my / the patient's care is occurring in a teaching hospital and there may be healthcare students (medical, nursing) present. I understand they will be appropriately supervised but at any time I can ask for them not to be present.
- I understand that no assurance can be given that a particular clinician will be performing my / the patient's procedure but that the clinician will be suitably qualified and, if in training, will be appropriately supervised by a senior clinician.

Misrepresentative using the term "present" for students. Group interprets this as <u>only observing</u>

Needs clarification between bullet point 4 and 5.
It was not clear that 'in training' refers to a different staff group to the students.

The delivery of this is confronting. Doesn't feel like there is an option to opt out.
The group would rather see an option to opt in to having a student

TMENT / CONSENT

Thoughts on the form (3 of 5)

Could be better phrased. Doesn't give confidence with process having 'accidents'

Blood accidents

- If a healthcare worker is accidentally exposed to my / the patient's blood or other body fluids, I agree to a sample of my / the patient's blood being taken and tested for transmissible diseases such as Hepatitis and HIV
- I understand I will be informed if this happens and test results will be discussed with me and if required treatment will be given.

Return of Body Parts

- I wish to have any body part / tissue removed during this procedure that is not required for diagnosis returned to me: Yes / No (***circle one***) if *yes ensure this is documented on the Laboratory form and Theatre staff have been informed.*

Perturbed / unsettling from first impression if presented with 'Return of Body Parts' before they have even had a chance to discuss with clinician

Patient / Welfare Guardian / Attorney's signature:_____ **Date:**_____/_____/_____

Interpreter's signature:_____ **Interpreter's name:**_____

AGREEMENT TO TREA

Thoughts on the form (4 of 5)

Comment from outside Consumer Council, but worth consideration

There is no consent for students under Anaesthesia. This has been removed from previous version of the form.

Is it appropriate for the consent to be obtained from the Surgeon compared to the Anaesthetist?

ANAESTHESIA

I, _____(name of patient / parent or guardian / welfare guardian or attorney under enduring power of attorney)

Agree that the Anaesthetic for me / my child / person in respect of whom I am welfare guardian or attorney under an enduring power of attorney has been explained to me for the procedure discussed overleaf

- I agree to the following Anaesthetic as discussed: _____

_____

- The possible benefits and risks of the Anaesthetic have been explained to me relating to my / the patient's clinical history and condition.

The risks include, but are not limited to: _____

_____

_____

_____

I / the patient have been advised NOT to drive a motor vehicle, operate machinery or potentially dangerous appliances, drink alcoholic beverages or make important decisions for 24 hours after having a general anaesthetic or sedation agents administered.

Patient / Welfare Guardian / Attorney's signature:_____ **Date:**_____/_____/_____

Interpreter's signature:_____ **Interpreter's name:**_____

Anaesthetist's signature:_____ **Anaesthetist Designation:** _____

Name of Anaesthetist:_____ **Date:**_____/_____/_____

Thoughts on the form (5 of 5)

Consideration of religious beliefs regarding the receipt of blood products.

Perhaps a question as a prompt may make patients feel more comfortable about stating their position

AGREEMENT TO TREATMENT / CONSENT

Name of Anaesthetist:_____ Date:_____/_____/_____

BLOOD COMPONENTS AND PRODUCTS

☐ I have been advised that I / the patient may require blood, or blood product transfusion. I have been advised of the possible risks, benefits and alternatives to blood transfusion. I understand the risks of blood transfusion refusal.

☐ I have had the opportunity to ask questions and discuss this with the Clinician whose signature appears below.

☐ I agree to receive blood or blood products if these are considered necessary by the Doctors looking after me / the patient. I understand I / the patient may need to receive repeated transfusions.

OR

☐ I DO NOT agree to receive blood components and / or products under any circumstance and I understand the risks of this decision.

Patient / Welfare Guardian / Attorney's signature: _____ Date: _____/_____/_____

Interpreter's signature: _____ Interpreter's name: _____

Clinician's signature: _____ Clinician's Designation: _____

Name of Clinician: _____ Date: _____/_____/_____

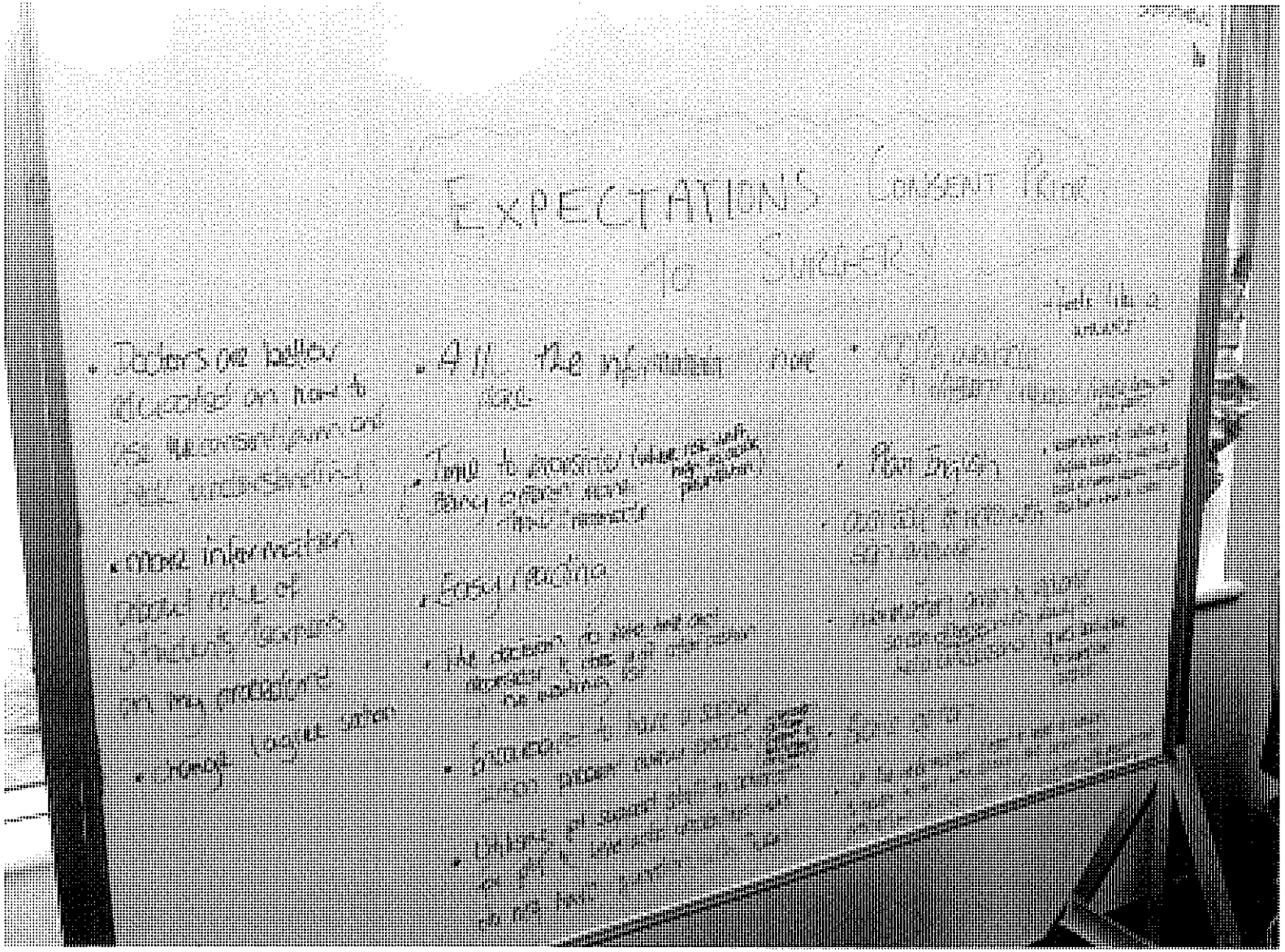
For consideration out of discussion

- More information about the role of the students / learners on the procedure would be useful to know.

- The delivery of the process is just as important to the content of the form.

- Some cultures see doctors as an authority figure – Patients may feel pressured to agree to consent terms, even when they aren't entirely convinced. Encouraging to have a support person at the time of consent would help rationalise the decision making process.

Appendix



Denise Poole (WDHB)

From: Ulrike Gerstenberger (WDHB)
Sent: Wednesday, 04 September 2019 14:02
To: Cath Cronin (WDHB); Michael Rodgers (WDHB); Kate Gilmour (WDHB); Jonathan Christiansen (WDHB); Diana Ackerman (WDHB); Amanda Mark (WDHB); Ara Cho (WDHB); Morgan Edwards (WDHB); Carlene Lawes (WDHB); Lisa Sue (WDHB); Deborah Davis (WDHB); Penny Andrew (WDHB)
Subject: Health Care Industry Reps in OR Policy
Attachments: Health Care Industry Reps in Perioperative Setting Draft 2.docx

Hi All

As discussed at today's meeting attached is Health Care Industry Reps in theatre policy for feedback/comments.

Kind regards,

Ulrike

Ulrike Gerstenberger I Clinical Nurse Director
Perioperative Service / North Shore Hospital
North Shore Hospital, Shakespear Road, Private Bag 93503 Takapuna
P 09 486 8920 extn 47198 mobile 021 874 090
ulrike.gerstenberger@waitematadhb.govt.nz

Waitemata
District Health Board

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Health Care Industry Representatives in the Perioperative Setting

Contents

1. Overview

Health Care Industry Representatives (HCIR) are sales representatives, technicians, repair/maintenance personnel who provide company services in the perioperative setting.

Unfamiliarity and use of complex technology by health clinicians without formal training is potentially hazardous to the patient and perioperative team members.

The knowledge and expertise of the experienced HCIR can play an important role in providing essential technical assistance, instruction and training to perioperative team members.
HCIR presence in the perioperative setting is either to support new equipment or processes or other business regarding the supply of surgical equipment.

Purpose

The purpose of this document is to provide guidelines for protocols and processes relating to the activities and conduct of the health care industry representative as a visitor to the perioperative department.
This in turn ensures the safety and privacy of the patient, staff and HCIR.

Scope

- All perioperative staff
- All visiting sales representatives, technicians, repair/maintenance personnel

2. Associated Documents

WDHB Documents	Informed Consent Policy: 2.10 – Observers Not Involved in Clinical Care Health Information/Privacy – General Policy
	Employee Privacy & Confidentiality Agreement
	Privacy & Confidentiality Brochure
Legislation	Code of Health & Disability Consumer Rights 1996 & Review 2004
	Privacy Act 1993
	Human Rights Act 1993
Medical Technology Association of NZ	MTANZ Code of Practice 6th Ed 2016

Health Care Industry Representatives in the Perioperative Setting

3. Role of the Health Care Industry Representative

HCIR have a valid but restricted role in the perioperative setting, but should not be considered part of the clinical team nor be requested to perform tasks outside their approved role.

Their role is to provide education, training and instruction related to new technology, equipment, techniques and procedures in order for the perioperative team to provide safe patient care under conditions prescribed by the specific healthcare organisation.

- To provide essential technical training and support related to a particular device or product for the safe care of the patient.
- To facilitate desired safe patient outcomes by providing procedural support for surgeons and nursing staff.
- It is not appropriate for HCIR to scrub in on a case unless it is solely for product demonstration purposes and at the specific request of the consultant surgeon in attendance.
- One HCIR in an operating room is generally all that is acceptable except when specialist equipment/products necessitate a second person's attendance.

4. Health Care Industry Representatives Eligibility Criteria

The HCIR must meet specific eligibility criteria to be granted access to the perioperative department. Evidence for eligibility may include (but not limited to) knowledge and compliance with:

- Infection control principals
- Aseptic technique requirements
- Perioperative department etiquette
- Privacy and Confidentiality policy
- Patient Code of Consumer Rights

5. Perioperative Manager's Responsibilities

All visitors to the perioperative department must be approved by the perioperative manager who may delegate authority to the ACCN's or Theatre Coordinator.

1	Ensure that the perioperative department guidelines for the conduct and activities of visiting HCIRs to gain admission are upheld.	To ensure the patient's safety, privacy and dignity and the safety of staff and HCIR in the perioperative setting.
2	To define the conditions under which the health industry representative may be present during a surgical or other invasive procedure.	
3	To ensure confidentiality and privacy rights are observed for all patients according to Health & Disability Sector Standards Code of Rights.	
4	Ensure that patient consent is obtained and documented for HCIR access	To ensure that the patient is informed about aspects of their care.
5	Ensure that HCIR access to the perioperative environment is at the discretion of the RN, and in	To ensure that the visit is necessary, that adequate staff are available to facilitate the

Health Care Industry Representatives in the Perioperative Setting

	consultation with the Medical Practitioner in charge of the patient's care.	visit and that staff numbers in the clinical area are kept to a minimum.
6	Deny HCIR access to the perioperative environment if guidelines and criteria are not met.	To ensure the patient's safety, privacy and dignity and the safety of staff and HCIR in the perioperative setting.

6. Nursing Staff Responsibilities

1	Responsibility for providing patient care, ensuring patient safety, privacy and dignity.	To ensure the patient's safety, privacy and dignity and the safety of staff and HCIR in the perioperative setting.
2	To ensure only authorised personnel are granted access to a theatre during an operation.	
3	To check that informed consent from the patient has been obtained according to WDHB protocols.	To ensure that the patient is informed about aspects of their care.
4	To welcome the HCIR to the perioperative area and introduce them to the team.	All team members are aware of the HCR attendance and activities
5	Orientate to the area, guide and support the HCIR and monitor HCIR activities and movements within the WDHB perioperative environment.	To prevent unauthorized access to other areas, to ensure that the HCIR is aware of emergency exits and to monitor and maintain the sterile field.
6	Ensure the HCIR does not provide patient care, nor act as part of the scrub/circulating team e.g. may not open any item on to the sterile field or fetch instruments. The HCIR role is to calibrate, assemble and provide instruction on the use of the equipment only.	Ensure that the HCIR remains within the WDHB and their company guidelines
7	Ensure that the HCIR's presence is documented on the intraoperative record and iPIMs stating name, company and role.	To provide complete documented record.

7. Surgeon's Responsibilities

1	The Medical Practitioner responsible for the patient must explain the observer's role and seek the patient's permission for the observer to be present before permitting a visiting HCIR into theatre. The consent must be documented in the clinical record.	To ensure compliance with WDHB Informed Consent, Confidentiality and Privacy and Visiting HCIR policies and protocols are met.
2	The person performing the procedure will ensure the HCIR has signed the WDHB Confidentiality and Disclaimer Agreement and Visitor's register before entering the theatre.	

Health Care Industry Representatives in the Perioperative Setting

8. Health Care Industry Representatives Responsibilities

1	Provide WDHB organization with their company guidelines and evidence to demonstrate that they meet the eligibility criteria.	To ensure the patient's safety, privacy and dignity and the safety of staff and HCIR in the perioperative setting.
2	Request permission for entry from the perioperative manager or delegated authority stating purpose of visit.	To ensure that the visit is necessary, that adequate staff are available to facilitate the visit and that staff numbers in the clinical area are kept to a minimum.
3	Contact the specialty ACCN to pre-schedule the visit with the ACCN responsible for the SU team member	
4	All visiting HCIR are required to wear approved WDHB theatre attire including a visible identification badge.	All team members are aware of the HCIR attendance and activities.
5	HCIR's must be accompanied by a WDHB staff member during the visit.	
6	HCIR's are required to sign the WDHB Confidentiality and Disclaimer Agreement and Visitor's register on all occasions before entering and leaving the theatre.	To ensure compliance with WDHB Informed Consent, Confidentiality and Privacy and Visiting HCIR policies and protocols are met.
7	HCIR must comply with WDHB organizational guidelines as required e.g. infection control and aseptic technique protocols.	
8	Attendance in the clinical area is for the required time only to achieve the purpose of the visit.	To ensure the patient's safety, privacy and dignity and the safety of staff and HCIR in the perioperative setting.
9	Leave the perioperative environment if asked to so do.	
10	It is not appropriate for HCIR's to wait or meet with WDHB staff in the Perioperative department staff tearoom.	To ensure the staff tea room is used for its designated purpose, not a meeting or waiting room.

9. Access to the Perioperative Department

Prior consent to access the perioperative department has been authorised before entering the department. For HCIR entry to check stock only during working hours, access is via Reception.

During Working Hours

- Via Reception
- Complete Visitor's Register with date, arrival time, name, company and person visiting/purpose of visit. Departure time is also required when leaving.
- Sign Confidentiality and Disclaimer Form

Health Care Industry Representatives in the Perioperative Setting

- Report to WDHB Staff member e.g. Team Leader/Floor Coordinator

Out of Working Hours

- Contact Theatre Coordinator who will allow access to the department
- Complete Visitor's Register with date, arrival time, name, company and person visiting/purpose of visit. Departure time is also required when leaving.
- Sign Confidentiality and Disclaimer Form
- Report to WDHB Staff member e.g. Team leader/Floor Coordinator

10. References

NZNO Perioperative Nurses College	Health Care Industry Representatives in the Perioperative Setting (No date)
AORN Perioperative Standards and Recommended Practices, 2009 Edition	AORN Guideline Statement: The Role of the Health Care Industry Representative in the Perioperative Setting, P 204 - 206
Medical Technology Association of NZ	MTANZ Code of Practice 2016, 6th Edition – 5. Interactions with Healthcare Practioners & other Professionals
ADHB	Visitors to the Operating Room and Central sterile Supply Department, 2018

Denise Poole (WDHB)

From: Lisa Sue (WDHB)
Sent: Wednesday, 11 September 2019 1S:34
To: Cath Cronin (WDHB); Jonathan Christiansen (WDHB); Penny Andrew (WDHB); Amanda Mark (WDHB); Diana Ackerman (WDHB); Michael Rodgers (WDHB); Kate Gilmour (WDHB); Ulrike Gerstenberger (WDHB); Ara Cho (WDHB); Deborah Davis (WDHB); Morgan Edwards (WDHB)
Subject: Healthcare student - informed consent poster
Attachments: Student Informed Consent Poster 1 1.pdf

Hi all,

As an action from the last informed consent steering group meeting, it was requested to have another chart or poster to summarise the student guidance email sent out – but have it broad enough to cover all students (i.e. nursing, techs).

Cassie has kindly designed a poster. Please advise any changes if required. After your suggestions, I will bring a final copy to the next steering group meeting (Oct 16) for approval.

Kind regards,
Lisa.

Lisa Sue
Project Manager | Institute for Innovation and Improvement
Conference Room 1, Lower Ground Floor, North Shore Hospital Site, Takapuna, Auckland 0740
Waitematā District Health Board
Private Bag 93503, Takapuna 0740
Mobile: 021 195 3378
Email: Lisa.Sue@waitematadhb.govt.nz
www.waitematadhb.govt.nz
www.i3.waitematadhb.govt.nz

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Informed Consent For Students at Waitematā DHB

Waitematā DHB strongly supports the supervised apprenticeship learning of medical students in our healthcare facilities.

There are three points to remember regarding consent for student involvement.

Patient consent is essential for the involvement of students in their care. Informed consent should be obtained relative to the situation.

The responsible clinician supervising is accountable for ensuring consent is obtained for the invovlement of students.

The following specific issues relating to the operating theatres and procedural areas.

All intimate examinations must have written consent. These must be directly supervised and limited to one student with a patient.

The statement regarding healthcare students in the Agreement to Treatment/Consent Form covers observation and very basic procedures only.

The responsible clinician should document the patient's consent to a student's active involvement prior to the procedure.

The responsible clinician must obtain verbal consent for a student to observe in theatre, or assist in a minor way (such as holding a retractor).

Denise Poole (WDHB)

From: Cath Cronin (WDHB)
Sent: Monday, 08 July 2019 13:19
To: Lisa Sue (WDHB)
Cc: Penny Andrew (WDHB); Kate Gilmour (WDHB); Jonathan Christiansen (WDHB)
Subject: RE: Informed consent education plan
Attachments: Education Plan - Informed Consent v2 redline accepted.docx

Thanks

Please see my changes. We need to focus on the all staff session as a priority – see suggestion re panel discussion.

The other option I can think of is a presentation at the next ASMS/WDHB session and on the same afternoon a focussed session for nurses, techs etc. This would be in addition to Friday's.

cath

Cath Cronin I Director Hospital Services I RN
Waitematā District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Lisa Sue (WDHB)
Sent: Monday, 08 July 2019 8:06 a.m.
To: Cath Cronin (WDHB)
Cc: Penny Andrew (WDHB)
Subject: RE: Informed consent education plan

Good morning Cath,

- Nursing: Kate Gilmour and the CNE's listed in the plan
- Anaesthetic Techs: Julie Bromley and Zoe Bunker
- Anaesthetist: Planned to work with Morgan Edwards – but she has been on sick leave
- Medical: Penny for now

Kate Gilmour has also had initial conversations with Mike Rodgers.

Regarding the Friday Theatre Education Session, the plan is for 30th August. I am aware Ara Cho previously had discussions with [redacted] to do a talk on July 26th. Changes in plans will need to be discussed with [redacted]

Kind regards,
Lisa.

Lisa Sue
Project Manager | Institute for Innovation and Improvement
Conference Room 1, Lower Ground Floor, North Shore Hospital Site, Takapuna, Auckland 0740
Waitematā District Health Board
Private Bag 93503, Takapuna 0740

Mobile: 021 195 3378
Email: Lisa.Sue@waitematadhb.govt.nz
www.waitematadhb.govt.nz
www.i3.waitematadhb.govt.nz

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From: Cath Cronin (WDHB)
Sent: Monday, 08 July 2019 7:58 a.m.
To: Lisa Sue (WDHB)
Cc: Penny Andrew (WDHB)
Subject: RE: Informed consent education plan

Thanks –I will read this.

Who from the services worked with you on this?

Cath

Cath Cronin I Director Hospital Services I RN
Waitematā District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Lisa Sue (WDHB)
Sent: Friday, 05 July 2019 5:32 p.m.
To: Cath Cronin (WDHB)
Cc: Penny Andrew (WDHB)
Subject: Informed consent education plan

Dear Cath,

Please find attached the first version of the education plan.

Kind regards,
Lisa.

Waitematā
District Health Board

Best Care for Everyone

Education Plan: Informed consent Part 1

Prepared By:	Lisa Sue Innovation and Improvement Project Manager Kate Gilmour, ADON Surgical and Ambulatory Services Julie Bromley Zoe Bunker Morgan Edwards
Input Provided By:	Penny Andrew Director – Institute of Innovation and Improvement
Approval required from:	Cath Cronin Director of Hospital Services Jonathan Christiansen Chief Medical Officer
Document changes:	

Comment [CC(1]: Ask her to review

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Contents

1. Introduction

In 2012, concerns were raised that procedures and protocols for gaining patient consent were not being adhered to within the Surgical Services. Failure to obtain informed consent according to these procedures and protocols is a serious issue: it is a breach to the patient's rights under the Code of Health and Disability Services Consumers' Code of Rights (The Code of Rights), and a breach of health professionals' expected standards of practice. To protect patient rights and safeguarde health care professionals, a review of the DHB's Informed Consent Policy and Agreement to Treatment / Consent Form was undertaken.

These documents were last updated in August 2018 to better meet the requirements in The Code of Rights. In particular:

- Right 6 - Right to be fully informed
- Right 7 - Right to make an informed choice and give informed consent
- Right 9 - Rights in respect of teaching or research

Since the updates to the policy and consent form in 2018, dissemination of education about the Informed Consent Policy, including its principles and process of obtaining informed consent, has been a departmental responsibility.

Variation in the application of the Informed Consent Policy across the Surgical Department provides the opportunity for a widespread programme of informed consent in surgery, with the aim of improving awareness of the principles of informed consent and consistency in the application of the Informed Consent Policy.

2. Objectives

All surgical health care professionals will:

- Understand the principles in the Informed Consent Policy
- Apply the principles of informed consent in day to day practice
- Recognise the importance of a properly carried out informed consent
- Have increased awareness of the implications when the informed consent policy is breached

3. Audience

All surgical health care professionals which include:

- Medical teams
- Nursing teams
- Anaesthesia teams
- Midwifery teams
- Trainees and Students

Across all surgical departments:

- General Surgery
- Orthopaedics
- Urology
- Gynaecology
- Obstetrics
- ORL

All roles are defined as per Informed Consent Policy. Please refer to Appendix 5.2 on page 119.

4. Education Approach

4.1 Friday Theatre Education Sessions

Target Audience	All health care professionals within Theatres and Surgical Wards. • Surgical consultants, registrars, house officers, trainee intern, medical students • Registered nurses, enrolled nurses, student nurses and health care assistants • Anaesthetist, Anaesthetic registrars, house officers, anaesthetic technicians, trainee anaesthetic technicians
Education content	Background and history of informed consent Consumer perspectives (Ethical considerations and cultural implications) High level review of informed consent policy and Case scenario discussions
Concept	Delivering education in a collaborative learning space; using methods such as problem based learning, case scenarios for simulation based education
Methods	A series of talks followed by case scenario discussions. **Background and history of informed consent** Potential Speakers: • Sandra Coney TBC [redacted] **Consumer Perspectives (Ethical considerations and cultural implications)** Potential Speakers include: • Professor Ron Paterson • Professor Catherine Cook **Policy and Case Scenarios** Speaker and facilitator Clinical champions, Clinical Nurse educators and Anaesthetic technician educator.
Roles & Responsibilities	**Content experts:** Informed consent project steering group (See Appendix 5.1 on page 119 for details) **Design and implementation:** Ara Cho — Clinical Nurse Educator – Theatres Zoe Bunker — Anaesthetic Technician – Educator Penny Andrew — Director – Institute of Innovation and Improvement Clinical Directors of each surgical service include General Surgery — Richard Harman Orthopaedics — Matt Walker Urology — Madhu Koya

Comment [CC(2)]: ? panel approach

Comment [CC(3)]: Who is this?

	Gynaecology and Obstetrics	Diana Ackerman
	ORL	David Grayson
	Anaesthesia	Charlie McFarlan
Duration	2 x Friday Theatre Education Sessions 30 August 4 October	

4.2

~~4.2~~4.3 Interactive Focus Boards

Target audience	All health care professionals within Theatres and Surgical Wards. • Surgical consultants, registrars, house officers, trainee intern, medical students • Registered nurses, enrolled nurses, student nurses and health care assistants • Anaesthetist, Anaesthetic registrars, house officers, anaesthetic technicians, trainee anaesthetic technicians • Midwifes, midwifery students • Medical radiation technicians
Policy reference	Informed Consent Policy, version August 2018 Section 1.2: What is informed consent? Section 1.5: Levels of consent - Implied, Verbal, or Written Section 1.6: Documentation of consent or written consent Section 1.7: What and How much information Section 1.8: Primary Responsibility for Information, consent, and delegation Section 2.0: Teaching, Students and Observers Section 2.1: Supervision
Concept	An eye catching and informative poster to create awareness of the principles of informed consent.
Method	**First roll out:** North Shore Hospital, posters distributed on o Theatre education focus board: Large poster A0 or multiple A3 depending on design o Surgical ward education focus boards: A3 to A4 sized posters for ward 4, 8, Hine Ora, Short Stay o PACU focus boards: A3 to A4 sized posters for Admissions Interview Room, Pre-Op, Day Stay, and Recovery. **Second roll out:** To include Waitakere Hospital and Elective Surgery Centre
Team Roles and responsibilities	**Content experts:** Informed consent project steering group (See Appendix 5.1 on page ~~119~~ for details) **Design and implementation:** Cassie Khoo — i3 Design fellow Lisa Sue — i3 Project manager Chari An Bakkenes — Surgical Nurse Educator Kerlvin Ocado — Surgical Nurse Educator Grace Gannaban — PACU Nurse Educator Ara Cho — Theatre Nurse Educator
Duration	Interactive posters will remain for a 2 month period
Milestones	Concept approved — 11 July 2019 – Steering group meeting Posters to print — 12 July 2019 Require a 2 to 5 day lead

Distribute and display	22 July 2019 for the first roll out 5 August 2019 for the second roll out
Example	See Appendix 5.3 on page 129

4.34.4 In service teaching sessions - Interactive quiz and discussions

Health care professionals across Surgical Wards and Theatre who are:

- Registered nurses, enrolled nurses, student nurses and health care assistants
- Anaesthetic technicians, trainee anaesthetic technicians

Informed Consent Policy, version August 2018
Section 1.2: What is informed consent?
Section 1.5: Levels of consent - Implied, Verbal, or Written
Section 1.6: Documentation of consent or written consent
Section 1.7: What and How much information
Section 1.8: Primary Responsibility for Information, consent, and delegation
Section 2.0: Teaching, Students and Observers
Section 2.1: Supervision

Delivering education through an interactive learning forum with the opportunity for collaborative feedback and discussion.

Each Kahoot quiz is bespoke to the role of the target audience, i.e. Nurse focus and Anaesthetic technician focus.

In order to retain engagement of staff, there will be 8 questions per quiz and section 1 and 2 will be separated.

- Kahoot Quiz 1: The questions will be specific to the policy sections 1.2, 1.5 – 1.8
- Kahoot Quiz 2: The questions will be specific to the policy section 2

Following each question, the answer will be revealed and there is an opportunity for the facilitator to discuss the answers with the audience.

Resources required include:

- Facilitator
- TV screen or laptop
- Prizes

Content experts:
Informed consent project steering group (See Appendix 5.1 on page 119 for details)

Design and implementation:

Lisa Sue	i3 Project manager
Chari An Bakkenes	Clinical Nurse Educator – Surgical
Kerlvin Ocado	Clinical Nurse Educator – Surgical
Grace Gannaban	Clinical Nurse Educator – PACU
Ara Cho	Clinical Nurse Educator – Theatres
Julie Bromley	Lead Anaesthetic Technician

	Zoe Bunker Anaesthetic Technician – Educator
	All surgical services will have 2 x 30 minute in-service teaching sessions.
	Nursing • The forum of choice is after the AM-PM handover. • The schedule of the teaching sessions will be completed per service by the respective Clinical Nurse Educator. • These sessions will aim to be rolled out and completed over an 8 week period **Anaesthetic Technicians** • The forum of choice is Friday Theatre Education Sessions, once every 5 weeks • The schedule of the teaching sessions will be completed by Zoe Bunker • These sessions will need to be held at the start of each Friday Theatre Session for the remainder of the year to capture the cohort.
Milestones	Concept approved 11 July 2019 – Steering group meeting
	Implementation 15 July to 6 September 2019 – Nursing 26 July to December – Anaesthetic Technicians
Example	See Appendix 5.4 to 5.5 on pages 13~~10~~ to 14~~11~~

Comment [CC(4]: How do we get a joined up session – 40 mins at least with all theatre staff. This could be a session – presentation of 2 case studies – discussion panel – JC, Ron Patterson, others x 2
We need this in Aug/September

4.44.5 In service teaching sessions - Talks and discussions

	All health care professionals within Theatres and Surgical Wards. • Surgical consultants, registrars, house officers, trainee intern, medical students • Anaesthetist, Anaesthetic registrars, house officers
	Informed Consent Policy, version August 2018 Section 1.2: What is informed consent? Section 1.5: Levels of consent - Implied, Verbal, or Written Section 1.6: Documentation of consent or written consent Section 1.7: What and How much information Section 1.8: Primary Responsibility for Information, consent, and delegation Section 2.0: Teaching, Students and Observers Section 2.1: Supervision
Content	Delivering education in problem based learning and discussion sessions.
	Senior medical officers The development of clinical champions is integral for adoption of best practice and role modelling. Discussions with this cohort will be facilitated by Cath Cronin and Penny Andrew. All other roles can be captured in their respective departmental meetings, journal club or medical grand round. <u>Departmental meetings</u>

	General Surgery – every Friday morning Orthopaedics – (still waiting for confirmation) Urology – every Week 3 Friday morning Gynaecology and Obstetrics – every Week 4 Tuesday ORL – (still waiting for confirmation) Anaesthesia – (still waiting for confirmation)
	Content experts: Informed consent project steering group (See Appendix S.1 on page 119 for details) **Implementation:** *Education to be delivered by clinical champion (SMO/Registrar) with the support of Penny Andrew* Clinical champions General Surgery *Insert name* Orthopaedics *Insert name* Urology *Insert name* Gynaecology *Insert name* Obstetrics *Insert name* ORL *Insert name* Anaesthesia *Insert name*
	Each respective surgical group and role will be have a talk
	Identified clinical champions By end of July 2019 Structured agenda for discussion By early August 2019 Completion By October 2019

4.54.6 ~~Friday Theatre Education Sessions~~

~~Target audience~~	~~All health care professionals within Theatres and Surgical Wards.~~ • ~~Surgical consultants, registrars, house officers, trainee intern, medical students~~ • ~~Registered nurses, enrolled nurses, student nurses and health care assistants~~ • ~~Anaesthetist, Anaesthetic registrars, house officers, anaesthetic technicians, trainee anaesthetic technicians~~
~~Education content~~	~~Background and history of informed consent~~ ~~Consumer perspectives (Ethical considerations and cultural implications)~~ ~~High level review of informed consent policy and Case scenario discussions~~
~~Concept~~	~~Delivering education in a collaborative learning space, using methods such as problem based learning, case scenarios for simulation based education~~
~~Methods~~	~~A series of talks followed by case scenario discussions.~~ ~~Background and history of informed consent~~

	~~Potential Speakers:~~ • ~~Sandra Coney~~ [redacted] ~~Consumer Perspectives (Ethical considerations and cultural implications)~~ ~~Potential Speakers include:~~ • ~~Professor Ron Paterson~~ • ~~Professor Catherine Cook~~ ~~Policy and Case Scenarios~~ ~~Speaker and facilitator Clinical champions, Clinical Nurse educators and Anaesthetic technician educator.~~
~~Content~~ ~~Engagement/Buy in~~	~~Content experts:~~ ~~Informed consent project steering group (See Appendix 5.1 on page 9 for details)~~ ~~Design and implementation:~~ ~~Ara Cho — Clinical Nurse Educator – Theatres~~ ~~Zoe Bunker — Anaesthetic Technician – Educator~~ ~~Penny Andrew — Director – Institute of Innovation and Improvement~~ ~~Clinical Directors of each surgical service include~~ ~~General Surgery — Richard Harman~~ ~~Orthopaedics — Matt Walker~~ ~~Urology — Madhu Koya~~ ~~Gynaecology and Obstetrics — Diana Ackerman~~ ~~ORL — David Grayson~~ ~~Anaesthesia — Charlie McFarlan~~
~~Duration~~	~~2 x Friday Theatre Education Sessions~~ ~~30 August~~ ~~4 October~~

Field Code Changed
Field Code Changed

5. Appendix

5.1 Informed consent project steering group

Name	Role
Cath Cronin	Director of Hospital Services
Penny Andrew	Director – Insititute of Innovation and Improvement
Michael Rodgers	Chief of Surgery
Kate Gilmour	Head of Division, Nursing – Surgical and Ambulatory Services
Jonathan Christiansen	Associate Chief Medical Officer
Diana Ackerman	Clinical Director, Gyanecology Acting Clinical Director, Obstetrics
Amanda Mark	Legal Counsel
Ulrike Gerstenberger	Clinical Nurse Director, North Shore Hospital Theatres
Morgan Edwards	Senior Medical Officer (Anaesthetist)
Ara Cho	Clinical Nurse Educator - Theatres
Lisa Sue	Innovation and Improvement Project Manager

5.2 Definitions of roles as per Informed Consent Policy

As per the Waitemata DHB Informed Consent Policy, updated August 2018, page 4

"Registered Health Professional" is defined as: a health practitioner who practises in a regulated profession in New Zealand and must be registered with the relevant responsible authority and hold an Annual Practising Certificate (APC) issued by that authority.

A registered health professional, who is employed by the DHB, has been assessed as competent and is enrolled in a training programme which will lead to a specialist qualification. They work in an indirect supervision arrangement with the training programme supervisor to meet advanced learning outcomes.

Student refers to someone not employed by Waitemata DHB and who is enrolled in a recognised health professional training programme and who is not ordinarily part of the health care team and works under the direction of a registered health professional who is responsible for the patient and the expected outcome.

Matrix of health care professionals within Surgical Services

Medical Roles	Definition as per Informed Consent Policy
Consultant (Senior Medical Officer)	Registered Health Professional
Registrar – Medical officer on special scale	Registered Health Professional
Registrar – Post exam	Registered Health Professional
Registrar – Pre exam	Registered Health Professional and Trainee
Registrar – Non training	Registered Health Professional
Surgical House Officer – Post Grad Year 2	Registered Health Professional and Trainee
Surgical House Officer – Post Grad Year 1	Registered Health Professional and Trainee
6th Year Medical Student / Trainee Intern	*To be clarified. They are employeed by the DHB but are*

	not registered health professionals.
2nd to 5th Year Medical Student	Student
Nursing Roles	**Definition as per Informed Consent Policy**
Registered nurse	Registered Health Professional
Enrolled nurse	*To be clarified. They are employeed by the DHB but are not registered health professionals.*
Nursing student	Student
Anaesthesia Roles	**Definition as per Informed Consent Policy**
Anaesthetist (Senior Medical Officer)	Registered Health Professional
Registrar – Post exam	Registered Health Professional
Registrar – Pre exam	Registered Health Professional and Trainee
Surgical House Officer – Post Grad Year 2	Registered Health Professional and Trainee
Midwifery Roles	**Definition as per Informed Consent Policy**
Midwife	Registered Health Professional
Midwifery student	Student
Miscellaneous Roles	**Definition as per Informed Consent Policy**
Paramedics	*To be clarified*
Health Care Assistants	*To be clarified*
Medcial Radiation Technicians	*To be clarified*
Orderlie	*To be clarified*

5.3 Example Poster

Insert poster sketch when completed

5.4 Example Kahoot Quiz 1: Informed Consent Policy, Section 1

https://create.kahoot.it/share/informed-consent-at-waitemata-dhb-part-1/ec0b5657-6b75-48f3-872f-969590e06239

No	Questions bespoke to Nursing	Answers
1.	Informed consent is not the process of filling out forms but rather it is the... a) checking that the patient has understood information b) patients freely given and competent consent c) information exchange so patients make an information decision d) All of the answer are correct	D
2.	What level of consent is needed for routine minor interventions such as taking a patient's blood pressure? a) Written b) Implied c) No consent necessary d) Both, Written & Implied	B
3.	Which of the following does not need a written consent? a) Student performing an intimate examination b) When an I.V cannula is to be inserted c) There is significant risk of adverse effects on the patient d) Patient is to be placed under general anaesthetic/sedation	B
4.	Verbal consent should be documented in the clinical notes True/False	True
5.	Where there arehigher risks or greater potential harm, more care & detail in giving information is required. True/False	True
6.	Where delegation is required, who can be delegated to obtain informed consent? a) On-call Registrar b) Only the Primary Registered Health Professional (RHP) c) RHP who understands the risks and benefits of the procedure and the patient's particular issues, risks & benefits d) The Clinical Nurse Specialist of the team	C
7.	Which is more correct? The clinician has an obligation to ensure the patient has had core... a) information on the procedure even if refused b) information on the implications even if refused c) information on the procedure & implications even if refused d) None, there are no obligations	C
8.	Where you witnessed informed consent not being obtained, who can you escalate it to? a) ACCN b) CNM c) CNE d) All – ACCN, CNM, CNE	D

5.5 Example Kahoot Quiz 1: Informed Consent Policy, Section 2

https://create.kahoot.it/share/informed-consent-at-waitemata-dhb-part-2/faf20d37-424f-4a94-b807-388275dacbef

No	Questions bespoke to Nursing	Answers
1.	Consent for involvement in teaching only applies to interventional procedures a) True b) False	B
2.	Who is responsible for eliciting the essential consent to teach procedures? a) CNM of the unit b) Shift coordinator c) Supervising clinical preceptor/mentor d) All answers are correct	C
3.	Where practicable, the request to the patient should be made **without** the student present. a) False. Student should be present, to aid patient's decision. b) True. So patient is able to freely decide their involvement. c) False. Student should be present, to get explicit consent. d) True. So the student can have time to prepare for the case.	B
4.	When a patient gave consent to a teaching session, they... a) Aren't allowed to withdraw at all. b) Aren't allowed to withdraw until the session is completed. c) Can withdraw from teaching session at any stage d) Can withdraw, only if teaching session was for observations.	C
5.	Multiple intimate examinations on one patient by a group of students ... a) Is prohibited b) Is not recommended c) Is allowed. This is a teaching hospital d) Is allowed if the patient consents to it.	A
6.	Whose responsibility obtaining consent for involving students to perform intimate examination? a) Supervising consultant b) Supervising senior registrar c) Student performing the intimate examination d) Supervising consultant or senior registrar	D
7.	Non-medical personnel i.e. company representative, observing a procedure using their products a) Don't require patient consent. They aren't directly involved b) Needs consent from the patient.	B
8.	Students do **not** need written consent to perform intimate examinations... a) if supervising consultant allowed them to participate b) if supervising consultant obtained verbal consent c) if supervising consultant documents in clinical records d) All answers are incorrect	D

Attachment 4

Denise Poole (WDHB)

From: Penny Andrew (WDHB)
Sent: Wednesday, 02 October 2019 16:08
To: Lisa Sue (WDHB); Jonathan Christiansen (WDHB); Ron Paterson
Subject: FW: Feedback about the Informed Consent session at the end of August

FYI here is the feedback Jos received (summarised by Jos) from the 1st session with staff.
I'll also forward you the most recent email from Jos with more issues raised by [redacted]

Penny

From: Jocelyn Peach (WDHB)
Sent: Friday, 13 September 2019 4:07 PM
To: Penny Andrew (WDHB) <Penny.Andrew@waitematadhb.govt.nz>; Amanda Mark (WDHB) <Amanda.Mark@waitematadhb.govt.nz>; Jonathan Christiansen (WDHB) <Jonathan.Christiansen@waitematadhb.govt.nz>
Subject: Feedback about the Informed Consent session at the end of August

I have received quite a bit of feedback about the session held on Informed consent.
A number of people are more confused than before
A number consider that comments made by the panel has given permission for the teams to not follow good practice
I think we need to discuss please.

Comments:

- *Not enough time to sit with patients to discuss thoroughly all requirements of informed consent*
- *Disconnection between NSH being a training hospital and requirement for informed consent for observers/trainees in theatre and/or trainees participating in a procedure*
- *General consensus that as a training facility, consent is not essentially required for trainees observing a procedure*
- *No reference made to 'Patients Rights' policy*
- *Legal Representative suggested informed consent not a legal requirement but a WDHB policy requirement*
- *Suggested that as there are no patient complaints regarding informed consent then there is not a problem!!!! How can patient complain about something they have no information or understanding of?*
- *CMO stated more than four times that it is a **courtesy** only to patients to inform of a trainee observing/participating in a procedure*

General summation very little contribution from panel; mainly random ideas shared from audience re their perceptions around the informed consent topic; absolutely no educational value in terms of clarifying actual responsibility for gaining informed consent, verbal for trainee/observer to be present or written for participation in procedure (no discussion at all re this latter particular aspect of consent).

Jos

Jocelyn Peach, RGON
Director of Nursing/ Emergency Systems Planner
Waitemata District Health Board
Private Bag 93-503, Takapuna, Auckland 0740

Phone 021784321 // Email Jocelyn.peach@waitematadhb.govt.nz

Friday 30 August – Theatre education session (case study discussions)

70 people attended.

Themes discussed from the session:

- Legal requirements vs. courtesy
- Complex – not just doctors
- Process is key not just the form
- On anticipated needs
- Constraints/context
    - Teaching environment
    - Time
    - Access to forms
    - Wording on forms
    - Language
- Recommended actions
    - Video as a tool to inform patients
    - Forms in advance

Survey Monkey Feedback

12 people gave feedback as by 3 September 2019 (AM).

Thoughts on the session length

50% felt it was too short	50% felt it was just the right length
Comments: • Need more time and more scenarios. • It would have been nice to further discuss the topics covered. • More time for discussions and also for recommendations to be put forward • A bit rushed. • A bit rushed would like to have had more panel discussions with clinicians	Comments: • Very informative • Good case study examples

What did you like from the session?

- Open discussion
- Open forum with panel
- That there was an open discussion
- The strong influence on making the session interaction
- Everyone's input matters
- Ability for all to offer viewpoints
- A chance to catch up with my colleagues
- Complex scenarios with multi-disciplinary perspectives

- A good mixture of disciplines but only seemed to be Obs & Gynae Surgeons, would like to have heard from other specialities
- Feedback from different specialties
- Discussion about such an important topic. Some good points were raised.
- The cases were really relevant; we have dealt with these exact situations multiple times, excellent wrap up by the man at the end of the pertinent points.

What could we improve from the session?

- Length of the session
- Felt the session should have been used to give us the actual facts of what is the legal stance on informed consent rather than what opinion was as I did not feel this really got us anywhere as everyone has differing beliefs and opinion due to working in different countries, training, working in other DHB's in NZ. Didn't feel the panel gave clear explanation of this.
- Offer solutions to our discussions, especially on the grey areas of the topic. What is the WDHB's stand on it?
- More focused - certain cross section in each group Was too wish washy Know if there is a problem that needs fixed and not just one or 2 people who are making a lot of noise internally which is how it seems
- Provide some DHB guidance / expectations on each scenario
- Just scheduling more time for discussion is all.
- Can't think of anything

Did you have other comments?

- The patient should be the main focus, we need to be proactive in informing our patients, as time goes on patient rights will become more and our legal requirements will become more we need to be prepared for this.
- Shame that the surgeons don't consider these sessions important as they can't bother turning up. It implies that they don't consider other practitioners important or relevant.
- No, thank you for a great day!
- The excuse of Teaching Hospital is too prevalent, being a teaching hospital does not exclude us from informing the likelihood of, and seeking consent from patients (particularly women in the Gynae service) for allowing trainees to be involved in interventions and examinations. This should be discussed with every patient pre-operatively and consent sought. It is a patient's right (not a courtesy) to know who is going to examine her or contribute to an intervention. We seek permission for every intervention from awake patients so what gives us the right to negate this because a patient is sedated. The Treaty of Waitangi, which in effect, applies to all human beings clearly states and supports protection participation and partnership and at the very essence is the information and consent from the patient for any intervention or examination planned.
- Would like to see more of these interdisciplinary discussions
- Thanks

Friday 4th October – Theatre education session

54 people attended.

Themes discussed from the session:

- Patient voice of informed consent
- Code of Health and Disability Services Consumer Rights and Medical Council guidance
- Students
- Team care and delegation
- Teaching
- Enduring power of attorney
- Communication and key discussions points before surgery

Staff Feedback

10 people gave feedback on Survey Monkey as of 11 October 2019 and 1 person provided email feedback

Thoughts on the session length

100% of participants that provided feedback agreed the session length was about the right length.

What they liked from the session? (Verbatim)

- Patient video, discussion, case study
- Informative and relevant
- Legal opinion
- Learnt that the doctors need to get consent before a student sutures
- Having all the relevant information pulling and presented together
- Case study
- The interactive element, with input from different staff members, from both medical and nursing The immediate clarification from the legal team about specific terms and scenarios I was able to talk to the facilitator afterwards for personal feedback on pertinent issues
- Was informative for me as I was not aware of what occurred
- Case study and patient stories. Interactive
- Interactive. All inclusive. Nice to have Drs and Nurses together

What could we improve from the session? (Verbatim)

- Can't think of anything
- I thought it was excellent and cannot think of needed improvements
- Please include nursing council guidelines on direction and delegation
- Have more of the theatre nurses to attend only one from ortho
- Nothing
- Nothing
- Nothing at this point
- Not sure
- Nothing jumps to mind. Perhaps less focused on doctors
- Friday is a challenging day for CNSs to attend – clinics running. But you will never please everyone.

Did you have other comments?

- The audience participation was interesting
- Please repeat this on the Waitakere Campus
- No need for any further sessions
- I enjoyed it immensely and took out elements I can definitely utilise clinically
- I attended as wanted to know how consent was granted. I work in surgical pathology and would like to know how consent is gained for histology testing to be performed on patients specimens and how the patient is informed on their tissue been returned to them (or not).
- Great reminder about importance of effective communication with patients and within teams
- Perhaps have it on a different day of the week rotating to try to catch as many as can possibly attend.

Email feedback

It was a great educational session, and I felt I was able to take away so much from it. The case discussion at the end was very thought provoking as intended.

Attachment 5

Denise Poole (WDHB)

From: Penny Andrew (WDHB)
Sent: Monday, 01 July 2019 19:34
To: Cath Cronin (WDHB); Jonathan Christiansen (WDHB)
Subject: RE: med students / new 1st year reg
Attachments: [P] Informed Consent Policy Aug18.pdf
Attachment previously provided in OIA response 19176

Hi

Do you want to circulate a policy specifically for maternity and gynae theatre; or applying to all of theatre; or applying to all services across the DHB?

Re circulating 'the student policy' there doesn't appear to be a single student policy. There is:

- the DHB's Informed Consent Policy (copy attached) –particularly section 2 (Teaching and Observers) covering students and consent: 2.1 Core principles; 2.2 Principles for Clinical Teaching; 2.3 Intimate Examinations; 2.4 Clinical Teaching of Students in Training; 2.5 Supervision of Student Experience; 2.6 Consent for Involvement of Students; 2.7 Consent for all Students in Theatre / Operating Room / Procedure Room
- UoA documents that Lisa and I have been given:
  - Interim Statement – Informed Consent
  - MBCHB Part 1 Year 2 Course Book
  - Medical and Health Sciences – Clinical Practice: guidelines, policies & legislation (contains a copy of the 'consensus statement' prepared by the UoA and University of Otago with DHB CMOs, NZ Med Students' Association and NZ Medical Council published in the NZMJ (9 pages))
  - Medical and Health Sciences Dept of Obs and Gynae Year 6 Course Book 2019

The last document – Year 6 Course Book for O&G has a succinct one-page ' requirements for informed consent' (copy below), which is practical and is consistent with both the Universities consensus statement and DHB's IC Policy. We could brand and circulate this document as a one-page protocol either just for gynae and maternity services; or make some simple changes to the wording to make it apply to all patients (eg replace women with patients). We can add as a reference the consensus statement and place for staff to find a copy.

CONSENT AND PATIENTS' RIGHTS

We would like to emphasise the importance of observing and respecting patients' rights as determined by the Consumer's Code of Rights, the New Zealand Medical Association's Code of Ethics, and the Medical Council's Ethical Guidelines.

A brief summary of essential consent requirements:

1. It is the woman's right to decide whether they agree to have their history taken or an examination/procedure performed by a student. Patients are to be informed of this right.

2. **The School of Medicine has a Sensitive Examination Policy which states the requirement for a staff member to be present when a student is performing any intimate examination.**

3. It is the woman's right to have a support person present.

4. It is the woman's right to refuse to participate in student teaching without this decision jeopardising her care.

5. **Hospital staff should obtain patient consent for medical student involvement in care;** verbal consent is sufficient prior to a student taking a history or performing an examination in a clinic setting or for observing in the operating theatre or delivery suite. Written consent is required for the student to perform a bimanual pelvic examination (or other procedures) under anaesthetic. **It is also the student's responsibility to ensure that patient consent has been given.**

6. Medical students are provided with a supply of stickers (example below) which they should complete and attach to the patient's surgical consent form to confirm patient consent for the named student to undertake a pelvic examination under anaesthesia.

> I, ... consent to senior medical student ..... conducting a pelvic examination in theatre during my anaesthetic.
>
> Signed & Date: .....
> Witnessed By:.....

7. The identity of students is to be made known at every patient encounter. Students must wear their identity badge in all clinical sessions.

8. Students are to respect patient confidentiality.

9. Situations needing particular care with regard to consent for student observation and/or involvement:
    - Children under 16 years of age
    - Patients with different cultural background to that of the student
    - Patients not proficient in English
    - Patients with confusion, mental incompetence or hearing problems

Penny

From: Cath Cronin (WDHB)
Sent: Monday, 01 July 2019 6:09 p.m.
To: Jonathan Christiansen (WDHB); Penny Andrew (WDHB)
Subject: RE: med students / new 1st year reg

Hi

As discussed I will set up at time for you, [redacted] and I to meet. (probably [redacted] as well)

We also need to circulate the student policy immediately – this cant wait to be socialised. How do you want to do this?

Thanks cath

Cath Cronin I Director Hospital Services I RN
Waitematā District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Jonathan Christiansen (WDHB)
Sent: Monday, 01 July 2019 1:29 p.m.
To: Cath Cronin (WDHB); Penny Andrew (WDHB)
Subject: RE: med students / new 1st year reg

I have reviewed the chart for [redacted] – noted as "1st year Reg performing Caesar" in the email below.

The patient was consented thoroughly by the Registrar who then performed the procedure.
Our normal consent form was completed.
All the documentation records that the SMO was present in direct supervision during the C-section.

This looks like normal practice for a teaching hospital and I can't identify any reason why we should further review this case.
Trainees must undertake a significant number of supervised procedures to gain credentialing and sign-off.

Jonathan

From: Jonathan Christiansen (WDHB)
Sent: Friday, 28 June 2019 8:45 a.m.
To: Cath Cronin (WDHB); Penny Andrew (WDHB)
Subject: RE: med students / new 1st year reg

Well in the case of the issues with the Med Students we need to work with the university to ensure that all students comply with the clear policy that consent MUST be obtained for any direct hands-on care.
We can do that through Martin and Laura, and reinforce that with the services (all DHB services) – the University Guidelines are clear that the primary responsibility/accountability for getting consent for the student is with the supervising clinician – not the student themselves.

The question on the "new" reg and the Caesarian will depend on the training level and experience of the Reg (some may have done a lot of procedures as an SHO for example), and the level of involvement of the SMO.
The Op note indicates that the SMO was the Assistant for the surgery – which would presume they are scrubbed.
There would have been consent for the C-section which in all likelihood was completed by the Reg themselves – but we will need to get the paper chart for that.

Jonathan

From: Cath Cronin (WDHB)
Sent: Friday, 28 June 2019 7:24 a.m.
To: Jonathan Christiansen (WDHB); Penny Andrew (WDHB)
Subject: FW: med students / new 1st year reg

Hi

Would you please review and update me. I will go back to [redacted]

I have asked her to send me an email or text on the day of the incident in future.

Thanks cath

Cath Cronin I Director Hospital Services I RN
Waitematā District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: [redacted]
Sent: Wednesday, 26 June 2019 1:44 p.m.
To: Cath Cronin (WDHB)
Subject: med students / new 1st year reg

Hi Cath ,
as discussed this am, 17/6 new reg with med student [redacted] 19/6 same new reg offering the med student to suture wound, 25/6 consultant letting new 1st year reg perform Caesar [redacted] 26/6 med student scrubbed in assisting [redacted] All fine if there is consent but there was none.
Med students just walk into theatre no introductions.

Regards
[redacted]

Denise Poole (WDHB)

From: Martin Connolly (WDHB)
Sent: Thursday, 04 July 2019 14:17
To: Jonathan Christiansen (WDHB)
Subject: UoA Policy of Clinical Ethics for med students

Importance: High

Hi Jonathan

All the programme policies are in the MBChB portal with consent being the first few pages

https://wiki.auckland.ac.nz/display/MBChB/MBChB+Portal?preview=/48562213/128619843/Clinical_Practice-guidelines_policies_legislation.pdf

`heers

Martin

Denise Poole (WDHB)

From: Cath Cronin (WDHB)
Sent: Monday, 08 July 2019 13:14
To: Jonathan Christiansen (WDHB)
Cc: Penny Andrew (WDHB)
Subject: Follow up from this am meeting
Attachments: IMG_4784.jpg

- Student communication – joint comms from you and Andrew Connelly. Can we do this by end of week?
- Process of consent – you and I (or just you) to meet with SMO and registrar
- Supervision (delegation). Role of SMO – how do we define this more clearly? See attached sheet
- Communication with patient – discussion with Ron Patterson
- HDC advice – on consent and consent form – how do we progress this?
- Overt communication with patient - ? Ron Patterson discussion and then agenda for consumer council

See attached sheet that Dianna and Adelle are working with i3. From capital and coast from memory.

Penny – when will this be ready to trial?

Thanks cath

Cath Cronin I **Director Hospital Services I RN**
Waitematā District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

Registrar Credentialing - 2019												
Year of Study	6	5	5/6	5	5	4	4	4	3	2	2	1
	Advanced ITP					Core ITP						
Obstetrics												
Delivery with significant maternal risk	3	3	3	3	3	3	2	3	1	1	1	2
Ventouse: Low/Outlet	3	3	3	2	4	3	3	3	1	1	2	1
Forceps: Low/Outlet	3	3	3	1	4	2	2	2	1	1	1	1
LSCS: Level 1	3	3	3	3	3	3	3	3	3	3	3	2
LSCS: Level 2	3	3	3	1	3	2	2	1	1	1	1	1
Manual Removal	3	3	3	2	3	3	2	2	1	1	1	1
3rd Degree Tear	3	4	3	1	4	3	3	3	1	1	1	1
Gynaecology												
D&C	3	3	3	3	3	3	3	3	3	3	3	3
D&C Postpartum	3	3	3	2	3	3	2	3	1	1	1	1
Bartholin's Management	3	3	3	3	3	3	3	3	3	3	2	2
Hysteroscopy	3	3	3	2	3	3	2	2	3	1	1	1
Laparoscopy: Level 1	3	3	2	2	2	3	2	2	1	1	1	1
Laparoscopy: Level 2	3	3	2	2	3	2	1	1	1	1	1	1
Laparotomy: (Simple/Stable)	3	3	3	1	3	3	2	2	1	1	1	1
Minor outpatient procedures under local +/- sedation						SMO to attand for all Advanced interventions with Core ITPs						
Obstetrics Advanced												
Instrumental: Rotational	3	3	1	1	2	Vaginal Delivery With Significant Maternal Risk: significant maternal co-morbidity, obesity (BMI>40), severe PET, cardiac disease						
Instrumental: Trial	2	2	1	1	1	Caesarean Level 1 - Elective, non labouring, early first stage, one previous CS, BMI<40						
Vaginal Breech	1	1	1	1	1	Caesarean Level 2 - Late first stage not Fully BMI >40 <34 weeks						
Vaginal Multiple	2	2	1	1	2	Low/outlet forceps - non rotation<45, presenting part > or = +2 station						
EUA for PPH>1000ML	2	2	2	1	2	Laparoscopy level 1 - diagnostic, tubal lign, simple cyst aspiration						
4th degree tear	1	1	1	1	1	Laparoscopy Level 2 - ovarian cystectomy, oophorectomy with normal anatomy, salpingectomy for ectopic preg, excisional endo AFS stage 1						
Synto (Induction; Primi Augmentation)	4	4	4	_	4	Laparotomy - Simple / Stable						
ECV	4	4	_	_	4	**SMO to be *informed* (Regardless of Seniority of Registrar)**			**SMO to *attend* (regardless of Seniority of Registrar)**			
						1) Any case requiring transfer to theatre/RMO called to OT by other specialty			If indicated by individual registrar's credentialing score			
Clinics						2) Fetal death in labour or unexpected still birth			Maternal death			
ANC						3) Delivery of fetus with lactate on cl >=8 or requiring active resuscitation			Caesarean Section - Second stage(Fully), transverse/breech lie			
Reg only; no extra RMO	✓	✓		✓	✓	4) A woman in labour who is JW (Refuses livesaving treatment (herself /baby)			Extreme prematurity (<30 weeks), placenta praevia, JW			
Reg only + RMO supervison	✓	✓		✓	✓	5) If a 2nd fetal blood sample is required			Eclampsia			
GOPD						6) Any transfer in labour from another unit or from intended homebirth			Vaginal breech delivery			
Reg only; no extra RMO	✓	✓		✓	✓				Laparotomy (Haemodinamicxally unstable			
Reg only + RMO supervison	✓	✓		✓	✓				EUA PPH - Shocked Pt			

Trainees may request consultant supervision in any clinical situation

Whether the Consultant attends or not should be determined by
(i) The request of the trainee
(ii) The trainee's level of credentialing for the procedure
(iii) The Consultant's assessment of the complexity of the case
(iv) The Consultant's knowledge of the capability of the trainee

1.In room active supervising/assisting

2. On Site

3. On Call (available ≤ 20 min)

Advanced ITP only

4. Proceed without informing SMO

Denise Poole (WDHB)

From: Angie Hakiwai (WDHB)
Sent: Monday, 22 January 2018 9:00 a.m.
To: David Price (WDHB); Jocelyn Peach (WDHB); Amanda Mark (WDHB)
Cc: Grace Ryu (WDHB)
Subject: WDHB Consent form
Importance: High

Dear All,

I have made the requested changes to the "Agreement to treatment / Consent" form as per the feedback from the CGB and CD forum and I would like this presented at the next CGB meeting on 8th February.

Amanda – is this form acceptable from a legal perspective?
Jos – Any feedback from the Nursing forum?
David – any feedback from the consumer group?
Any feedback is gratefully received.

Regards,

Angie

Angie Hakiwai I ***Practice Improvement Nurse Specialist***
Department of General Surgery I Waitemata DHB
North Shore Hospital, 124 Shakespeare Road, Private Bag 93-503,
Takapuna, Auckland 0740
Mobile: 021818701

Agenda item 1.2.8.6

Action item follow up re "Feedback received regarding the change to the informed Consent form"

Background details are below.

The current form was first tabled by Grace Ryu at a Clinical Governance Board meeting on 26June. The minutes from that meeting are below.

5	New Business
5.1	**Patient's consent form, Asian perspectives, *Grace Ryu*** Grace provided a presentation which outlined the following concerns. • The red text on the current consent form looks "like a warning" • In the Asian culture, writing names in red is for the deceased only • ADHB has a rule that "no forms be created using red text" • CMDHB are using black text with coloured logos Grace provided the following recommendation:- • Keep the frame and large (main) titles in red for visibility if necessary • Use black or navy text for the context

The revised form was tabled at the last Clinical Governance Board meeting on 24 Aug. The minutes from that meeting are below. As you can see the document has not as yet been endorsed by CGB and the members are waiting the outcome of any further feedback from the various clinical groups as per the "new action items".

3. **Informed Consent, revised document, seeking endorsement**

Grace Ryu presented a request for change to the Informed Consent form at the last meeting. As a result an updated document was tabled at the meeting today.

Kate Gilmour confirmed that the document has been discussed with the theatre group and reviewed by Amanda Mark. Kate discussed the following main changes to the form:-

- Changed the name from Request for Treatment/Consent to Agreement to treatment/Consent
- The bold red text has been removed
- The bullet points under the heading "I agree that" have been made much clearer and more user friendly.

Penny confirmed that there is a Treatment/Procedure Without Consent form which helps guide clinicians through Right 7(4) Consumers' Code of Rights process (i.e. what to do when a patient is incompetent and you are intending to treat without consent. Penny advised that this may be helpful when you speak to the clinicians about the proposed new form for Agreement to treatment. This document was not endorsed.

NEW ACTION ITEM

1. Feedback to Angie Hakiwai to advise document needs to be discussed with the following groups
2. Nursing forum
3. CD Forum
4. Consumer group
5. Then new mark up to be sent back to Amanda Mark for another legal review
6. Send a further updated document to Paula to table at CGB meeting

Feedback received below is from clinical directors forum

Hi Paula

My comments:

- The title of this is inconsistent. The horizontal heading at the top of p1-3 is "Agreement to Treatment/Consent"; but the vertical (red) title along the right and left hand sides and at the top of page 4 (last page) states "Request for Treatment/Consent"
- Second bullet point under "I agree that:..." should be edited for consistency (add in 'the patient's highlighted in yellow below i.e.

I understand that during this procedure images or pictures relevant to my/the patient's care may be captured and incorporated into my/the patient's clinical record.

- Return of body parts 'has' should read 'have' i.e.

theatre staff have been informed

- Page 2, Anaesthesia, second bullet point add in /the patient's i.e.:

The possible benefits and risks of the Anaesthetic have been explained to me relating to my/the patient's clinical history and condition.

- Page 2 Blood Components and Products, second box, the form needs to be consistent – Doctor is used in this sentence i.e. I have had the opportunity to ask questions and discuss this with the Doctor whose signature appears below. But the signature below specifies "Clinican" and clinician is used throughout the rest of the document
- Page 2 Blood Components and Products, third box, again need to add in '/the patient' i.e. I agree to receive blood or blood products if these are considered necessary by the doctors looking after me/the patient. I understand I/the patient may need to receive repeated transfusions.

Thanks
Penny

Hello
This was discussed at the CD forum and I've since discussed it with Charlie McFarlan.
The anaesthesia side of the form is fine and needs no further change.

Thanks
Mark Chaddock

As mentioned, does not indicate name of patient.
John Scott

Hi
I have no concerns about the revised form.
Kind regards,
Janak de Zoysa

Denise Poole (WDHB)

From: Jonathan Christiansen (WDHB)
Sent: Saturday, 09 November 2019 08:56
To: Diana Ackerman (WDHB)
Cc: Karen Hellesoe (WDHB)
Subject: Email to your SMOs

Importance: High

Hi Diana,
Could you forward this email below to all Obstetric SMOs.
With thanks
Jonathan

Communication from the CMO.

Dear Colleagues,

On August 6th you received an email outlining concerns regarding the filing of incident forms by theatre nurse [redacted] for perceived breaches of the DHB's consent policy.

I have been requested to advise you all that [redacted] had been instructed to raise these concerns directly with the then Director of Hospital Services, Ms Cath Cronin.

I am aware there has been considerable focus and attention on informed consent in your department, and commend you on your continuing drive for patient focused care and clinical excellence.

Regards

Jonathan

Jonathan Christiansen I Chief Medical Officer
Waitemata District Health Board
Mobile 021 2654385

FRACP ADULT MEDICINE RACP

There is only one day left, always starting over: it is given to us at dawn, and taken away from us at dusk. Jean-Paul Sartre

Denise Poole (WDHB)

From:	Ian Wallace (WDHB)
Sent:	Monday, 16 September 2019 09:30
To:	Jonathan Christiansen (WDHB)
Cc:	Naomi Heap (WDHB)
Subject:	FW: Informed consent training/education
Attachments:	Legal Talk Feb 2017.ppt; Informed Consent Talk Dec 2018.pptx

Dear Jonathan

Attached are the PP presentations Amanda Mark and I have put together. We usually give these talks early in the PGY 1 teaching program. Also the link to the Controlled Docs policy document is on the RMO portal for easy reference.

I am planning to do this in one of the PGY 2 workshops to cover those PGY 2 who did not do PGY 1 with us. Also, the revision for the others would be useful.

Kind regards,

Ian

Dr Ian Wallace Mb,Bch, FCP(SA), FRACP, FACG
Director Clinical Training
Waitemata DHB
North Shore Hospital | Whenua Pupuke Building | Level 1
Takapuna | Auckland | New Zealand
09 4868920 x 9636
0274974549
Honorary Clinical Senior Lecturer
University of Auckland
www.waitematadhb.govt.nz

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WHENUA PUPUKE

From: Naomi Heap (WDHB)
Sent: Monday, 16 September 2019 8:31 a.m.
To: Jonathan Christiansen (WDHB)
Cc: Ian Wallace (WDHB)
Subject: RE: Informed consent training/education

Hi Jonathan
Ian and Amanda Mark do a session with them
Ian I wonder if you could send your power point through to Jonathan please ?
Many thanks
Naomi

From: Jonathan Christiansen (WDHB)
Sent: Saturday, 14 September 2019 11:03 a.m.
To: Naomi Heap (WDHB)
Subject: Informed consent training/education

Hi Naomi,

Could you clarify for me what training our PGY1s and 2s get in informed consent.

With thanks

Jonathan

Protection of Personal and Property Rights Act

Dr Ian Wallace
Director of Clinical Training
Amanda Mark
Legal Services Manager

Waitemata District Health Board
Te Wai Awhina

Protection of Personal and Property Rights Act 1988 - Overview

- A useful mechanism for protecting and promoting the personal and property rights of individuals who are not fully able to manage their own affairs.

Presumption of Competence

- **Section 5 – Every individual is presumed competent until proven otherwise**

Test for Incompetence

- **Does the person lack, wholly or partly, the capacity to understand the nature or foresee the consequences of decisions in respect of matters relating to his or her personal care and welfare?** *Section 6 – personal rights*

- **Or wholly or partly lack the competence to manage his or her own affairs n relation to property?** *Section 25 – property rights*

Types of Orders

- Welfare Guardian - EPOA
- Property Manager - EPOA
- Personal Orders – Section 10 of the Act

Enduring Powers of Attorney

- **Two types**
  - **Personal care and welfare (Welfare Guardian)**
    - this covers an individual's health, accommodation and associated decisions.
    - comes into effect only if a medical practitioner or the Family Court decides the individual does not have the mental capacity to make decisions about their care and welfare.
  - **Property (Property Manager)**
- this covers an individual's money and assets. It can come into effect immediately the individual signs it or when the individual is assessed as lacking mental capacity to make decisions about their property.

Enduring Powers of Attorney (EPOA)

- Individuals can appoint an attorney to make decisions about personal care and welfare *or* property in the event that person becomes mentally incapable = enduring power of attorney.
- The attorney will usually be a family member. (Can be the Public trust for property)
- Appointment of attorney can be in relation to personal care and welfare and/or property generally or limited to specific aspects.
- **The person appointing the attorney must be competent when they sign the EPOA.**

Requirements for valid EPOA

- EPOA must be in prescribed form
- Signed by donor
- Donor's signature must be witnessed by lawyer/legal executive or officer/employee of trustee company who is independent of attorney
- Signed by attorney
- Attorney's signature witnessed by someone other than donor or donor's witness
- Witness to donor's signature must explain the effect and implications of EPOA
- Witness must certify that explanation has been given, witness is independent of attorney *and* that there is no reason to suspect that donor was/may have been incapable at time of signing

Powers of Welfare Guardians

- **Full powers to make and carry out decisions for person concerned.**
- **Must act to promote and protect welfare and best interests of person.**
- **Must consult with person and other interested individuals (e.g. family).**

Restrictions on powers

- Welfare guardian cannot make decisions relating to:
  - marriage and dissolution of marriage
  - adoption of person's children
  - refusal of life saving medical treatment
  - consenting to ECT or brain surgery
  - consenting to participation in medical experiment except to save life.

Powers of Property Managers

- Maintain, repair, rent and sell property, make investments, provide for dependents etc .
- Must promote and protect interest of person concerned.
- Must consult with person concerned, welfare guardian, other interested individuals (eg family).

Vital to Sight EPOA

- Always sight enduring power of attorney and copy for file before acting on it.
- Check EPOA in proper format, properly executed and witnessed and certificate attached.
- Check whether power of attorney specifies any restrictions/conditions on the attorney's powers.
- If EPOA is in relation to property, check whether it is effective on execution or only when donor becomes mentally incapable.
- Make sure EPOA covers the matter which the attorney is making decisions about.

“Next of kin”

- The term ‘next of kin’ has no legal meaning or effect.
- A patient’s next of kin does not have the right to make decisions about the patient’s care and welfare or property unless they are appointed as attorney under an EPOA.
- Next of kin do need to be consulted for their views on proposed treatment where a patient is incompetent. (Right 7(4) of the Code of Health and Disability Services Consumers’ Rights (Code of Rights).
- In this situation the next of kin is not giving consent but is providing their views on what the patient would have wanted if they were competent.

When is EPOA activated?

- **EPOA activated when donor becomes mentally incapable.**
- **In relation to property "mentally incapable" means not wholly competent to manage his/her own affairs.**
- **In relation to personal care and welfare "mentally incapable" means partly or wholly lacking the capacity to understand the nature, and to foresee the consequences, of decisions relating to her his/her personal care and welfare *or* having the capacity but wholly lacking the capacity to communicate decisions about personal care and welfare.**

Activation of EPOA

- **EPOA in relation to personal care and welfare activated *only* when donor becomes mentally incapable.**

- **In relation to personal care and welfare "mentally incapable" means donor lacks capacity:**
  - **To make a decision relating to personal care or welfare**
  - **Understand the nature of such decisions**
  - **Foresee the consequences of making or failing to make such decisions**
  - **To communicate decision about personal care or welfare**

- **EPOA in relation to property can take effect immediately EPOA executed or only when donor becomes mentally incapable. EPOA must specify which**

EPOA – Certification of Incapacity

- Set form prescribed by Regulations.
- No prescribed method for assessing incapacity.
- Reasons for opinion must be recorded in certificate.
- Must be certified by health practitioner whose scope of practice includes assessing mental incapacity.

Personal Orders

- Section 10

- Orders can include directions that person be provided with medical advice or treatment of a specific kind, attend a particular hospital or service for treatment, live in supported accommodation etc.

Least Restrictive Intervention

- If jurisdiction can be established, what is the least restrictive intervention possible to address the problem?

- Is a section 10 personal order sufficient, rather than an application for a Welfare Guardian or Property Manager?

Applications

- Explore non legal options first.
- Identify an appropriate family member/friend who can make the application?
- Obtain suitable medical reports, that specifically address the relevant issues and the competency test?
- Obtain consents from family/proposed appointees where possible?

Supporting Evidence

- Prepare affidavit evidence to support application – must address issue of competence.

- Obtain medical report confirming:
  - report writer's professional status and qualifications
  - personal assessment of patient by report's author

Supporting Evidence (cont)

- person's current situation (reasons for admission, observations during admission)

- diagnosis and prognosis - competency – reasons for believing person unable to understand the nature and foresee the consequences of decisions about welfare

- recommendation re service of documents and attendance at court

Other Considerations

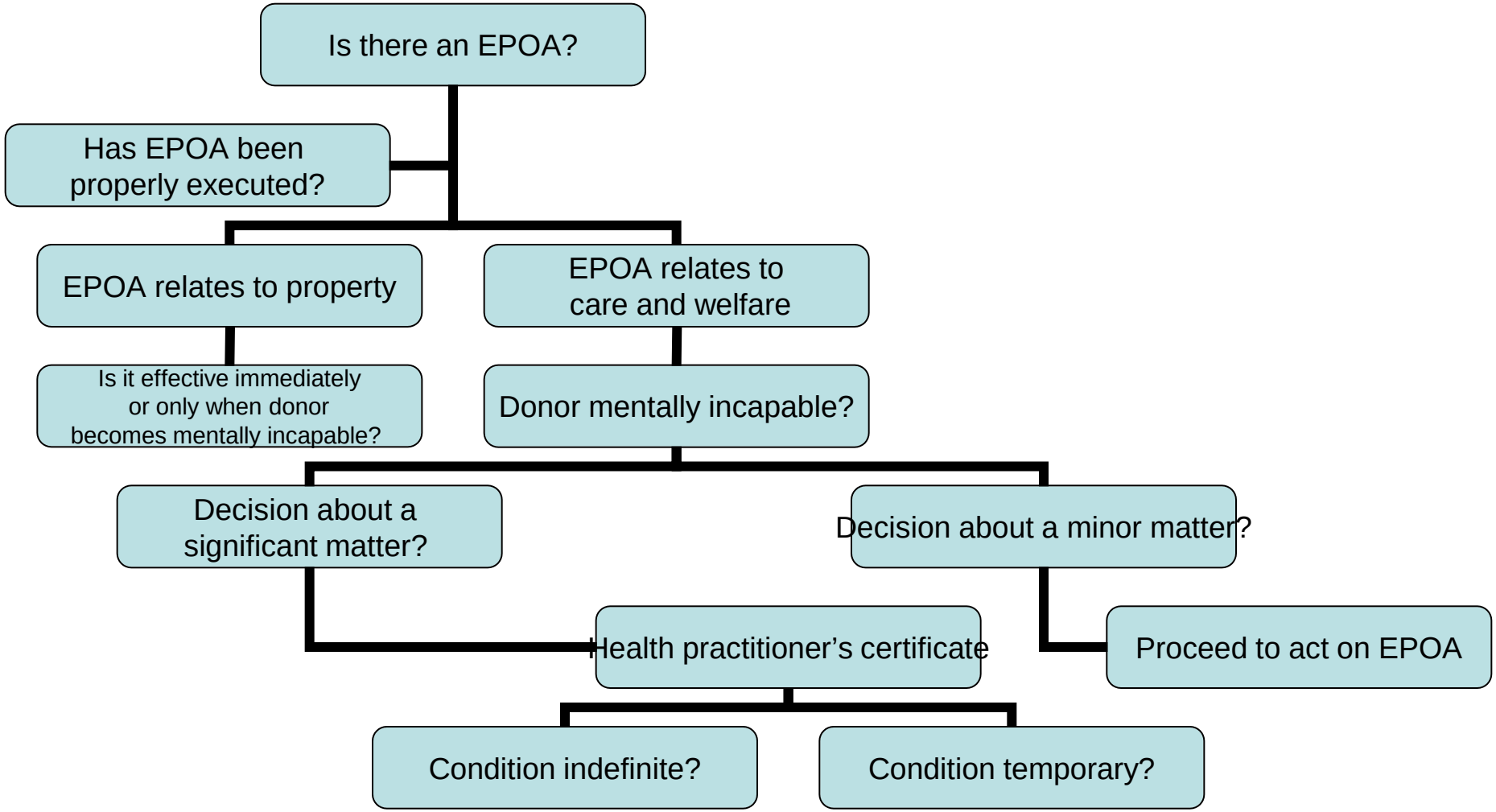
- Check the procedural requirements at the local Court. Applications must usually be filed at the Court closest to where the person resides.

- Do you need to make an application to excuse service of documents or attendance of the subject person?

Ex Parte Applications

- Deprive the other parties of the right to be heard.
- Should only be considered in exceptional cases, usually where there are safety issues.
- The Courts are able to make interim orders in urgent situations.
- Should be supported by affidavit evidence.

Acting on an EPOA



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Limitations on Attorney's powers under EPOA

- Attorneys cannot make decisions:
  - about marrying/dissolving a marriage
  - about the adoption of the donor's children
  - refusing consent to standard medical treatment designed to save donor's life or prevent serious damage to health

Limitations on Attorney's powers under EPOA (cont)

- consent to ECT
- consent to surgery designed to destroy any part of donor's brain or brain functions for the purposes of changing behaviour
- consent to donor's participation in medical experiment (except for purposes of saving life or preventing serious damage to health).

Court's powers to review EPOA

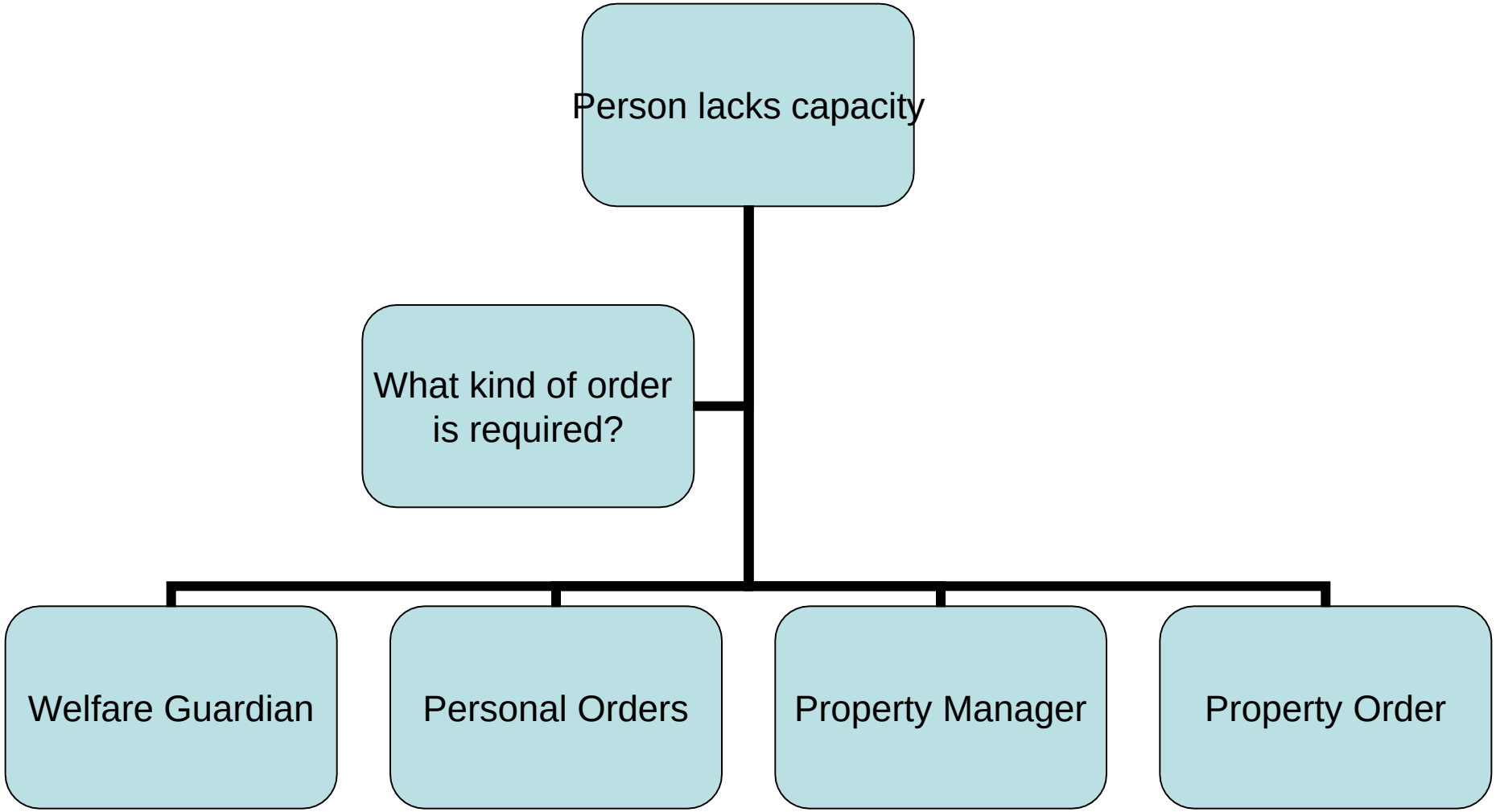
- **Court has power to review whether attorney properly appointed, whether donor mentally incapable, attorney's exercise of powers and to give directions to attorney.**

- **Enduring powers of attorney are subject to personal and property orders**

Summary

- An EPOA should be put in place well before it is required.
- Patients should be actively encouraged to put these in place whilst they are still competent
- For an EPOA to be implemented it has to be activated (usually by SMO).
- Where there are no family members available

Decision Tree



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Personal care and welfare

Person lacks capacity to make decisions about care and welfare

- 18 years or older
- Less than 18 years old but married or in civil union
  - Welfare guardian
  - Personal orders
- 16 years or older and living/has lived in a de facto relationship

Property

Person lacks capacity to manage property

Person ordinarily resident in NZ *or* property in NZ but person not ordinarily resident here

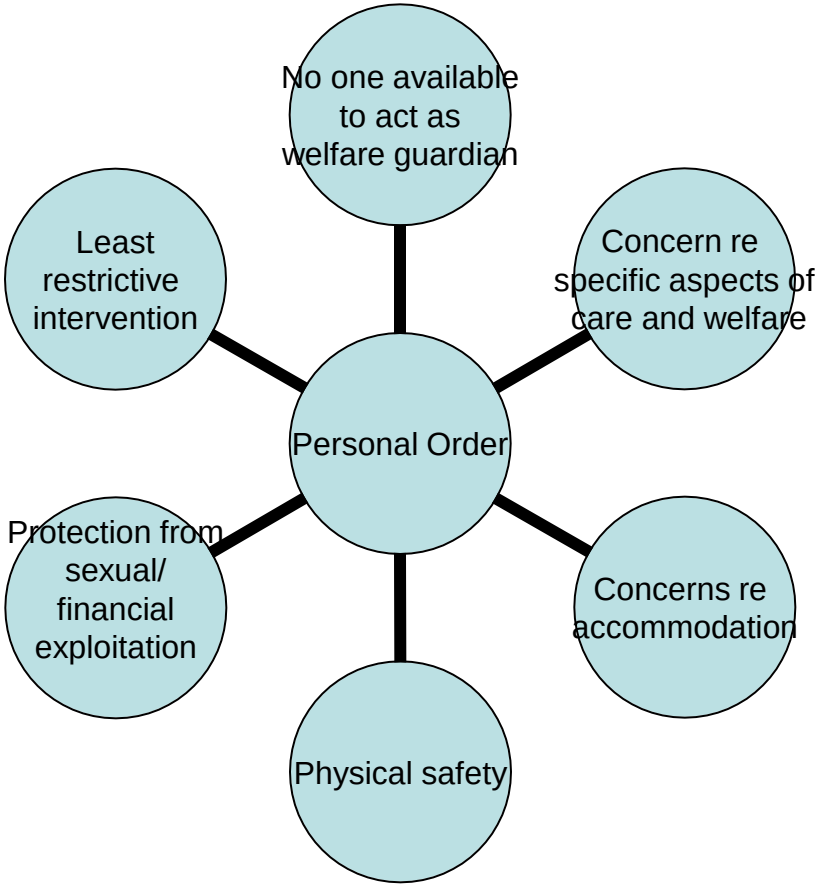
Property worth more than $2,000 or income more than $20,000 pa

Property worth less than $2,000 or income less than $20,000 pa

Property Manager

Orders to Administrate Property

Personal Orders re Care and Welfare



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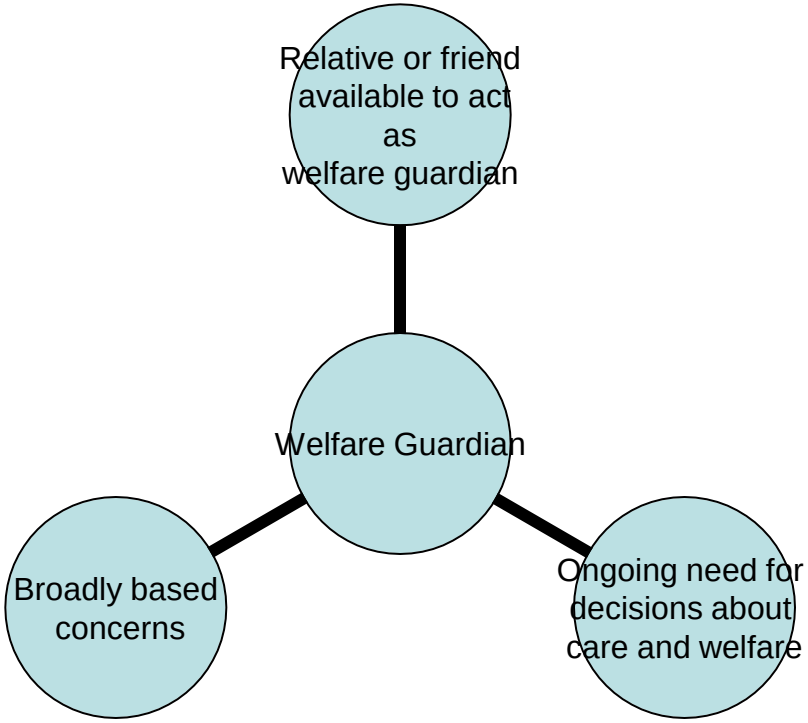
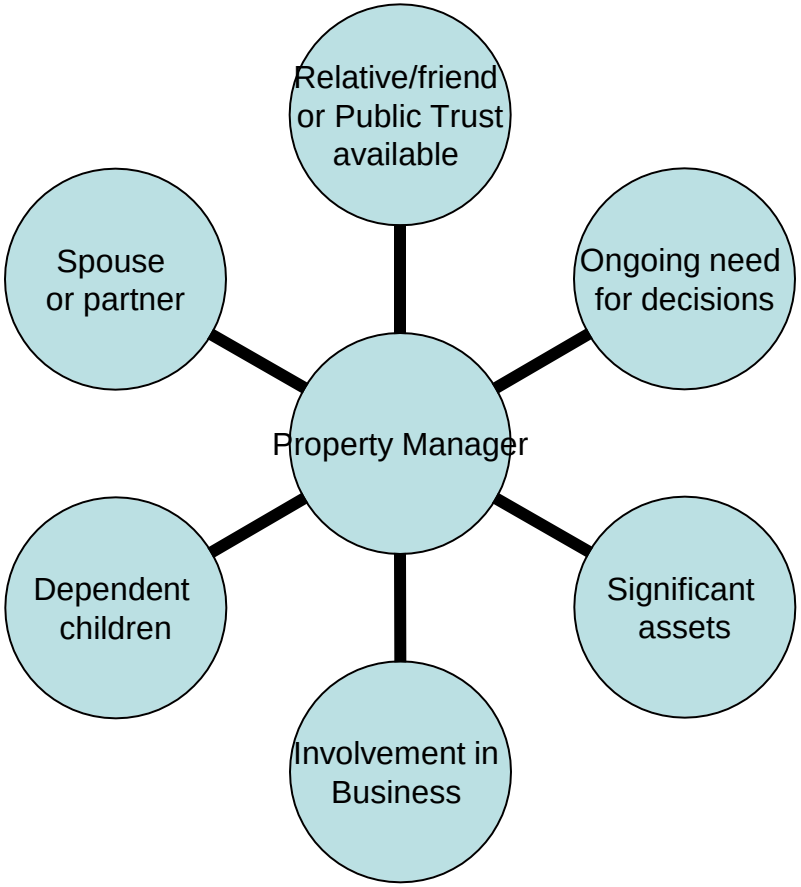
Welfare Guardian



Property Manager



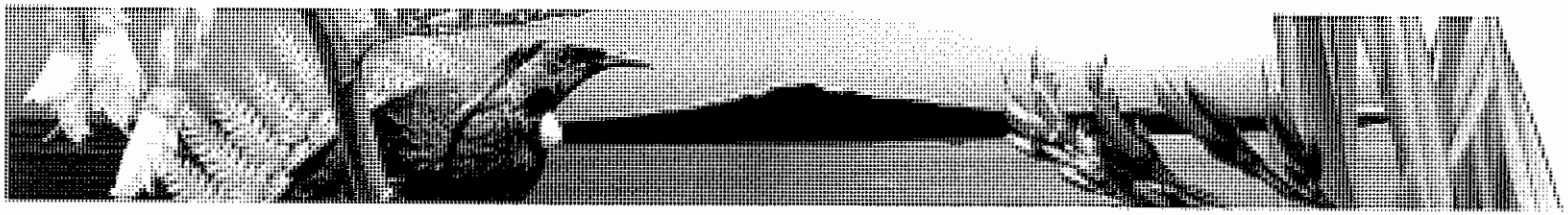
Informed Consent – a Practical guide

Dr Ian Wallace

Director of Clinical Training

Amanda Mark

Legal Services Manager



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Denise Poole (WDHB)

From: Nicola Nell (WDHB)
Sent: Tuesday, 24 September 2019 11:06
To: Jonathan Christiansen (WDHB)
Cc: Diana Ackerman (WDHB); Wendy Burgess (WDHB)
Subject: Informed consent in Gynae
Attachments: Gynae procedures informed consent presentation.pptx

Dear Jonathan,

I have been asked to consult you on a small Gynaecology project around Informed Consent given your position and recent work in the field of Informed Consent. We would value your expert opinion and approval to the proposal below.

It has been raised that the women undergoing a gynaecology surgical procedure are not well informed that their procedure is likely to also include a vaginal examination.

A straight forward solution to this is to add this information to the pre-surgical information sheets. This sheet is normally given out to the patients in outpatient clinics - discussion and agreement as and when a gynaecology procedure is to take place. These information sheets are currently provided by RANZCOG.

We have contacted RANZCOG to inform them that the pamphlets we currently have do not contain information regarding the procedure including a vaginal examination. They have taken this into consideration and will review if this need to be added to their next edition.

In the meantime, we have proposed that stickers should be added to the information sheets that inform the patients - **'Your procedure may also include a vaginal examination'.** We will also inform the gynaecology medical team that they are to write in the pre-op Agreement to Treatment/Consent form - 'the specific procedure **plus pelvic or vaginal examination'**.

Please see the attached presentation that will be used once we get your approval.

If you have any further questions please feel free to make contact.

I look forward to your feedback.

Thank you and kind regards,
Nicola

Nicola Nell nee Marsh I **Project Manager**
Child, Women & Family I Waitemata DHB
37 Taharoto Road, North Shore Hospital
p: 09 484 6150 ext 45450 m: 021573120
Work: Monday 8-2, Tuesday 8-2 and Thursday 8-4

Gynaecology Procedures Informed Consent

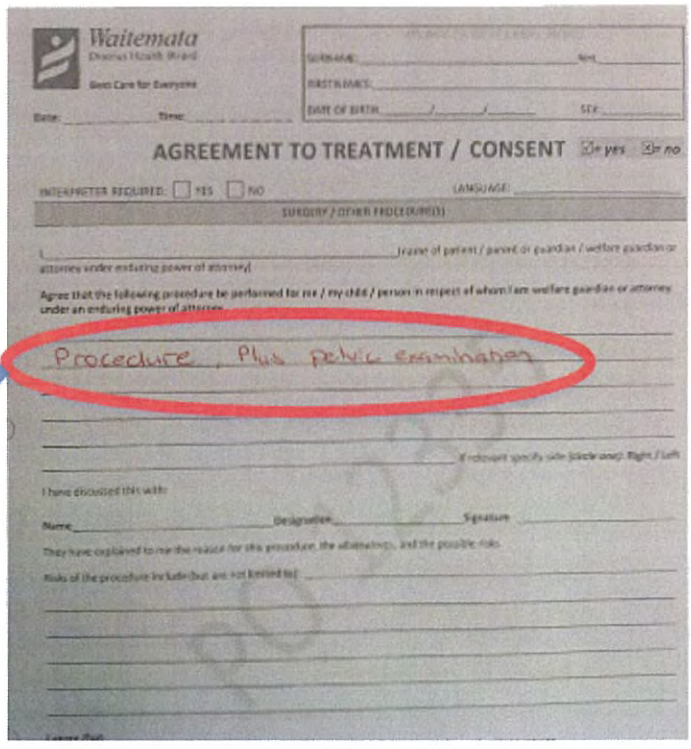
1. Give and discuss Patient Procedure Pamphlet which includes procedure may include vaginal examine
Effective Communication (Right 5)

2. ADD sticker to patient paper file
Patient given all the necessary information (Right 6)

3. ADD PLUS (or WHICH INCLUDES) a pelvic/ Vaginal examination when filling consent form

NOTE if you are not credentialed to do the procedure by yourself you need to write - 'WITH SMO"

Patient competent and freely given consent (Right 7)



Denise Poole (WDHB)

From: Penny Andrew (WDHB)
Sent: Wednesday, 02 October 2019 16:32
To: Jocelyn Peach (WDHB); Amanda Mark (WDHB)
Cc: Jonathan Christiansen (WDHB)
Subject: RE: Informed Consent Education

Thank you Jos, we will check the document. I've just met with Jonathan Christiansen and Ron Paterson in preparation for Friday's session with staff (the 2nd session).

Apparently Judy (chair) and Dale asked that there be one person who corresponds with [redacted] and [redacted] and [redacted] and [redacted] were advised this would be Cath. With Cath going we need to identify someone in her place. Jonathan and I recommend that this should be Karen Hellesoe, acting GM. If you agree, we can confirm at ELT on Monday, Jonathan or I will then speak with Karen, and Karen can let [redacted] know. If [redacted] thereafter continues to correspond with you, you can forward it to Karen to coordinate a response.

Many thanks

Penny

From: Jocelyn Peach (WDHB)
Sent: Wednesday, 02 October 2019 8:13 a.m.
To: Amanda Mark (WDHB); Penny Andrew (WDHB)
Subject: FW: Informed Consent Education

I have received this.
As I have not seen the document referred to, please can this be checked.
Jos

Jocelyn Peach, RGON
Director of Nursing/ Emergency Systems Planner
Waitemata District Health Board
Private Bag 93-503, Takapuna, Auckland 0740

Phone 021784321 // Email Jocelyn.peach@waitematadhb.govt.nz

From: [redacted]
Sent: Wednesday, 02 October 2019 7:54 a.m.
To: Jocelyn Peach (WDHB)
Cc: [redacted]
Subject: Informed Consent Education

Hello Jos,

There is a further Education session scheduled for Fri 4th Oct at 8am. The information about it says it is about the Informed Consent Poster displayed.

Whoever designed the poster is quoting different sections from the informed consent policy.

Some of the statements made do not correlate with the WDHB informed consent policy on the controlled documents section of the intranet and in fact they contradict it.

Also stated at the bottom of the poster it says it is version 19 of the policy, is this a new version that has not been published?

This is concerning as the statements are certainly not adhering to the HDC code of consumer rights and further reinforces the breaches of patients rights which are continuing to occur.

I look forward to hearing from you regarding this urgent matter

Kind regards

[redacted]

Denise Poole (WDHB)

From: Lisa Sue (WDHB)
Sent: Thursday, 03 October 2019 08:49
To: Jonathan Christiansen (WDHB); Ron Paterson; Amanda Mark (WDHB); Penny Andrew (WDHB); Diana Ackerman (WDHB); Kate Gilmour (WDHB); Ulrike Gerstenberger (WDHB); Michael Rodgers (WDHB); Ara Cho (WDHB); Morgan Edwards (WDHB); Deborah Davis (WDHB)
Subject: Informed consent education session - 4 Oct 2019
Attachments: Run Sheet for Friday 4th October Theatre Education Session - FINAL.pdf; Slides for Oct 4 2019 Session FINAL and Case Study.pdf

Hi All,

Please find the finalised run sheet and slide set used for the education session tomorrow morning at 8am, Whenua Pupuke Auditorium.

A copy of the patient video can be viewed with this link: https://vimeo.com/363737015 **Password to view video:** [redacted]

I will bring a few printed copies of the run sheet for the discussion panel and a few copies of the case study to circulate to the audience, due to feedback on the difficulty to read the case on the screen.
As with the last session, I will get audiences to register their name and email for their feedback via survey monkey, https://www.surveymonkey.com/r/TZV8CPV

If you have any questions, please let me know.

Kind regards,
Lisa.

Lisa Sue
Project Manager | Institute for Innovation and Improvement
Conference Room 1, Lower Ground Floor, North Shore Hospital Site, Takapuna, Auckland 0740
Waitematā District Health Board
Private Bag 93503, Takapuna 0740
Mobile: 021 195 3378
Email: **Lisa.Sue@waitematadhb.govt.nz**
www.waitematadhb.govt.nz
www.i3.waitematadhb.govt.nz

Run Sheet for Friday 4th October Theatre Education Session:

Informed Consent - Patient experience, presentation, & case study discussion

Multi-disciplinary target audience: All surgical health care professionals (i.e. doctors, nurses, technicians etc.)

Time	Content	By Whom	Location
08:00	**Welcome** (5min) • Welcome to staff • Introduce discussion panel • Brief overview of format for the session	Jonathan Christiansen	Whenua Pupuke Auditorium
08:05	**Patient Experience** (10min) 5 min video 5 min debrief	Jonathan Christiansen	
08:15	**Presentation** (15mins) Covering specific content about students and RMOs	Jonathan Christiansen	
08:30	**Case study** (20mins) 5 min Read case and discuss with person next to you (small groups) 10 min Discussion panel 5 min Questions from audience	**Discussion Panel:** 1. Ron Paterson 2. Amanda Mark 3. Jonathan Christiansen	
08:50	**Wrap up / Conclusion** (10min) • Take home messages from the session • Thank staff for attendance • Request to fill in staff feedback survey	Facilitated by Jonathan Christiansen, Final words from Discussion panel	
09:00	**END OF INFORMED CONSENT SESSION**		

Case Study

Mrs K presented to hospital acutely with right lower quadrant abdominal pain.

She is 81years old and has early signs of dementia. She does not speak or understand English. Her daughter is her enduring power of attorney.

After investigations

- The consultant speaks to Mrs K & her daughter that she would need surgery. Her daughter interpreted and Mrs K did not want any open procedure.
- They agreed for just a diagnostic laparoscopy as the next step.
- The surgical registrar obtains consent:
  "Since we don't have a clear idea what is causing the pain, the next best option is have key hole surgery to have a look. We think it may be the appendix. Would that be what your mother would like to do? Do you have any further questions?"
- The procedure on the consent form states "Diagnostic laparoscopy +/- proceed"
- Mrs K's daughter gives consent and signs the form.
- Mrs K is placed on the acute list, but higher priority cases meant she would have to wait until the next day.

Day of surgery

- A different registrar comes to introduce themselves and speak to Mrs K. They check if there are any questions with her daughter before commencing surgery. There were no issues raised so they proceeded to theatre.
- Due to the degree of inflammation and anatomic difficulty, the surgeon decides to convert from laparoscopic appencidicetomy to an open limited right hemi-colectomy.
- In recovery, Mrs K makes a complaint she didn't want open surgery.

Facilitator to ask questions, for the audience to reflect on:

- What issues can you identify in the scenario?
- How would you have approached this scenario differently?

Themes for discussion

- Enduring power of attorney case and patient's competency to understand
- Language barriers / Interpreters
- Procedures documented different to what was agreed verbally

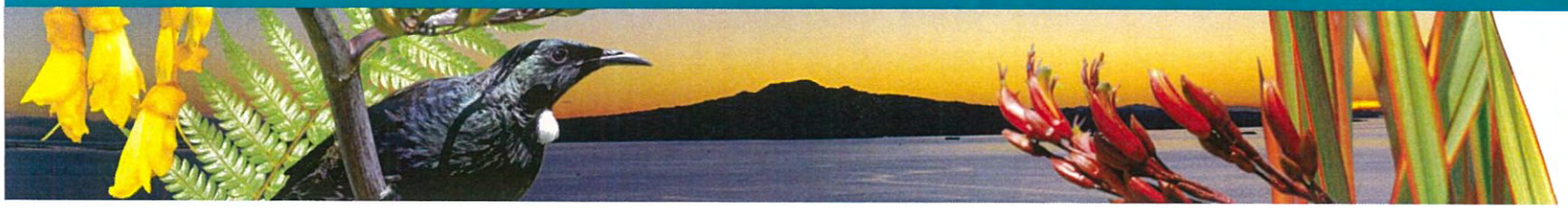
Issues in the case

- Absence of independent translator; Bias of family translation; Risk of family interpreting understands the terms/context of what is being said.
- Lack of documentation / communication between clinicians about what is consented
- Ambiguity on the consent form with +/- proceed ; Patient having additional procedure they did not agree to

SELECTED ISSUES IN INFORMED CONSENT

4 October 2019

Dr Jonathan Christiansen
Chief Medical Officer, Waitemata DHB



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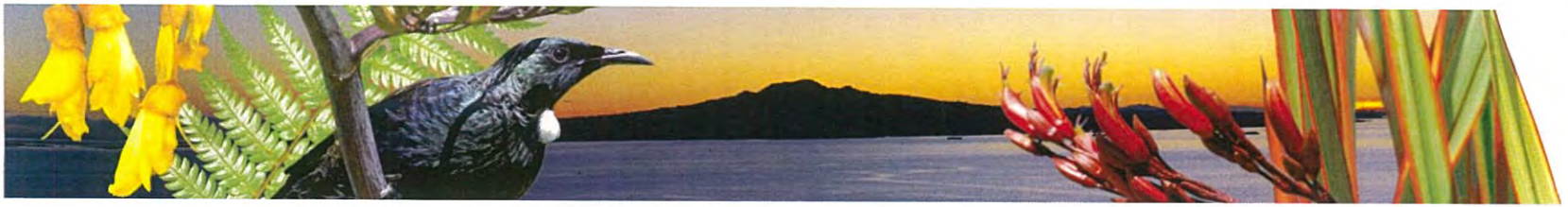
STUDENTS



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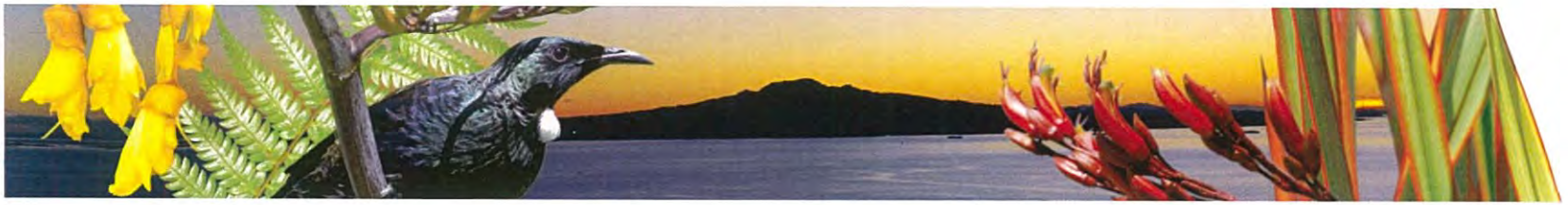
ARTICLE

Medical Students and informed consent:

A consensus statement prepared by the Faculty of Medical and Health Sciences of the University of Auckland and the University of Otago Medical School, Chief Medical Officers of District Health Boards, New Zealand Medical Students' Association and the Medical Council of New Zealand

Warwick Bagg, John Adams, Lynley Anderson, Phillipa Malpas, Grant Pidgeon, Michael Thorn, David Tulloch, Cathy Zhong, Alan Merry



MEDICAL STUDENTS – Summary

- Patient consent is essential for the involvement of students in their care. Such consent should be informed and sensitively obtained, and **proportional** to the situation.

- **"Verbal consent, obtained simply, politely and in the context of the general interactions between practitioners and patients is both adequate and appropriate for most situations."**

- The **responsible clinician** (eg, SMO or RMO) **is accountable for ensuring consent is obtained** for the involvement of students. Students are responsible for ensuring that such consent has been gained by the responsible clinician.

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MEDICAL STUDENTS

- The generic statement on Waitemata's 'Consent Form' regarding the involvement of students should be understood to be **limited** to observation and very basic procedures only.

- For a student to observe in theatre, or assist in a minor way (such as holding a retractor), Waitemata DHB's consent policy requires that the **responsible clinician obtain verbal consent** for that student's involvement.

- For a student to **actively** undertake aspects of a procedure (eg, suturing at closure in surgery) the **responsible clinician should document the patient's consent** prior to the procedure.

- **Written consent is mandatory for students to undertake intimate examinations** (such as vaginal or rectal exams), and such examinations must be **directly supervised** and **limited to one student** with a patient.

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TEAM CARE AND DELEGATION

Waitemata
District Health Board

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CODE of HEALTH and DISABILITY SERVICES CONSUMERS' RIGHTS

General provider duties arising from consumer rights

Right 4

Duty of care: "the right to have services provided with reasonable care and skill"

Right 6(1)

Duty to inform: "the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive…"

Right 6(2)

Duty to respond: "the right to honest and accurate answers to questions relating to services"

Right 7(1)

Consent duties: "[the right make] an informed choice and give informed consent…"

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CODE of HEALTH and DISABILITY SERVICES CONSUMERS' RIGHTS

Specific consumer rights relating to provider

Right 6(3)(a)

"the right to honest and accurate answers to questions relating to services including…the identity and qualifications of the provider"

Right 7(8)

"the right to express a preference as to who will provide services and have that preference met **where practicable**."

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MCNZ GUIDANCE 2019 (Proposed)

If you delegate the provision of treatment or advice to another doctor, **you must make sure the person you delegate to:**

(a)is sufficiently skilled and qualified in the relevant area of medicine;

(b) has sufficient knowledge of the proposed intervention, and understands the risks involved and the potential benefits;

(c) is sufficiently informed of the patient's needs and their clinical information (including their clinical history, test results and diagnosis);

(d) understands and agrees that they will contact you for further advice or information if necessary; and

(e) is clear about which doctor is responsible for obtaining informed consent from the patient and ensuring that the patient has made an informed decision.

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MCNZ GUIDANCE 2019 (Proposed)

When deciding whether it is appropriate to delegate, you should consider:

(a)the nature of the intervention, including its risks and complexity;

(b) the level of uncertainty surrounding the outcome of the intervention;

(c) your existing relationship with the patient and any relationship your patient has with the person to whom you are considering delegating;

(d) any concerns you anticipate the patient may have; and

(e) whether the patient or anyone else who is involved in the decision has enough time and information to make a decision, and/ or to express their views.

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TEACHING

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District Health Board

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CODE of HEALTH and DISABILITY SERVICES CONSUMERS' RIGHTS

General duties / rights in teaching situations

Right 9

"The rights in this Code extend to those occasions when a consumer is participating in, or it is proposed that the consumer participate in, teaching or research."

Right 6(1)

"Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive including …

(d) **notification** of any proposed participation in teaching or research …"

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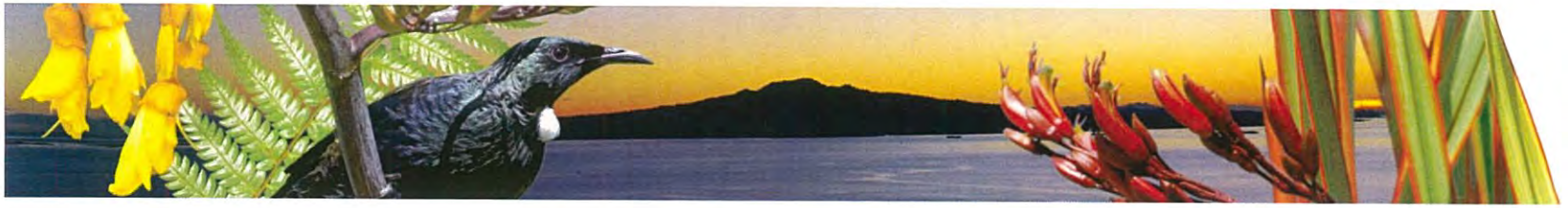
OTHER GUIDANCE

MCNZ

- Guidance limited to medical students and observers
- no specific guidance on teaching



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WAITEMATA DHB POLICY

Waitemata DHB Policy:

All healthcare settings should be learning environments where **clinical teaching and learning occur as part of day to day practice**. Additionally, as a teaching institution, formal teaching occurs. This includes further education for registered and employed clinical staff and training for unqualified students.

Some teaching occurs within the clinical team **as part of the optimal provision of care for that patient** eg, … **assistance with a procedure**. Teaching is simply a secondary element of sound care provision. The basic provisions of common **courtesy and respect** apply, however **specific patient consent is not required**.

Where teaching occurs that is **additional to normal clinical requirements** or involves someone not qualified to undertake the procedure **on their own**. In this case, an explanation is to be given to the patient and explicit permission sought.

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Suggested approach for RMOs in the clinical team:

The RMO should introduce themselves and explain their role:

"I'm Dr Jones, I'm the doctor who will be undertaking your surgery today. I'm an advanced trainee in surgery and will be undertaking this procedure with the supervision of Dr Smith who is the consultant operating with me."

As part of the general duty to inform and obtain consent, there is no specific requirement to obtain consent to the participation of a junior doctor who is employed as a member of the clinical team providing care.

If the registrar is asked directly about their training level/competence they should respond honestly and appropriately.

CODE of HEALTH and DISABILITY SERVICES CONSUMERS' RIGHTS

A provider's overarching duty of compliance (DHB or individual staff)

Clause 3

(1)"A provider is not in breach of the Code if the provider has taken *reasonable actions in the circumstances* to give effect to the rights, and comply with the duties, in this Code."

(2) "The onus is on the provider to prove it took reasonable actions."

(3) … "the circumstances means *all the relevant circumstances*, including the consumer's clinical circumstances and the provider's resource constraints."

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CASE STUDY

Mrs K presented to hospital acutely with right lower quadrant abdominal pain.
She is 81years old and has early signs of dementia. She does not speak or understand English. Her daughter is her enduring power of attorney.

Assessment

- The consultant speaks to Mrs K & her daughter that she would need surgery. Her daughter interpreted and Mrs K did **not** want any open procedure.
- They agreed for just a diagnostic laparoscopy as the next step.
- The surgical registrar obtains consent:
  "Since we don't have a clear idea what is causing the pain, the next best option is have key hole surgery to have a look. We think it may be the appendix. Would that be what your mother would like to do? Do you have any further questions?"
- The procedure on the consent form states "Diagnostic laparoscopy +/- proceed"
- Mrs K's daughter gives consent and signs the form.
- Mrs K is placed on the acute list, but higher priority cases meant she would have to wait until the next day.

Day of surgery

- A different registrar comes to introduce themselves and speak to Mrs K. They check if there are any questions with her daughter before commencing surgery. There were no issues raised so they proceeded to theatre.
- Due to the degree of inflammation and anatomic difficulty, the surgeon decides to convert from laparoscopic appencidicetomy to an open limited right hemi-colectomy.
- In recovery, Mrs K makes a complaint she didn't want open surgery.

Denise Poole (WDHB)

From: Lisa Sue (WDHB)
Sent: Tuesday, 15 October 2019 14:11
To: Penny Andrew (WDHB); Jonathan Christiansen (WDHB)
Subject: Informed consent updated work plan and education plan
Attachments: Workplan checklist action sheet - V4.docx; Education Plan - Informed Consent v4.docx

Hi All,

Attached are the plans we had for informed consent. These may need to be revised after tomorrow's meeting.

Kind regards,
Lisa.

Lisa Sue
Mobile: 021 195 3378

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Work Break Down Structure: Informed Consent

Key dates

Steering group meetings: 13 June, 11 July, 7 August, 4 September, 16 October, 12 November, 11 December
Theatre education sessions 30 August, 4 October

Section	Task	Who
A	Informed consent process	Jonathan Christiansen, Penny Andrew, Diana Ackerman, Ulrike Gerstenberger, Lisa Sue
B	Informed consent documentation	Steering group
C	Informed consent patient information	Fiona Connell, Lisa Sue
D	Supervision in theatre	Adele Barr, Lisa Sue
E	Education and training	Kate Gilmour, Ara Cho, Zoe Bunker, Lisa Sue

Status	Planned	In progress	100% Complete	Caution	Behind

A	Works stream 1 - Informed consent process			
		Start	End	Status
1.	Identify working group	Jun 19	Jun 19	Completed
2.	Scope expectations from medical team (O&G)	Jun 19	Jul 19	Completed
3.	Draft informed consent summary of national guidance for medical team	30 Jul 19	30 Aug 19	Completed
4.	Draft guidance documentation on informed consent for other students / industry representatives	11 Jul 19	30 Aug 19	In progress
5.	Create a theatre etiquette policy	4 Sep 19	1 Nov 19	In progress
6.	Guidance documentation for other students/ industry representatives to be reviewed by steering group	4 Sep 19	4 Sep 19	Behind
7.	Guidance documentation to be reviewed by steering group	12Nov 19	12Nov 19	Planned
B	Works stream 2 - Informed consent documentation			
		Start	End	Status
1.	Review policy	13 Jun 19	13 Jun 19	Completed
2.	Review position on the Treatment Without Consent Form	7 Aug 19	4 Sep 19	Completed
3.	Review Informed Consent Form with Consumer Council	13 Jun 19	Aug 19	Completed
4.	Agree actions from Consumer Council	Aug 19	16 Oct 19	Planned
5.	Agree actions for policy amendments	Aug 19	16 Oct 19	Planned
C	Works stream 3 - Informed consent patient information			
		Start	End	Status
1.	Review current state through patient interviews	Jul 19	Oct 19	Completed
2.	Create themes from interviews around patient information issues	Oct 19	Oct 19	Completed
3.	Develop solutions to bridge gap in patient information	Oct 19	Oct 19	Planned
4.	Draft proposal to steering group	12 Nov 19	12 Nov 19	Planned
5.	Change implementation	Nov 19	Dec 19	Planned
6.	Monitor and evaluate change	Dec 19	Dec 19	Planned
D	Works stream 4 - Supervision in theatre			
		Start	End	Status
1.	Identify SMO to be involved for current state mapping of credentialing and supervision	Jun 19	Jul 19	Completed
2.	Draft current state of credentialing and supervision into an excel table	Jul 19	Aug 19	Completed
3.	Scope electronic platform options for transparent register of credentialing and supervision information	Jul 19	Jul 19	Completed
4.	Data modelling and test on electronic platform	Aug 19	Oct 19	Completed
5.	End user testing	Oct 19	Nov 19	In progress
6.	Endorsement from department and steering group (includes protocol set up around who has access)	12 Nov 19	12 Nov 19	Planned
7.	Implementation	Dec 19	Dec 19	Planned
8.	Monitor and evaluate change	Dec 19	Jan 20	Planned
E	Works stream 5 - Education and training			
		Start	End	Status
1.	Draft and agree education plan for phase 1	26 Jul 19	31 Jul 19	Completed
2.	Education plan for phase 1 reviewed by steering group	11 Jul 19	11 Jul 19	Completed
3.	Plan Friday theatre education sessions with discussion panel	Jul 19	Oct 19	Completed
4.	Plan and implement education focus boards on Informed Consent Policy Awareness	Jul 19	Aug 19	Completed
5.	Plan in service clinical quiz sessions for nursing	Jul 19	Aug 19	Completed
6.	Trial in service clinical quiz with theatre nurses	Sep 19	Oct 19	Completed
7.	Plan in service clinical quiz for anaesthetic technicians	Sep 19	Oct 19	On hold
8.	Plan and implement education focus boards on Informed Consent and Students	Sep 19	Nov 19	In progress

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Education Plan: Informed consent Part 1

Prepared By:	Lisa Sue, Innovation and Improvement Project Manager
Input Provided By:	Penny Andrew, Director – Institute of Innovation and Improvement Kate Gilmour, ADON Surgical and Ambulatory Services Julie Bromley, Lead Anaesthetic Technician
Approval required from:	Cath Cronin, Director of Hospital Services Jonathan Christiansen, Chief Medical Officer

1. Introduction

In 2012, concerns were raised that procedures and protocols for gaining patient consent were not being adhered to within the Surgical Services. Failure to obtain informed consent according to these procedures and protocols is a serious issue: it is a breach to the patient's rights under the Code of Health and Disability Services Consumers' Rights 1996 (The Code of Rights), and a breach of health professionals' expected standards of practice. To protect patient rights and safeguarde health care professionals, a review of the DHB's Informed Consent Policy and Agreement to Treatment / Consent Form was undertaken.

These documents were last updated in August 2018 to better meet the requirements in The Code of Rights. In particular:

- Right 6 - Right to be fully informed
- Right 7 - Right to make an informed choice and give informed consent
- Right 9 - Rights in respect of teaching or research

Since the updates to the policy and consent form in 2018, dissemination of education about the Informed Consent Policy, including its principles and process of obtaining informed consent, has been a departmental responsibility.

Variation in the application of the Informed Consent Policy across the Surgical Department provides the opportunity for a widespread programme of informed consent in surgery, with the aim of improving awareness of the principles of informed consent and consistency in the application of the Informed Consent Policy.

2. Objectives

All surgical health care professionals will:

- Understand the principles in the Informed Consent Policy
- Apply the principles of informed consent in day to day practice
- Recognise the importance of a properly carried out informed consent
- Have increased awareness of the implications when the informed consent policy is breached

3. Audience

All surgical health care professionals which include:

- Medical teams
- Nursing teams
- Anaesthesia teams
- Midwifery teams
- Trainees and Students

Across all surgical departments:

- General Surgery
- Orthopaedics
- Urology
- Gynaecology
- Obstetrics
- ORL

All roles are defined as per Informed Consent Policy. Please refer to Appendix 5.1 on page8.

4. Education Approach

There will be 4 approaches that will be used to promote awareness of the informed consent core principles. These are:

1. Friday theatre education sessions
2. Focus boards
3. In service teaching sessions – Interactive quiz and discussions (Nursing/Anaesthetic technician)
4. In service teaching sessions – Talks and discussions (Medical doctors)

4.1 Friday Theatre Education Sessions

Target audience	All health care professionals within Theatres and Surgical Wards. • Surgical consultants, registrars, house officers, trainee intern, medical students • Registered nurses, enrolled nurses, student nurses and health care assistants • Anaesthetist, Anaesthetic registrars, house officers, anaesthetic technicians, trainee anaesthetic technicians
Teaching Content	**August 30th** • High level review of informed consent policy in terms of legal requirements and what is courtesy • 2 x Case scenario discussions **October 4th** • Patient perspective • Code of Health and Disability Services Consumer Rights and Medical Council guidance • Summary of guidance on students, teaching, team care and delegation • Further case scenario and discussion panel
Concept	Delivering education in a collaborative learning space; using methods such as problem based learning, case scenarios for simulation based education
Methods	• Case studies. These case studies be discussed in an open and interactive session • Policy and Code of Rights Discussion To provide guidance but allow audience to ask questions and discuss • Video or Guest speaker To have a different platform to engage the staff
Roles & Responsibility	**Governance:** Informed consent project steering group **30th August Discussion Panel:** Jonathan Christiansen, Amanda Mark, Penny Andrew and session is facilitated

	by Jay O'Brien. **4th October Discussion Panel:** Ron Paterson, Amanda Mark, Jonathan Christiansen. Also facilitated by Jonathan Christiansen.
	2 x Friday Theatre Education Sessions 30 August – 60 minutes MDT session 4 October – 60 minutes MDT session

4.2 Focus Boards

	All health care professionals within Theatres and Surgical Wards. • Surgical consultants, registrars, house officers, trainee intern, medical students • Registered nurses, enrolled nurses, student nurses and health care assistants • Anaesthetist, Anaesthetic registrars, house officers, anaesthetic technicians, trainee anaesthetic technicians • Midwifes, midwifery students • Medical radiation technicians
	Informed Consent Policy, version August 2018 Section 1.2: What is informed consent? Section 1.5: Levels of consent - Implied, Verbal, or Written Section 1.6: Documentation of consent or written consent Section 1.7: What and How much information Section 1.8: Primary Responsibility for Information, consent, and delegation Section 2.0: Teaching, Students and Observers Section 2.1: Supervision
Concept	An eye catching and informative focus board to create awareness of the principles of informed consent in plain English.
	North Shore Hospital and Elective Surgery Centre, posters distributed on o Theatre education focus board: Large poster A1 o Surgical ward education board: A3 posters for ward Short Stay, and Cullen. o PACU focus boards: 7 x A3 sized posters for Admissions Interview Rooms, Pre-Op, Day Stay, and Recovery.
	Governance: Informed consent project steering group (See Appendix 5.1 on page 7 for details) **Design and implementation:** Cassie Khoo — i3 Design fellow Lisa Sue — i3 Project manager Chari An Bakkenes — Surgical Nurse Educator Kerlvin Ocado — Surgical Nurse Educator Grace Gannaban — PACU Nurse Educator Ara Cho — Theatre Nurse Educator

Duration	1 month. Posters were placed up in mid-September

4.3 In service teaching sessions - Interactive quiz and discussions

Target participants	Health care professionals across Surgical Wards and Theatre who are: • Registered nurses, enrolled nurses, student nurses and health care assistants • Anaesthetic technicians, trainee anaesthetic technicians
Policy information	Informed Consent Policy, version August 2018 Section 1.2: What is informed consent? Section 1.5: Levels of consent - Implied, Verbal, or Written Section 1.6: Documentation of consent or written consent Section 1.7: What and How much information Section 1.8: Primary Responsibility for Information, consent, and delegation Section 2.0: Teaching, Students and Observers Section 2.1: Supervision
Concept	Delivering education through an interactive learning forum with the opportunity for collaborative feedback and discussion.
Activities	Each Clinical quiz is bespoke to the role of the target audience, i.e. Nurse focus and Anaesthetic technician focus. A core element of this approach is to have the facilitator direct critical thinking and discussion in a safe and open manner after each question. The quiz set up is to help engage staff and obtain greater involvement. In order to retain engagement of staff, there will be 8 questions per quiz and section 1 and 2 will be separated. • Clinical Quiz 1: The questions will be specific to the policy sections 1.2, 1.5 – 1.8 • Clinical Quiz 2: The questions will be specific to the policy section 2 Following each question, the answer will be revealed and there is an opportunity for the facilitator to discuss the answers with the audience. **Resources required include:** • Facilitator • TV screen or laptop • Prizes
Roles & responsibilities	**Governance:** Informed consent project steering group (See Appendix 5.1 on page 7 for details) **Design and implementation:** Lisa Sue — i3 Project manager Chari An Bakkenes — Clinical Nurse Educator – Surgical Kerlvin Ocado — Clinical Nurse Educator – Surgical Grace Gannaban — Clinical Nurse Educator – PACU

Ara Cho	Clinical Nurse Educator – Theatres
Julie Bromley	Lead Anaesthetic Technician
Zoe Bunker	Anaesthetic Technician – Educator

All surgical services will have 2 x 30 minute in-service teaching sessions.

Nursing

- The forum of choice is after the AM-PM handover.
- The schedule of the teaching sessions will be completed per service by the respective Clinical Nurse Educator.
- These sessions will aim to be rolled out and completed over an 8 week period

Anaesthetic Technicians

- The forum of choice is Friday Theatre Education Sessions, once every 5 weeks
- The schedule of the teaching sessions will be completed by Zoe Bunker
- These sessions will need to be held at the start of each Friday Theatre Session for the remainder of the year to capture the cohort.

Concept approved	11 July 2019 – Steering group meeting
Implementation	15 July to 6 September 2019 – Nursing 26 July to December – Anaesthetic Technicians

4.4 In service teaching sessions - Talks and discussions

All health care professionals within Theatres and Surgical Wards.

- Surgical consultants, registrars, house officers, trainee intern, medical students
- Anaesthetist, Anaesthetic registrars, house officers

Informed Consent Policy, version August 2018
Section 1.2: What is informed consent?
Section 1.5: Levels of consent - Implied, Verbal, or Written
Section 1.6: Documentation of consent or written consent
Section 1.7: What and How much information
Section 1.8: Primary Responsibility for Information, consent, and delegation
Section 2.0: Teaching, Students and Observers
Section 2.1: Supervision

Delivering education in problem based learning and discussion sessions.

To have a meeting to discuss with senior medical officers in Obstetrics and Gynaecology department their perception of informed consent and their understanding on expectations.

Discussions with this cohort will be facilitated by Cath Cronin, Penny Andrew, and Jonathan Christiansen.

Governance:
Informed consent project steering group
Implementation:

	Jonathan Christiansen and Penny Andrew
Duration	1 hour To add to agenda onto existing departmental SMO meeting.

5. Appendix

5.1 Informed consent project steering group

Name	Role
Cath Cronin	Director of Hospital Services
Penny Andrew	Director – Insititute of Innovation and Improvement
Michael Rodgers	Chief of Surgery
Kate Gilmour	Head of Division, Nursing – Surgical and Ambulatory Services
Jonathan Christiansen	Associate Chief Medical Officer
Diana Ackerman	Clinical Director, Gyanecology Acting Clinical Director, Obstetrics
Amanda Mark	Legal Counsel
Ulrike Gerstenberger	Clinical Nurse Director, North Shore Hospital Theatres
Morgan Edwards	Senior Medical Officer (Anaesthetist)
Ara Cho	Clinical Nurse Educator - Theatres
Lisa Sue	Innovation and Improvement Project Manager

Denise Poole (WDHB)

From: John Cullen (WDHB)
Sent: Thursday, 21 November 2019 15:25
To: Jonathan Christiansen (WDHB)
Cc: Matthew Walker (WDHB); Janine Wells (WDHB)
Subject: FW: WDHB HCIR policy JW.docx
Attachments: WDHB HCIR policy JW.docx

FYI
The policy regarding reps in theatre is still an issue. Understandably to do this for every patient prior to surgery may be best and more reliably be obtained if it was on the consent form. Needs some discussion. John C

From: Janine Wells (WDHB)
Sent: Thursday, 21 November 2019 8:35 a.m.
To: Matthew Walker (WDHB)
Cc: John Cullen (WDHB)
Subject: WDHB HCIR policy JW.docx

Hi Matt

Attached is the document we looked at together. There are 2 pieces in Red which I would like you to look peruse. The second regarding the consent, I understand is not how you would like it, and I have raised the idea of updating the consent form.

John Cullen will present the document as it stands, to Jonathan Christianson. I understand that the document originated out of work that Jonathan was involved in, and obviously consent is his area of particular interest. I am told that Jonathan has already been given the earlier version , so I think it important that we move on this as soon as possible.

Kind regards
Janine

Janine Wells I Operations Manager
Elective Surgery Centre I Waitemata DHB

124Shakespeare Rd, Private Bag 93503, North Shore 0740
DDI: 09 4846055 extn: 5355

janine.wells@waitematadhb.govt.nz

Healthcare Industry Representatives in the Perioperative Setting

Contents

1. Overview

The Operating Rooms are supported by Health Care Industry Representatives (HCIR). These people are sales representatives, technicians, repair/maintenance personnel who provide company services in the perioperative setting. HCIR presence in this environment is either to support new equipment or processes or other business regarding the supply of surgical equipment.

The knowledge and expertise of the experienced HCIR can play an important role in providing essential technical assistance, instruction and training to perioperative team members. Unfamiliarity and use of complex technology by health clinicians without formal training is potentially hazardous to the patient and perioperative team members. Some procedures, due to their specific requirements, cannot proceed without the HCIR technical support. They perform an essential role.

Purpose

The purpose of this document is to provide guidelines relating to the activities, conduct and expectations of the HCIR, as a visitor in the perioperative setting and to ensure appropriate discussion and consent by the consumer of care. It is underpinned by protocols and processes to ensure the safety and privacy of the patient, as well as the staff and the HCIR.

Scope

- All perioperative staff (inclusive of medical staff)
- All visiting sales representatives, technicians, repair/maintenance personnel

Healthcare Industry Representatives in the Perioperative Setting

2. Associated Documents

WDHB Documents	Informed Consent Policy: 2.10 – Observers Not Involved in Clinical Care Health Information/Privacy – General Policy
	Employee Privacy & Confidentiality Agreement
	Privacy & Confidentiality Brochure
	Contractor Health and Safety Requirements June 2019
Legislation	Code of Health & Disability Consumer Rights 1996 & Review 2004
	Privacy Act 1993
	Human Rights Act 1993
Medical Technology Association of NZ	MTANZ Code of Practice 6th Ed 2016

3. Definitions (for the purpose of this document)

Representatives providing Technical support for surgical interventions.
This is the group of HCIR whose expertise or technical knowledge **will be** required by the surgeon during the procedure. They provide advice on specialised equipment and are necessary for the safe management of the procedure, and best patient outcomes. This group of people may also be involved in review/ documentation and/or management of stock consigned by the company they represent.

*NB. These HCIR requiring regular access to the peri-operative setting **may** be granted personal swipe-card access to the department. Any such access will be agreed by the Theatre Manager of the unit, and follow completion of the Waitemata DHB Contractor documentation.*

Industry Sales representatives and repair/maintenance personnel
This is the group of HCIR who visit the department to meet with staff to promote products or services, provide inservice training, or at the request of WDHB staff to provide equipment servicing. These Company representatives must make an appointment with the staff member/s they are wishing to visit. Access to the department will be granted via the receptionist. No appointment – no access to the department.

4. Role of the Health Care Industry Representative

HCIR have a valid but restricted role in the perioperative setting. They should not be requested to perform tasks outside their approved role.

- To provide education, training and instruction related to new technology, equipment, techniques and procedures in order for the perioperative team to provide safe patient care.
- To provide essential technical training and support related to a particular device or product for the safe care of the patient.
- To facilitate desired safe patient outcomes by providing procedural support for surgeons and nursing staff.
- It is not appropriate for HCIR to scrub in on a case unless it is solely for product demonstration purposes and at the specific request of the consultant surgeon in attendance.
- While the HCIR has case and instrument specific knowledge, it is expected that WDHB staff will collect instruments from CSSD under their guidance, rather than the HCIR being relied upon to undertake this task.
- One HCIR in an operating room is generally all that is required. The surgeon may request additional support when specialist equipment/products necessitate it.
- To sign Confidentiality and Disclaimer Form

Healthcare Industry Representatives in the Perioperative Setting

5. Health Care Industry Representatives Eligibility Criteria

The HCIR must meet specific eligibility criteria in line with the contractors Health and Safety requirements policy. Health and safety documentation must be completed prior to being granted access to the perioperative department. HCIR must also abide by WDHB policies/ guidelines including, but not limited to:

- Infection control policy
- Aseptic technique
- Theatre Attire (it is requested that HCIR wear a red hat to provide a visual cue, indicating their role)
- Perioperative department etiquette
- Privacy and Confidentiality
- Patient Code of Consumer Rights

6. Access to the Perioperative Department

During Working Hours access will be via reception. Press the intercom for access to the Main building OR, or visit the reception at Waitakere theatres or ESC

Outside of working hours access to the Main building OR will be granted via the OR Coordinator

- All HCIR entering the operating room at any time, are required to sign in to the visitor register at the OR reception/ ESC reception. Please ensure that prior consent to access the perioperative department (as highlighted above) has been authorised before entering.
- When leaving the department please sign out of the visitor register

NB. Even if you have been granted swipe-card access to the department, you need to follow the above

7. Perioperative Manager's Responsibilities

All visitors to the perioperative department must be approved by the perioperative manager who may delegate authority to the ACCN's or Theatre Coordinator.

1	Ensure that the perioperative department guidelines for the conduct, gaining admission to, and activities of visiting HCIRs are upheld.	To ensure the patient's safety, privacy and dignity and the safety of staff and HCIR in the perioperative setting.
2	To define the conditions under which the health industry representative may be present during a surgical or other invasive procedure.	
3	To ensure confidentiality and privacy rights are observed for all patients according to Health & Disability Sector Standard Code of Rights.	
4	Ensure that patient consent is obtained and documented for HCIR access	To ensure that the patient is informed about aspects of their care.
5	Ensure that HCIR access to the perioperative environment is at the discretion of the RN, and in consultation with the Medical Practitioner in charge of the patient's care.	To ensure that the visit is necessary, that adequate staff are available to facilitate the visit and that staff numbers in the clinical area are kept to a minimum.
6	Deny HCIR access to the perioperative environment if guidelines and criteria are not met.	To ensure the patient's safety, privacy and dignity and the safety of staff and HCIR in the perioperative setting.

Healthcare Industry Representatives in the Perioperative Setting

8. Nursing Staff Responsibilities

1	Responsibility for providing patient care, ensuring patient safety, privacy and dignity.	To ensure the patient's safety, privacy and dignity and the safety of staff and HCIR in the perioperative setting.
2	To ensure only authorised personnel are granted access to a theatre during an operation.	
3	To check that informed consent from the patient has been obtained according to WDHB protocols.	To ensure that the patient is informed about aspects of their care.
4	To welcome the HCIR to the perioperative area and introduce them to the team.	All team members are aware of the HCR attendance and activities
5	Orientate the HCIR to the area, guide and support them. Ensure the HCIR is not requested to get equipment or complete activities which are outside the scope of a visitor to the dept.	To prevent unauthorized access to other areas, to ensure that the HCIR is aware of emergency exits and to monitor and maintain the sterile field.
6	Ensure the HCIR does not provide patient care, nor act as part of the scrub/circulating team e.g. may not open any item on to the sterile field or fetch instruments. The HCIR role is to calibrate, provide guidance to assemble instrumentation and instruction on the use of the equipment.	Ensure that the HCIR remains within the WDHB and their company guidelines
7	Ensure that the HCIR's presence is documented on the intraoperative record and iPIMs stating name, company and role.	To provide complete documented record.

9. Surgeon's Responsibilities

1	The Medical Practitioner responsible for the patient must gain permission for the HCIR to be present. This is part of the consenting process and should be included on the consent documentation	To ensure compliance with WDHB Informed Consent, Confidentiality and Privacy and Visiting HCIR policies and protocols are met.
2	To be aware of the requirements outlined in this policy	

Healthcare Industry Representatives in the Perioperative Setting

10.Health Care Industry Representatives Responsibilities

1	Provide WDHB organization with their company guidelines and evidence to demonstrate that they meet the eligibility criteria. (NB part of H&S induction)	To ensure the patient's safety, privacy and dignity and the safety of staff and HCIR in the perioperative setting.
2	Request permission for entry from the perioperative manager or delegated authority stating purpose of visit.	To ensure that the visit is necessary, that adequate staff are available to facilitate the visit and that staff numbers in the clinical area are kept to a minimum.
3	Contact the specialty ACCN to pre-schedule the visit with the ACCN responsible for the SU team member	
4	All visiting HCIR are required to wear approved WDHB theatre attire including a visible identification badge and Red Hats	All team members are aware of the HCIR attendance and activities.
5	HCIR's are required to sign the WDHB Confidentiality and Disclaimer Agreement on first visit to the unit. HCIR's are required to sign in and out of the department at each visit	To ensure compliance with WDHB Informed Consent, Confidentiality and Privacy and Visiting HCIR policies and protocols are met.
6	HCIR must comply with WDHB organizational guidelines as required e.g. infection control and aseptic technique protocols.	
7	Attendance in the clinical area is for the required time only to achieve the purpose of the visit.	To ensure the patient's safety, privacy and dignity and the safety of staff and HCIR in the perioperative setting.
8	Leave the perioperative environment if asked to so do.	

11.References

NZNO Perioperative Nurses College	Health Care Industry Representatives in the Perioperative Setting (No date)
AORN Perioperative Standards and Recommended Practices, 2009 Edition	AORN Guideline Statement: The Role of the Health Care Industry Representative in the Perioperative Setting, P 204 - 206
Medical Technology Association of NZ	MTANZ Code of Practice 2016, 6th Edition – 5. Interactions with Healthcare Practioners & other Professionals
ADHB	Visitors to the Operating Room and Central sterile Supply Department, 2018

Healthcare Industry Representatives in the Perioperative Setting

Attachment 6

Anna Monastra (WDHB)

From: Amanda Mark (WDHB)
Sent: Monday, 01 April 2019 16:35
To: Cath Cronin (WDHB); 'Judy McGregor'; Dale Bramley (WDHB); Andrew Brant (WDHB)
Cc: Peta Molloy (WDHB)
Subject: RE: Informed consent.

Hi

Re the tweak to the policy to include statement re SMO supervision, it will probably fit best in section 2 of the policy, possibly as a new section 2.8.

The new 2.8 might be something like:

2.8 Responsibilities of SMOs for supervision of RMOs.

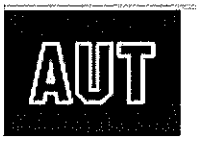
SMOs are responsible for providing appropriate supervision of RMOs taking into account all the circumstances of the case including the patient's condition, the complexity of the proposed procedure, and the RMOs level of experience (both generally and with the particular procedure proposed).

We can fiddle around with this to get this right but it should at least get us started.

Regards Amanda

From: Judy McGregor [mailto:judy.mcgregor@aut.ac.nz]
Sent: Monday, 01 April 2019 3:16 p.m.
To: Cath Cronin (WDHB); Dale Bramley (WDHB); Andrew Brant (WDHB)
Cc: Amanda Mark (WDHB); Peta Molloy (WDHB)
Subject: RE: Informed consent.

Hi Cath. Thanks for all your work on this. I am happy with the letter (see the odd change here and there.) However, re the table of actions, the fourth action troubles me because we say completed. It referred to the development of a training module which we now say is not required because staff can access training on line? Is that enough and have re conflated orientation with training? Will that be acceptable? Can we ensure it is sent to Sandra, too, if she is coming to the meeting? Cath/ Amanda at the meeting can we identify the policy tweak we talked about and where it might be added in the policy? Judy.



Professor Judy McGregor
Associate Dean Postgraduate
Faculty of Culture and Society
Auckland University of Technology

P 09 921 9999 ext 9349 M 021431391 E judy.mcgregor@aut.ac.nz W aut.ac.nz

From: Cath Cronin (WDHB) <Cath.Cronin@waitematadhb.govt.nz>
Sent: Monday, 1 April 2019 2:34 PM
To: Judy McGregor <judy.mcgregor@aut.ac.nz>; Dale Bramley (WDHB) <Dale.Bramley@waitematadhb.govt.nz>; Andrew Brant (WDHB) <Andrew.Brant@waitematadhb.govt.nz>
Cc: Amanda Mark (WDHB) <Amanda.Mark@waitematadhb.govt.nz>; Peta Molloy (WDHB) <Peta.Molloy@waitematadhb.govt.nz>
Subject: RE: Informed consent.

Hi Judy

As per our discussion I have pulled the letter back to basics. Let me know if you would like any changes? If not Peta could tidy up and send off.

Regards cath

Cath Cronin I Director Hospital Services I RN
Waitemata District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Judy McGregor [mailto:judy.mcgregor@aut.ac.nz]
Sent: Thursday, 28 March 2019 10:49 a.m.
To: Dale Bramley (WDHB); Cath Cronin (WDHB); Andrew Brant (WDHB)
Subject: Informed consent.

Hi, have just had a moment to properly look at the NZNO letter and the proposed response. I think the response is perhaps too long and detailed which may get us into contestable territory (RMO/SMO.)?
I do think we need to have the update on the promised actions, so thanks for that.

I think we do need to meet and formally apologise for the non attendance meeting and perhaps go through the issues and agree action points?

One of the troubling aspects of the position re SMO responsibilities, particularly statements like "the duty of care is with the SMO to determine the adequacy of supervision" is that the Code states that it is the provider that has the duty. 1(2) every provider is subject to the duties in the Code and i(3) every provider must tack action to inform consumers of their rights and enable them to exercise them.

So this rather suggests that if the WDHB delegates the RMOs responsibility/accountability for informed consent into the rubric of the SMO's supervision, it should make it an explicit component of adequate supervision. Otherwise it may be arguable as to whether the provider has exercised its duty of care. It may not be a defence for WDHB to say it relied on the adequacy of supervision by other employees because the code doesn't contemplate it.

I had the following other questions from the material.

1. Do we have a failsafe system to ensure "no health care procedure is carried out without informed consent". In Stephanie's letter re the 14 December incident it appears that we are relying on other staff raising the flag?
2. Is there a central repository/point for the informed consent issue- complaints, auditing, near misses etc
3. Are we best practice compared with others (Auckland, Canterbury etc).
4. Can the presentation of the forms be improved for patients? (and staff?)

Anyway happy to meet with [redacted] when we feel we are ready but sooner rather than later?

I hope this helps and it was interesting to see what we do.
Kindest, Judy.

AUT
Professor Judy McGregor
Associate Dean Postgraduate
Faculty of Culture and Society
Auckland University of Technology

P 09 921 9999 ext 9349 M 021431391 E judy.mcgregor@aut.ac.nz W aut.ac.nz

Denise Poole (WDHB)

From: Board Chair (WDHB)
Sent: Monday, 22 April 2019 12:12 p.m.
To: Cath Cronin (WDHB)
Subject: RE: Informed consent and culture

Hi Cath, They were 1. Ensuring [redacted] was okay as a 'whistleblower' and ensuring it was save for nurses and others to speak up about informed consent. 2. The informed consent form itself, how user friendly it is or isn't and the tick boxes issue; 3. Cultural norms at WDHB around informed consent given that it should be both clinician and the organisation being accountable; and 4. Staff education and consumer literacy.
Hope this helps. Judy.

From: Cath Cronin (WDHB) <Cath.Cronin@waitematadhb.govt.nz>
Sent: Thursday, 18 April 2019 3:45 PM
To: Board Chair (WDHB) <BoardChair.WDHB@waitematadhb.govt.nz>; 'Judy McGregor' <judy.mcgregor@aut.ac.nz>
Subject: Informed consent and culture

Hi

Thanks for your discussion in the meeting yesterday. Would you please send me your 4 points that you noted yesterday.

I will do some thinking over the weekend.

Have a great Easter break

cath

Cath Cronin I **Director Hospital Services I RN**
Waitemata District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

Anna Monastra (WDHB)

From: Peta Molloy (WDHB)
Sent: Tuesday, 16 April 2019 8:23 a.m.
To: Amanda Mark (WDHB); Cath Cronin (WDHB)
Cc: Kathy Briant (WDHB)
Subject: FW: Meeting with NZNO - correspondence

HI Amanda and Cath

Attached is what I have sent both Judy and Sandra ahead of tomorrow's meeting with NZNO.

Kind regards

Peta


2019-03-15 NZNO Ltr WDHB Chair...


NZNO 20.03.19.pdf


Consent Kate Weston April 20...

NEW ZEALAND NURSES ORGANISATION
TŌPŪTANGA TAPUHI
KAITIAKI O AOTEAROA

15 March 2019

Professor Judy McGregor
Chairperson
Waitemata District Health Board
Private bag 93-503
Takapuna

Email BoardChair.WDHB@waitematadhb.govt.nz

Dear Professor McGregor

Breaches of the Code of Health & Disability Services Consumers' Rights

- **Right 6 - Right to be fully informed**
- **Right 7 - Right to make an informed choice and give informed consent**
- **Right 9 - Rights in respect of teaching or research**

In Waitemata DHB there has been and remains a poor understanding by many medical and nursing staff with regard to the implementation of the **Code of Health & Disability Services Consumers' Rights (The Code).** Specifically there appears to be a poor understanding of consent issues for patients when health professionals are in training.

The "consent issue" is misunderstood with many senior staff being of the view that North Shore is a Teaching Hospital, therefore health professionals in training observing or undertaking procedures or examinations, especially under anaesthetic, is somehow not subject to the legal provision of full informed consent by patients.

Concerns about the issue were first raised in 2012. In 2016, NZNO wrote to Dr Bramley and was responded to. Please refer to attached.
1) NZNO letter to Dale Bramley RE Breaches of WDHB Consent Policy (2 pages).
2) Dale Bramley response letter (1 page).

At this time, there was action to review the Informed consent policy and to update the consent form which better met the requirements of the Code of Rights. Unfortunately, the revised form was not well accepted by medical staff. The updated forms were removed, replacing the form with the earlier versions which was not so easily auditable. The form was then reviewed again and the "tick boxes" removed completely. Please refer to attached.
3) Consent forms (3 pages).

The staff member, [redacted] who had been the strongest advocate for upholding patient rights then unfortunately went on a period of extended leave due to health issues. She returned to work to find that all the good work done in 2016 was undone in 2017 and by 2018 the issues of breaches of consent were, if anything, worse than before. Meetings started with Child Women & Family Clinical Director Dr Meia Schmidt-Uili and General Manager Stephanie Doe in October 2018. Numerous NHIs have been provided of cases where there had been poor process of gaining consent, or inadequate senior supervision, however

Auckland Office
11 Blake Street
Ponsonby
Auckland 1011
PO Box 8921
Symonds Street
Auckland 1150
T 0800 28 38 38
www.nzno.org.nz

there has been a frustrating lack of progress and breaches continue. A review of NHIs provided was promised, with a report back in December. No report back was provided, other than the review had not in fact been conducted.

Initial meetings were had with Lyn Wardlaw and progress started to be made. However, Ms Wardlaw's role has subsequently been disestablished. Meetings with the new Clinical Nursing Director for Surgical services Ulrike Gerstenberger have not resulted in any further actions. Ms Gerstenberger clearly indicated her sphere of influence was in the realm of nursing only. Disappointingly, there has been no feedback on the actions to have been taken in January or February. A meeting scheduled for 22 January where [redacted] came in to work to attend on her day off did not occur. None of the DHB personnel turned up for the meeting and there was no attempt to communicate cancellation. This reinforced the dismissive attitude of many of the DHB personnel to this ongoing and serious breach of patient rights. This letter indicates the timeline thus far. Please refer to attached.

4) Letter to [redacted] (4 pages).

This issue has now been a problem for over six years, which is beyond any acceptable time frame. Remedial actions have been taken over the course of the time, however nothing seems to have changed this poor practice, which is regularly modelled for new staff. Anyone who questions or advocates for patients' rights is bullied and told to keep quiet.

A recent email from Cath Cronin indicates that without further investigation there will be "no change in SMO practice". Please refer to attached.

5) Email RE Informed Consent in Theatres (2 pages).

This matter has been investigated now for six years on and off with numerous recent cases documented. The lack of progress of this issue is deeply concerning. It is distressing to have to write this letter over thirty years after the breaches at National Women's Hospital, and the subsequent Cartwright Enquiry that lead to the development of the Code of Rights.

Waitemata DHB has a legal responsibility to keep patients safe and to ensure that their rights are upheld. To this end, I would like to propose a meeting with myself, [redacted] (NZNO Theatres delegate who raised the issues), Sandra Coney and Dr Dale Bramley to progress with urgency resolution to this serious issue that affects the rights and safety of women in the DHB region.

We look forward to a response within 10 working days of receipt of this letter.

Kind regards

[redacted]

[redacted] NZNO

Cc Sandra Coney
Dr Dale Bramley

Waitemata
District Health Board

Best Care for Everyone

Office of the Chair
Waitemata DHB
Level 2, 15 Shea Terrace, Takapuna, Auckland
Private Bag 93-503, Takapuna, Auckland 1332
Telephone: 09 441 8938
Facsimile: 09 486 8924

20 March 2019

[redacted]
New Zealand Nurses Organisation
P O Box 8921
Symonds Street
Auckland 1150.

Sent by email: [redacted]

Dear [redacted]

I am in receipt of your letter re the Code of Health and Disability Services Consumers' Rights and have asked the Chief Executive Officer for a response to the issues raised. I will be in touch as soon as I can about this important matter. Please be assured that the Waitemata DHB would not tolerate any repercussions for any staff member or member of the public who raised consumer rights with us.

Yours sincerely

JMcGregor

Professor Judy McGregor
Chair
Waitemata DHB

Waitemata
District Health Board

Best Care for Everyone

Office of the Chair
Waitemata DHB
Level 2, 15 Shea Terrace, Takapuna, Auckland
Private Bag 93-503, Takapuna, Auckland 1332
Telephone: 09 441 8938
Facsimile: 09 486 8924

08 April 2019

[redacted]
NZ Nurses Organisation
P O Box 8921
Symonds Street
Auckland 1150

Via email: [redacted]

Dear [redacted]

I am writing further to your letter dated 15 March 2019 in which you outline your concerns about the level of understanding of consent issues for patients when health professionals are in training and the lack of progress in resolving this issue.

Thank you for raising these concerns with me. I have asked Cath Cronin (Director Hospital Services), Andrew Brant (Chief Medical Officer) and Amanda Mark (Legal Advisor) to review the issues you have outlined and we will discuss further when we meet.

Firstly, I would like to pass on my apologies to both you and [redacted] It was disappointing to hear that the staff invited to the meeting on 22 January 2019 did not attend or let [redacted] know that they were unavailable.

I am sorry for the poor communication that has occurred and that there was no update on the agreed actions. I have attached a table that outlines the status of each action and the timeframes for completion for the actions that have not yet been completed.

Cath has offered to arrange a regular meeting with you and [redacted] until all actions have been completed.

Thank you again for your letter. I would like to invite you to meet with Dr Dale Bramley, Sandra Coney and me. I will also ask Cath Cronin and Amanda Mark to attend.

I propose 17 April at 12.30pm, as this is our Board day and both Sandra Coney and I will be on site.

I look forward to meeting with you and [redacted] in order to discuss your concerns.

Yours sincerely

Professor Judy McGregor
Chair
Waitemata District Health Board

Review of actions

Action	Responsibility	Timeframe	Status	Commentary
Immediate action as per Director Hospital Services All RMOs working in Obstetrics and Gynaecology will be required to receive a hardcopy of the consent policy and will meet with Diana Ackerman (clinical director gynaecology) to ensure that the policy is clearly understood by the RMO. The RMO then signs a letter acknowledging this. This will be completed at handover.	Diana Ackerman	19 Dec 2018	**Completed**	This was initially undertaken with the team on 19 Dec 2018. A process is now in place where the chief resident discusses the policy with all RMOs and HOs at the beginning of each new run. The RMO/HO then signs the letter acknowledging they understand the policy and their responsibilities.
Organise a meeting between [redacted] Diana, Adele and Lyn. Stephanie will facilitate this – but date to be confirmed, as Adele is on annual leave this week.	Stephanie Doe	Jan 2019	**Outstanding**	Going forward, Cath will be organising a regular time to meet with [redacted] and team until all actions have been completed.
Meia to meet with Diana to review the cases identified.	Meia Schmidt Uili	19 Dec 2018	**In progress**	Review is currently being completed. A formal response will be sent to [redacted] with a cc Cath Cronin by 10 April 2019.
Meet with Debbie Eastwood and Mike Rodgers to discuss the development of the informed consent training module and the opportunity to modify and implement this across all surgical specialities.	Lyn Wardlaw	Jan 2019	**Completed**	On-line training is available to Waitemata staff via Ko Awatea. Note request to implement this across all surgical specialties. Online training not mandatory. We will also consider the orientation book for wider use
Ensure that there is a clear and agreed process in place for the nursing team to escalate specific concerns about clinical practice, supervision or consent in theatre.	Ulrike Gerstenberger	Jan 2019	**In progress**	Existing escalation process is in place. Meeting to be scheduled with the team to reiterate process. This will be completed by 12 April 2019.

Action	Responsibility	Timeframe	Status	Commentary
Meet with nursing team who work in the obstetrics and gynaecology theatres to discuss how they can support the consistent implementation of the informed consent policy and how they can escalate concerns.	Ulrike Gerstenberger	Jan 2019	**In progress**	Ulrike will meet ACCN tomorrow to discuss and arrange for initial meeting with nursing team to discuss the policy and reinforce escalation process. Meeting with nursing team will occur by 12 April. Going forward escalation of concerns will become a regular part of the daily debriefing process within theatre (to be built into the flowchart).
Complete the review of the consent form and present the recommendations to theatre leadership group.	Ulrike Gerstenberger	20 Feb 2019	**In progress**	An initial review of the consent form has been completed. The decision to implement any changes to form will sit with the Director of Hospital Services and Chief of Surgery, rather than the theatre leadership group. The findings of the review are currently under consideration, in consultation with the Waitemata DHB legal advisor. Revised timeframe for completion is (20 May 2019
Develop an orientation and training package on informed consent. This will include information on the DHB policy, the consent form, documentation expectations and legislative requirements.	Diana Ackerman	28 Feb 2019	**Completed**	Orientation pack has been developed and is now in use.
Commence auditing of informed consent.	Mike Rodgers and Ulrike Gerstenberger	20 May 2019	**Yet to commence**	To be progressed following once the consent form review has been completed.

Attachment 7

Anna Monastra (WDHB)

From: Dale Bramley (WDHB)
Sent: Friday, 15 March 2019 8:59 p.m.
To: Judy McGregor; Cath Cronin (WDHB); Stephanie Doe (WDHB); Amanda Mark (WDHB); Jocelyn Peach (WDHB)
Subject: Fwd: Consent issues - CONFIDENTIAL

Hi Judy
Please see attached.
Cath could you please brief me and Judy on this issue (including follow up actions that happened since my letter went out with initial actions) and also draft a response for Judy to review.
I note a letter from Stephanie was attached which is helpful background.
Thanks
Dale

Denise Poole (WDHB)

From: Dale Bramley (WDHB)
Sent: Monday, 01 April 2019 09:19
To: Cath Cronin (WDHB); Andrew Brant (WDHB)
Subject: FW: Consent issues - CONFIDENTIAL
Attachments: 2019-03-15 NZNO Ltr WDHB Chair.pdf
Letter supplied in Attachment 6

Hi both
Can you discuss this together after or ELT today.\
Judy needs the response letter updated.
Cath can you send that to Andrew.
D

Dr Dale Bramley
Chief Executive Officer
Waitemata District Health Board
Private Bag 93 503, Takapuna 0740
www.waitematadhb.govt.nz

From: [redacted]
Sent: Friday, 15 March 2019 5:30 p.m.
To: 'BoardChair.WDHB@waitematadhb.govt.nz'

Cc: 'dale.bramley@waitemata.govt.nz'
Subject: Consent issues - CONFIDENTIAL

Dear Professor McGregor

It is with great sadness that I write the attached letter with regard to serious beaches of informed consent and concerns about junior medical staff supervision, particularly in obstetric and gynaecology theatres at North Shore Hospital .
This letter is the culmination of a six year journey to try to improve practice and advocate for the rights of women receiving services from WDHB.

Hard copies of this letter and its attachments have also been sent to you, Dr Bramley CEO and Sandra Coney Board Member.

I look forward to your response and the opportunity to meet and discuss these concerns.

Kind regards

[redacted]

[redacted]

[redacted] | www.nzno.org.nz
New Zealand Nurses Organisation | PO Box 8921 Symonds St | Auckland 1150
11 Blake Street Ponsonby

NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

NEW ZEALAND NURSES ORGANISATION

22 August 2016

Dale Bramley
Chief Executive
Waitemata District Health Board
Private bag 93-503
Takapuna
Auckland 0740

BY EMAIL: dale.bramley@waitematadhb.govt.nz

Dear Dale

Breaches of WDHB Consent Policy

It has been brought to NZNO's attention yet again, that there are WDHB policies that are not being complied with in theatres at North Shore Hospital. Unfortunately we are hearing of further incidences occurring in theatres where medical staff are failing to follow the DHB's policy in regards to obtaining the proper consent from patients prior to procedures/treatment being carried out. This blatant breach against the WDHB policy poses a serious risk in that WDHB's staff are not following their own "Informed Consent" and "Consent to Treatment" Policies. If there was an adverse impact on a patient's procedure and it was found that proper consent was not obtained, the WDHB leaves itself wide open to public backlash should anyone decide to complain to the HDC.

This issue of staff gaining patient consent seems to have caused some division amongst the theatre teams as to the correct procedures. Some staff are following the policy guidelines, while some are not, believing that because the consent form had been completed, that they did not need to gain further consent from the patient when carrying out any "teaching" procedures. Clause 2.1 in the "Informed Consent" policy is quite clear and should be read in conjunction with the Request for Treatment/Consent form by staff.

The following is an account of events to date in regards to breaches of these policies since this issue was first raised back in February 2014.

1. December 2012 – NZNO member became concerned that procedures and protocols around gaining patient consent were not being adhered to.
2. 14 June 2013 – An Informed Consent In-Service training session was held with Amanda Marks. Amanda was asked at that time by our delegate whether patients needed to consent to be involved in any "teaching" procedures. Amanda explained that no medical student or house surgeons should be involved in teaching without the appropriate consent from the patient.
3. In October 2013 – Our delegate member spoke to Liz Hollier about an incident that she had observed regarding another breach of the policy by a medical student. Liz called a meeting with all Theatre ACCNs to remind them of the informed consent policy. There were two further incidences observed in October where consent was not properly sought.

4. 4 November 2013 – Another further incident, no consent was documented.
5. 19 December 2013 – [redacted] (former NZNO [redacted]), and [redacted] (NZNO Delegate Theatres), met with Jos Peach, Director of Nursing and Midwifery, WDHB. At this meeting [redacted] provided examples of breaches of consent that have occurred. It was agreed that a possible strategy to address this issue was to review and recommend any changes to the "Informed Consent" policy and "Consent" form. This was supported by the DHB and NZNO and education for nurses regarding their role as patients' advocates was held with the nursing team. I am unsure what education sessions were held with the medical team.
6. On 5 March 2014, Jos Peach sent out copies of the updated Informed Consent and Consent form policies in an email (see attached) advising staff that the policies have been formally approved and requesting that the nursing management team bring the new policy to the attention of their teams. It is clear in Jos' communication as to how the new policy should be rolled out.

In summary

There had been other meetings to discuss this issue (these are not listed above), involving Jos Peach, Cath Cronin, Julia Davenport (HR) and at another meeting, Mike Rogers, Chief of Surgery and Liz Hollier, General Manager along with myself and NZNO [redacted] The purpose of this letter is to highlight that there has been slippage around the correct procedure in medical staff gaining informed consent from their patients. We have received this further information from our NZNO delegate [redacted] and we request that the DHB treats this issue with confidentiality to ensure [redacted] protection and safety in the worksite in case there is any "backlash" from colleagues.

We acknowledge the DHB's proactive stance in reviewing the policy and outlining very clearly that proper patient consent must be obtained, however, there continues to be breaches of this policy by medical staff and this must cease.

We look forward to hearing your response and the actions you will be taking to address this issue with your multi-disciplinary teams at North Shore Hospital Theatres.

Kind regards

[redacted]

NZNO [redacted]

c.c. [redacted] NZNO [redacted]
Jos Peach, Director of Nursing and Midwifery WDHB
Mark Lennox, Employment Relations Manager WDHB

Waitemata
District Health Board

Best Care for Everyone

DHB Board Office
Private Bag 93-503, Takapuna
Auckland 0740
Telephone: 09 486 8900
Facsimile: 09 486 8924
www.waitematadhb.govt.nz

6 September2016

[redacted]
NZNO [redacted]
New Zealand Nurses Organisation
P O Box 8921
Symonds Street
Auckland 1150

Dear [redacted]

Waitemata DHB Consent Policy

I write further to your letter dated 22 August in which you outline the issue of compliance with the consent policy and discussions since 2012. Thank you for bringing to my attention the concerns of your NZNO member.

The DHB takes the matter of informed consent very seriously and I have asked Amanda Mark, Legal Counsel, to confirm that our policy addresses all issues and that there is discussion and training of medical staff about policy requirements. She has assured me that the policy and requirements are up to date and that she provides regular training of medical staff about the expectations.

I have also asked Dr Andrew Brant, Chief Medical Officer, to discuss this letter with the Clinical Directors of the DHB. I have asked Andrew and Mr Michael Rodgers, Chief of Surgery, to confirm with the surgical specialists and anaesthetists that the senior medical staff know the policy requirements and review this with their teams.

Dr Jocelyn Peach, Director of Nursing and Midwifery is also engaging with nurses and midwives to remind them of the policy requirement and their role in advocating for their patients, escalating issues to the Charge Nurse Manager/Unit Manager. Jocelyn will ask the Theatre Manager to discuss the matter with the senior nurses in Theatres as well.

If the NZNO member you mention has any particular concerns please invite them to immediately contact Mr Rodgers. He will work with the member on any issues that might be identified.

Yours sincerely,

Dr Dale Bramley
Chief Executive
Waitemata District Health Board

cc: [redacted] NZNO [redacted]
Jos Peach, Director Nursing and Midwifery, Waitemata DHB
Mark Lennox, Employment Relations Manager, Waitemata DHB

Waitemata
District Health Board
Best Care for Everyone

Waitemata DH8 Wide

[PLACE PATIENT LABEL HERE]

First Name: _____ Gender: _____
Surname: _____
Address: _____
[AFFIX PATIENT LABEL HERE]
Date of Birth: _____ NHI#: _____
Ward/Clinic: _____ Consultant: _____

Consent to Treatment

If you need a trained interpreter – please ask your doctor/ nurse

Maori	Memea kaore koe e mohio ki te korero whaaki ngai ki te takuta (korero)
Samoan	Afai ete le malamalama i le gagana fa'aperetania fa'amolemole talanoa i lau foma'i
Tongan	Ka'olu 'ikai ke mahino kiate koe 'a e lea fakapilitani fakamolemole 'o tala ki ho'o toketa
Simplified Chinese	假若你需要一位翻译员，请告诉医生或护士
Korean	만일 전문 통역사가 필요하 시면 · 귀하의 의사나 간호사에게 부탁하십시오
Vietnamese	Neu quy vi can thông dich viên thành thao xin hoi nhân viên bênh viên
Niuean	Ka ai loa poke ai maama e kouv e vagahau faka peritania fakamolemole talaage ke he ekekafo (toketa)
Cook Island	Me kare koe e marama i te tuatua papaa e akakite mai ki te taote

Interpreter required? ☐ Yes ☐ No Language spoken: _____

Surgery/ Procedure/ Treatment

I, _____ being the proposed patient or Next of kin / Guardian / Legal Representative (circle one) of _____ (name of person)

- I agree to the following surgery / procedure / treatment: _____
- I agree that I have been able to discuss this with Dr _____ (name) _____ (designation) whose signature appears below
- He / she has explained the possible benefits and risks to me of the surgery / procedure / treatment relating to my clinical history and condition. The risks include, but are not limited to _____
- I agree to such further emergency measures that are directly related to the surgery / procedure / treatment and are necessary to save my life ☐ Yes ☐ No
- It has been explained to me that as a teaching hospital that there may be students / trainees present and I agree to their involvement in my care or procedure under direct trained supervision ☐ Yes ☐ No
- I wish to have any body part / tissue removed during this procedure returned to me (except that used for diagnostic purposes) ☐ Yes ☐ No
- Release of tissue / body part request documented ☐ Yes ☐ No
- I acknowledge that no assurance has been given that the operation will be performed by any particular surgeon ☐ Yes ☐ No

SIGNED _____ SIGNED _____
Patient / Next of Kin / Guardian *Interpreter*

SIGNED _____ DESIGNATION _____
Clinician

DATE ____ / ____ / ____

Please note: ***If you are aware of any reason why others should be consulted about this consent either legally, as in the case of joint guardianship, or for cultural reasons, please discuss this with your doctor or nurse.***

Waitemata District Health Board

Best Care for Everyone

Waitemata DHB Wide

(PLACE PATIENT LABEL HERE)

First Name: _____ Gender: _____

Surname: _____

Address: _____

Date of Birth: _____ NHI#: _____

Ward/Clinic: _____ Consultant: _____

Consent to Treatment

Anaesthesia

I, _____ being the proposed patient **or** Next of Kin / Guardian / Legal Representative

(circle one) of _____ *(name of person)*

- Agree that the anaesthetic has been explained to me for the procedure listed overleaf
- Agree to the following anaesthetic _____
- Acknowledge that I have been given and read the Waitemata DHB anaesthetic leaflet and further acknowledge that I have been given ample opportunity to ask questions
- He / she has explained the possible benefits and risks to me of the anaesthetic relating to my clinical history and condition. The risks include, but are not limited to _____

_____

_____

- Acknowledge that I have been advised **NOT** to drive a motor vehicle, operate machinery or potentially dangerous appliances, drink alcoholic beverages or make important decisions for 24 hours after having a general anaesthetic or sedation agents administered
- It has been explained to me that as a teaching hospital that there may be students / trainees present and I agree to their involvement in my care or procedure under direct trained supervision ☐ Yes ☐ No

SIGNED: _____ SIGNED _____

Patient / Next of Kin / Guardian *Interpreter*

NAME OF ANAESTHETIST _____ DESIGNATION _____

SIGNED _____ DATE ____ / ____ / ____

Blood Components and Products

I, _____ being the proposed patient **or** Next of Kin / Guardian / Legal Representative

(circle one) of _____ *(name of person)* ***Tick boxes below as appropriate:***

- ☐ I have been given the New Zealand Blood Service information pamphlet entitled "*Your Guide to Blood Transfusion*" and I have had time to read the information
- ☐ My questions have been answered and I have obtained all the information that I want
- ☐ I have had the risks and benefits of the use of blood components and/or products explained to me
- ☐ I understand that I may need to receive repeated transfusions
- ☐ I understand that I may withdraw consent at any time
- ☐ I agree to receive blood components and/or products as required } **OR** *(delete one)*
- ☐ **I DO NOT** agree to receive blood components and/or products
- ☐ I understand that should a member of the healthcare team be directly exposed to my blood or other body fluids, I agree to blood samples being taken and tested. These samples will be tested only to identify such transmissible diseases that are considered of significant risk e.g. Hepatitis and HIV. I understand I will be fully informed of the results of such tests and the need for any medical referral. The results of these tests are confidential to me, the health professional and the team member involved.

SIGNED: _____ SIGNED _____

Patient / Next of Kin / Guardian *Interpreter*

SIGNED _____ DATE ____ / ____ / ____

Clinician

Consent to Treatment

Date Issued: March 2014

Waitemata District Health Board

Best Care for Everyone

Date: ..... Time: .....

SURNAME: _____ NHI: _____

FIRST NAMES: _____

DATE OF BIRTH: ____/____/____ SEX: _____

AGREEMENT TO TREATMENT / CONSENT

☑= yes ☒= no

INTERPRETER REQUIRED: ☐ YES ☐ NO LANGUAGE: _____

SURGERY / OTHER PROCEDURE(S)

I, _____ (name of patient / parent or guardian / welfare guardian or attorney under enduring power of attorney)

Agree that the following procedure be performed for me / my child / person in respect of whom I am welfare guardian or attorney under an enduring power of attorney

_____

_____

_____

_____

_____

_____ If relevant specify side *(circle one)*: **Right / Left**

I have discussed this with:

Name _____ **Designation** _____ **Signature** _____

They have explained to me the reason for this procedure, the alternatives, and the possible risks.

Risks of the procedure include (but are not limited to): _____

_____

_____

_____

_____

_____

I agree that:

- I have had adequate opportunity to ask questions and I have received all the information that I require.
- I understand that during this procedure images or pictures relevant to my / the patient's care may be captured and incorporated into my / the patient's clinical record.
- I understand that in the event of an emergency, and as determined by my / the patient's medical team at the time, there may be other procedures undertaken to save my / the patient's life or prevent harm.
- I understand that my / the patient's care is occurring in a teaching hospital and there may be healthcare students (medical, nursing) present. I understand they will be appropriately supervised but at any time I can ask for them not to be present.
- I understand that no assurance can be given that a particular clinician will be performing my / the patient's procedure but that the clinician will be suitably qualified and, if in training, will be appropriately supervised by a senior clinician.

Blood accidents

- If a healthcare worker is accidentally exposed to my / the patient's blood or other body fluids, I agree to a sample of my / the patient's blood being taken and tested for transmissible diseases such as Hepatitis and HIV
- I understand I will be informed if this happens and test results will be discussed with me and if required treatment will be given.

Return of Body Parts

- I wish to have any body part / tissue removed during this procedure that is not required for diagnosis returned to me: Yes / No (circle one) if yes ensure this is *documented on the Laboratory form and Theatre staff have been informed.*

Patient / Welfare Guardian / Attorney's signature: _____ Date: ____/____/____

Interpreter's signature: _____ Interpreter's name: _____

AGREEMENT TO TREATMENT / CONSENT

Classification 5.9.060 (Reviewed Date: February 2018)

From: Cath Cronin (WDHB)
Sent: Tuesday, 06 August 2019 5:30 p.m.
To: Dale Bramley (WDHB)
Subject: RE: HDC complaint from NZ Nurses Organisation

Hi

I have attached the summary of work to date. The education plan timeline has ended up sitting with Penny and Lisa Sue (i3) project manager.

There was active pushback when I tried to get some sessions commenced immediately. I can discuss further.

There is a lot of work completed and substantive work actively in progress.

As I said [redacted] came to see me today and she told me she has not lost confidence in the work we are doing. There are improvements in the theatre and she was pleased when I updated her regarding the O&G gynae meeting. I have encouraged her to meet with Diana Ackerman regarding concerns/issues with particular cases and build a trust working relationship there. Diana could look at cases with her rather than using riskpro for this.

The work can seem slow but I encouraged her to think cup ½ full than ½ empty.

She says she has confidence in me staying with this. I offered [redacted] the opportunity to join the steering group if she agreed a positive frame of mind and team collaboration. She would join as a specialty RN and [redacted] wouldn't be invited. She has agreed but will check in with group first to get their views.

I will follow up with [redacted] tomorrow to check if she realised that the letter to HDC and gone in this form. She gave me the impression that [redacted] was the lead here and I'm curious to know if she has a copy of the letter.

Jonathan and Penny have met with O&G SMOs
Jonathan has sent email to all SMOs and RMOs re consent – attached

Have flagged with David to add to Consumer Council agenda in August

I said to [redacted] she didn't know of the work progressing as she stopped meeting with me.

Let me know if you need more for now.

cath

Cath Cronin I Director Hospital Services I RN
Waitematā District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

Begin forwarded message:

From: "Nigel Swain-Williams (WDHB)" <Nigel.Swain-Williams@waitematadhb.govt.nz>
Date: 6 August 2019 at 2:49:52 PM NZST
To: "Amanda Mark (WDHB)" <Amanda.Mark@waitematadhb.govt.nz>, "Andrew Brant (WDHB)" <Andrew.Brant@waitematadhb.govt.nz>, "Ann Young (WDHB)" <Ann.Young@waitematadhb.govt.nz>, "Jacky Bush (WDHB)" <Jacky.Bush@waitematadhb.govt.nz>, "Penny Andrew (WDHB)" <Penny.Andrew@waitematadhb.govt.nz>, "Jocelyn Peach (WDHB)" <Jocelyn.Peach@waitematadhb.govt.nz>, "Cath Cronin (WDHB)" <Cath.Cronin@waitematadhb.govt.nz>, "Dale Bramley (WDHB)" <Dale.Bramley@waitematadhb.govt.nz>, "Peta Molloy (WDHB)" <Peta.Molloy@waitematadhb.govt.nz>, "Jonathan Christiansen (WDHB)" <Jonathan.Christiansen@waitematadhb.govt.nz>, "Stephanie Doe (WDHB)" <Stephanie.Doe@waitematadhb.govt.nz>
Subject: HDC complaint from NZ Nurses Organisation

Good afternoon,

We have been sent the attached complaint from [redacted] and [redacted] that raises concerns about informed consent for the involvement of junior staff

and students in patient care at Waitematā DHB.

This matter was raised in 2012, again in 2016, then followed up in April 2019 with the Board Chair, Dale Bramley, and Jocelyn Peach. Meetings have also occurred with Cath Cronin and Jonathan Christiansen.

I suggest reading the letter of concern in detail. Unfortunately the letters mentioned have not been provided.

We have been asked to provide the following:

Denise Poole (WDHB)

From: Cath Cronin (WDHB)
Sent: Monday, 26 August 2019 16:50
To: Dale Bramley (WDHB)
Cc: Jonathan Christiansen (WDHB)
Subject: FW: Informed consent
Attachments: Action Tracker.xlsx

Hi

Latest updated as per below and action tracker attached.

Thanks cath

Cath Cronin I **Director Hospital Services I RN**
Waitematā District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Lisa Sue (WDHB)
Sent: Monday, 26 August 2019 4:32 p.m.
To: Cath Cronin (WDHB)
Cc: Kate Gilmour (WDHB)
Subject: RE: Informed consent

Hi Cath,

Confirmed education sessions

- Friday Education sessions: 30 August – 0800 to 0900hrs (Case study discussions on informed consent application); 4 October – 0800 to 0900hrs (Patient experience/Theatre etiquette). Please note there is no Friday Theatre Education Session in September.
- Clinical Quiz sessions: Trial with nurses held by Ara planned for 5 September – 1500hrs to 1400hrs, 12 September – 1300hrs to 1400hrs. Roll out of more sessions subject to feedback received.

The next steering group meeting will be next Wednesday 4 September, 1130 to 1230hrs. I am preparing a draft agenda, which I will send out by midweek.

I will be meeting with Jonathan, Amanda, Penny and Jay to finalise a few details for this Friday's session tomorrow.

Updated action tracker attached.

Kind regards,
Lisa.

Lisa Sue
Mobile: 021 195 3378

Training

Date	Meeting	Action	Deliverable	Owner	Due	Progress	Comments
26-Jun-19	NZNO	Develop plan in place for training day on the 26th July, 30 August, and 4 October and lunch time sessions.	Friday education session	Kate Gilmour, Lisa Sue	01-Jul-19	In progress	Education plan submitted to Cath. Will need to discuss further at steering group.
26-Jun-19		Friday Education Session - Case study discussions	Friday education session	Kate Gilmour, Lisa Sue	30-Aug-19	Planned	
01-Jul-19	ADON SAS	To follow up with Mike Rodgers if the Friday theatre session can be intergrated as a whole MDT, rather than silo edcuation sessions	Friday education session	Lisa Sue	11-Jul-19	Completed	9-Jul-19: Emailed Mike Rodgers. He is not involved with planning. To be directed to Clinical directors when comms ready.
01-Jul-19	ADON SAS	To invite Cassie Khoo (i3 design fellow) to meeting with CNE's to discuss plans on a focus board	Focus Board Poster	Lisa Sue	01-Jul-19	Completed	
01-Jul-19	CC,KG, PA, LS	To send a draft copy of the education plan to Cath by the end of the week	Education Plan	Lisa Sue, Penny Andrew	05-Jul-19	Completed	1st draft sent
01-Jul-19	ADON SAS	To arrange meeting with CNE's to discuss ideas for lunch time sessions	Clinical Quiz	Kate Gilmour, Lisa Sue	01-Jul-19	Completed	
01-Jul-19	ADON SAS	To plan meeting with anaesthetic technicians on in service session plan	Clinical Quiz	Lisa	11-Jul-19	Completed	
02-Jul-19	CNEs	To arrange a meeting with Cassie to plan focus board story board	Focus Board Poster	Lisa Sue	09-Jul-19	Completed	
02-Jul-19	CNEs	To plan clinical quiz questions and focus board content	Clinical Quiz	Chari An Bakkenes, Kerlvin Ocado, Grace Gannaban	03-Jul-19	Completed	Agreed to separate into 2 kahoot quizzes
02-Jul-19	CNEs	To arrange a meeting to review clinical quiz content with CNEs	Clinical Quiz	Kate Gilmour, Lisa Sue	03-Jul-19	Completed	
03-Jul-19	CNEs	To input clinical quiz questions into Kahoot website	Clinical Quiz	Lisa Sue	04-Jul-19	Completed	Kahoot has a letter and word limit; therefore questions had to be simplifed and altered
04-Jul-19	CNEs	Distributed clinical quiz for review with CNE's	Clinical Quiz	Lisa Sue	05-Jul-19	Completed	
04-Jul-19	JB, ZB, LS	To send a copy of the nursing clinical quiz to Julie and Zoe	Clinical Quiz	Lisa	05-Jul-19	Completed	
04-Jul-19	JB, ZB, LS	To review clinical quiz, and amend questions to suit the anaesthetic technicians	Clinical Quiz	Julie Bromley, Zoe Bunker	19-Jul-19	In progress	Lisa to create questions into Kahoot when feedback received Feedback received from Zoe - yet to hear back from Julie.
08-Jul-19	Email	To update the education plan from Cath's feedback	Education Plan	Lisa Sue	11-Jul-19	Completed	
09-Jul-19	CK,LS	To arrange meeting with Penny to run through draft concept	Education Plan	Lisa Sue	10-Jul-19	Completed	
10-Jul-19	PA, CK, LS	Decision to have a rolling focused board. To have initial A1 poster as the foundation of information and smaller A3 posters with a specific topic i.e. teaching, consent when patient is not competent etc. To discuss at the steering group	Focus Board Poster	Lisa Sue	11-Jul-19	Action changed	
10-Jul-19	PA, CK, LS	To arrange a meeting with Cassie to plan specific A3 posters and content	Focus Board Poster	Lisa Sue	16-Jul-19	Action changed	
15-Jul-19	YM, UG, KG, LS	To arrange poster Focus board consultation with ACCN's	Focus Board Poster	Ulrike Gerstenberger	31-Jul-19	Completed	Lisa to collate feedback and embed changes with Cassie.
26-Jul-19	CC, KG, LS	Plan Aug 30th Education session based on 2 videos; 1 - on a patient's journey and 2 - a role played scenario and then discussion piece	Friday education session	Kate Gilmour, Lisa Sue	30-Aug-19	Action changed	29-Jul: Difficulties with video resource. Only given resource to do 1 video. Follow up with Penny 1-Aug: Penny clarified that the SMO's wanted more emphasis on the time to discuss cases, therefore it would be more time efficient to have 2 case scenarios, each with multiple issues embedded.
26-Jul-19	CC, KG, LS	To provide Lisa with cases for case studies for the Aug 30th Education Session	Friday education session	Kate Gilmour, Ulrike Gerstenberger	31-Jul-19	Action changed	Advised to talk to Penny / Cath for case studies
31-Jul-19	ACCN meeting	Embed feedback and changes from ACCN's into poster	Focus Board Poster	Cassie Khoo, Lisa Sue	07-Aug-19	Completed	ACCN's agreed 1 high level poster was required for the the theatre focus board.
01-Aug-19	PA, LS	To provide a list of case scenarios for education session	Friday education session	Penny Andrew	09-Aug-19	Action changed	
08-Aug-19	Steering group minutes	Final feedback for focus board poster with steering group	Focus Board Poster	Lisa Sue	16-Aug-19	Delayed	12-Aug: Message from Jonathan: The poster will need more work – we will need to meet and discuss, as it doesn't reflect the appropriate pathway for registered practitioners who are employed and participate in advanced training programs under an apprenticeship model (RMOs mostly). Policy section 2.1 will also need to be amended. **Meeting scheduled for 27 August.**
12-Aug-19	AC, LS	Writing case scenario for education session	Friday education session	Ara Cho, Lisa Sue	16-Aug-19	Completed	20-Aug: Sent scenario to Penny for review (Scheduled meeting to discuss 26 Aug)
16-Aug-19		Send out run sheet for 30 Aug Education session to discussion panel and facilitator	Friday education session	Lisa Sue	27-Aug-19	In progress	
21-Aug-19		Book sessions for clinical quiz - to trial 2 sessions and collect feedback	Clinical Quiz	Ara Cho	16-Sep-19	Planned	Booked sessions: 5 & 16 September. Lisa to send Ara feedback form
26-Aug-19		Send out reminder to Ops Managers / CDs / CNE's - regarding education session	Friday education session	Lisa Sue	28-Aug-19	Planned	

Action Tracker - Work stream 3: Patient Information

Date	Meeting	Action	Owner	Due	Progress	Comments
27-Jun-19	VJ, LS	Lisa to send Vijay a list of examinations and procedures	Lisa Sue	28-Jul-19	Completed	Sent comprehensive list; To revise list to match the list given from Supervision work stream
27-Jun-19	VJ, LS	To review list of examinations and procedures - commenting current state of patient information	Vijay Bhoola	26-Jul-19	Completed	15-Jul: Completed half the list. Vijay queried the aim of this work stream. To be redefined.
15-Jul-19	Email VJ, LS	To review the aim and scope of this work stream	Vijay Bhoola, Lisa Sue	31-Jul-19	On hold	01-Aug: Feedback from Fiona Kong (re: SMO meeting on 30/07) about the importance to provide patient information regarding being explicit about circumstances where patient will be sedated and have an intimate examination.
01-Aug-19	PA, LS	To follow up with Fiona Kong about being a clinical lead on the patient information work	Penny Andrew	16-Aug-19	In progress	
01-Aug-19	PA, LS	To look up existing patient information leaflets from Australia or NHS	Lisa Sue	16-Aug-19	Completed	Found leaflet series from Guy's and St Thomas' NSH Foundation Trust

Attachment 8

Informed Consent

Agenda for the Steering Group Meeting, Thursday 11 July 2019, 14:00 to 15:00

Waitemata District Health Board
Best Care for Everyone

Chaired by Cath Cronin

Requested attendance:
Amanda Mark, Ara Cho, George Gorringe, Jonathan Christiansen, Kate Gilmour, Lisa Sue, Michael Rodgers, Morgan Edwards, Penny Andrew, and Ulrike Gerstenberger

Apologies:
Carlene Lawes, Deborah Davis, Diana Ackerman

No.	Item
1)	**Review of actions from last meeting** 1. Professional documentation providing guidance on informed consent for other students. 2. Draft work plan overview
2)	**Education Plan** 1. Friday theatre education sessions – Discussion panel 2. Focus board – Proposal of first draft concept designed by Cassie Khoo (i3 Design Fellow) 3. Kahoot quizzes – in service sessions; review of sample questions 4. ASMS/WDHB session
3)	**Consent Form and documentation and auditing** 1. To confirm position on Consent Form, expectations for documentation and approach to audit. 2. Treatment without Consent Form
4)	**Any other business**

Informed Consent

Agenda for the Steering Group Meeting

Wednesday 7 August 2019, 11:30 to 12:30

Waitemata District Health Board

Best Care for Everyone

Chaired by Cath Cronin

Requested attendance:
Amanda Mark, Ara Cho, Carlene Lawes, Deborah Davis, Diana Ackerman, Lisa Sue, Morgan Edwards, Penny Andrew, and Ulrike Gerstenberger

Apologies:
George Gorringe, Jonathan Christiansen, Kate Gilmour, Michael Rodgers

No.	Item
1)	**Update on SMO meeting with Jonathan and Penny**
2)	**Informed Consent documentation** 1. Update on Treatment without Consent Form 2. Update on Agreement to Treatment / Consent Form
3)	**Education Plan** 1. Friday theatre education session 30 August • Session format, content • Plan comms approach 4 October • Agree content topics a. Theatre etiquette b. Patient experience 2. Focus board • Present Poster – 2nd Draft for approval • Agree start date and timeframe 3. In service clinical quiz • Agree start date
4)	**Update on actions from last meeting** 1. AM/JC – Aligning Informed consent policy to consent form regarding teaching. 2. UG/LS – Plan function and implementation of theatre focus board 3. JC – Arranging Roundtable with Ron Paterson 4. UG/KG – Arranging a senior RN/educator or quality lead to work with Cath 5. CC – Arrange the consent form as an agenda item on the consumer council 6. UG – Draft professional guidance documents for other students / representatives
5)	**Any other business**

Informed Consent

Agenda for the Steering Group Meeting

Wednesday 4 September 2019, 11:30 to 12:30

Waitemata District Health Board

Best Care for Everyone

Chaired by Jonathan Christiansen

Requested attendance:

Amanda Mark, Ara Cho, Carlene Lawes, Deborah Davis, Diana Ackerman, George Gorringe, Kate Gilmour, Lisa Sue, Michael Rodgers, Morgan Edwards, Penny Andrew and, Ulrike Gerstenberger

Apologies:

Cath Cronin

No.	Item
1)	**Education session** 1. Update from the session on 30 August 2. To agree approach for next education session on 4 October
2)	**Agreed next steps** 1. Consumer council 2. Informed consent process 3. Informed consent policy 4. Documentation
3)	**Update on supervision** 1. Qlik application with registrar credentialing
4)	**Any other business**
5)	**Next meeting – 16 October**

Informed Consent

Agenda for the Steering Group Meeting

Wednesday 16 October 2019, 11:00 to 12:00

GM HODs Meeting Room, LGF NSH

Waitemata District Health Board

Best Care for Everyone

Chaired by Jonathan Christiansen

Confirmed attendance:

Amanda Mark, Deborah Davis, Lisa Sue, Morgan Edwards, Penny Andrew and, Ulrike Gerstenberger

Apologies:

Ara Cho, Carlene Lawes, Diana Ackerman, George Gorringe, Kate Gilmour and, Michael Rodgers

No.	Item
1)	**Education session** 1. Reflection education session on 4 October and staff feedback 2. To agree next steps for ongoing education
2)	**Review Informed consent project plan and agree next steps** 1. HDC response: Confirm if further actions are required 2. Informed consent policy: Confirm the amendments required 3. Consent form: Consumer council feedback after 2nd session. To discuss actions from this. 4. Informed consent process: Confirm if further actions required and student poster
3)	**Any other business**
4)	**Next meeting** – Tuesday 12 November, GM HODs Meeting Room LGF NSH , 12:00 to 13:00

Attachment 9

Waitemata District Health Board
Best Care for Everyone

Informed Consent

11 July 2019, 14:00 to 14:30

Chaired by: Cath Cronin ***Attendees:*** Amanda Mark, Ara Cho, Jonathan Christiansen, Lisa Sue, and Ulrike Gerstenberger ***Apologies:*** Carlene Lawes, Deborah Davis, Diana Ackerman, George Gorringe, Kate Gilmour, Michael Rodgers, Morgan Edwards, and Penny Andrew

Minutes	
1.	Discussed poster for focused board. The group endorsed concept of a poster but will require revision of content and function i.e. removing "teaching".
2.	Further work redefining "teaching" in the policy required. Current policy discusses teaching from the perspective of students and an opportunity exists to reflect teaching for employed learners (i.e. registrars) in the policy.
3.	Consent form to be taken to Consumer Council with David Price. Opportunity for David to review poster and make consumer friendly.
4.	No available professional documentation providing guidance on informed consent for other students or representatives. Decision to create Waitemata DHB professional documentation using existing guidance documents such as medical students as a template.
5.	Aspects of education plan discussed: • Friday theatre session: 40 minute sessions best in the theatre tea room to encourage attendance across MDT • Opportunity to make online tests mandatory for theatre groups. • Opportunity to talk with SMOs at the next ASMS/WDHB session in November.

Actions		Owner	Due
1.	Align the informed consent policy to the consent form regarding teaching. Suggestion of creating a glossary attached to the policy.	Jonathan Christiansen, Amanda Mark	31 July 2019
2.	Send an electronic copy of the informed consent form to Jonathan.	Lisa Sue	11 July 2019
3.	Work with Ulrike on the function and implementation of the educational poster in theatre.	Lisa Sue, Ara Cho	19 July 2019
4.	Distribute electronic copy of the poster for steering group to review content and provide feedback.	Lisa Sue	15 July 2019
5.	Continue case reviews and apply each case in different settings (i.e. what are the expectations in acute, or elective	Cath Cronin	31 July 2019
6.	Prepare roundtable discussion with Ron Paterson	Jonathan Christiansen Cath Cronin	31 July
7.	Work with David Price and the Consumer Council on the consent form.	Cath Cronin	August meeting
8.	Identify a senior nurse/quality lead to support case reviews with Cath.	Ulrike Gerstenberger, Kate Gilmour	15 July 2019
9.	To create professional documentation providing guidance on informed consent for other students.	Ulrike Gerstenberger	31 July 2019
10.	To create professional documentation providing guidance on informed consent for industry representatives.	Cath Cronin, Ulrike Gerstenberger	31 July 2019
11.	Review draft work plan, education plan and action tracker and provide feedback to Lisa.	Cath Cronin	15 July 2019

Informed Consent

7 August 2019, 11:30 to 12:30

Waitemata District Health Board
Best Care for Everyone

Chaired by: Cath Cronin ***Attendees:*** Amanda Mark, Ara Cho, Deborah Davis, Diana Ackerman, Lisa Sue, Morgan Edwards, Penny Andrew and Ulrike Gerstenberger

Apologies: Carlene Lawes, George Gorringe, Kate Gilmour, Jonathan Christiansen, Michael Rodgers

Minutes	
1.	SMO meeting update • A good session that clarified responsibilities and expectations of the informed consent process. • Identified 3 key areas of work 1. Updating comms and orientation material on what can students/registrars do in terms of assisting? Defined responsibilities. Further work with medical students to prevent turning up to theatre without prior introduction to team or patient. 2. Electronic register of credentialing 3. Standardise some outpatient procedure information. Explaining explicitly what examination under anaesthetic involves for intimate procedures.
2.	Treatment without Consent Form The group endorsed this form remains available as guidance only and not mandatory. The form is available when clinicians seek legal advice. Agreed that this form will not be widely promoted to encourage obtaining informed consent.
3.	Education Session • The group agreed to move session into Whenua Pupuke as a number of theatre staff will still be assigned to acute lists requiring use of the Theatre Tea Room. • Format will remain with 2 case studies, a facilitator and discussion panel.
4.	Focus Board and Clinical Quiz • The group accepted the proposal to launch poster and clinical quiz at the start of September. • The approach of initiating the clinical quiz was discussed. Agreed to pitch with first cohort that this was a test to see if this format works with the group and seek qualitative feedback.
5.	Patient Experience and Co-design • The group supported further work to understand the patient's perspective. • Initial discussions with Jay O'Brien on patient interviews and focus group to help inform how to structure 4th October education session, and patient information work stream.
6.	Any other business • Informed consent is on the August agenda of the Consumer Council.

Actions		Owner	Due
1.	To circulate a copy of the email sent to clinicians on the medical student process (See page 3)	Lisa Sue	12/08/2019
2.	To ask Wendy Burgess to update orientation booklet to reflect agreed informed consent process and	Diana Ackerman	12/08/2019

	responsibilities		
3.	To start conversation with Wendy / Adele about arranging orientation where new medical staff meet with the CNM for each specialty.	Penny Andrew / Diana Ackerman	23/08/2019
4.	To circulate theatre etiquette policy to wider group for feedback	Ulrike Gerstenberger	23/08/2019
5.	To work on a glossary of definitions missing in the policy	Amanda Mark / Penny Andrew	4/09/2019
6.	To arrange Ron Paterson's availability for discussion panel	Penny Andrew / Amanda Mark	12/08/2019
7.	To change the education session from 10am to 8am	Lisa Sue	09/08/2019
8.	To send out comms poster for education session for the steering group to circulate	Lisa Sue	09/08/2019
9.	To start comms for education session with surgical clinical directors	Cath Cronin	12/08/2019
10.	To start comms for education session with anaesthesia department	Morgan Edwards	12/08/2019
11.	To start comms for education session with nursing groups	Ara Cho	12/08/2019
12.	To amend the text in the focus board poster	Lisa Sue	09/08/2019

Informed Consent

4 September 2019, 11:30 to 12:30

Chaired by: Penny Andrew ***Attendees:*** Amanda Mark, Ara Cho, Deborah Davis, Kate Gilmour, Lisa Sue, and Ulrike Gerstenberger

Apologies: Cath Cronin, Carlene Lawes, Diana Ackerman, George Gorringe, Jonathan Christiansen, Michael Rodgers, Morgan Edwards

Minutes	
1.	Education Session – 30 August, Survey Monkey Feedback • 50% felt session was too short – would like to have more time for further discussion, 50% felt the session was the right length. • Themes of what staff liked about the session: Open forum to discuss, inclusion of all viewpoints, MDT approach and relevant case scenarios. • Themes of session improvements staff would like: Discussion panel to provide recommendations or solutions to the scenario, and longer sessions.
2.	Education Session – 4 October, Approach • Another session with similar set up, to have another case scenario and invite Ron Paterson to be on the panel. • To include in the session a patient experience video, i.e. format like "in your shoes".

3.	Agreed next steps
	• Consumer council: Mike Rodgers to attend next Consumer council meeting. The group discussed the idea for a national consent form.
	• Informed consent process:
	  ○ To use the medical student guidance as a template to create guidance for other students i.e. nursing, anaesthetic technicians.
	  ○ Agreed to create a visual display / chart of the summarised guidance for students at Waitemata DHB.
	  ○ To progress work on the policy for medical sales/technical representatives in theatre.
	  ○ Further work on informed consent process with General Surgery.
	• Informed consent policy: Work on changes relating to RMO teaching with some guidance from Ron Paterson.

4.	Update on supervision • Qlik app created with Obs & Gynae registrar credentialing. Making a few changes before user testing. • Further clarification on who should have access to this information and what is an appropriate escalation path?

5.	Any other business
	• Focus board: Delayed roll out – minor changes required relating to students.
	• Patient information work stream:
	  ○ Work started on defining common gynae procedures and patient interviews to inform creating patient information.
	  ○ Idea to create video suite i.e. What to expect at: clinic, on day of surgery and pre-op (link current pre-op video with additional consent component). These could be displayed together in package with Patient Safety video.
	  ○ Discussed the need to separate elective and acute process. Hypothesis is that acute is where the challenges are currently.

Actions		Owner	Due
1.	To distribute a copy of staff feedback from the education session from the 30th August	Lisa Sue	6 Sep 2019
2.	To start coordinating education session for 4th October	Lisa Sue	4 Oct 2019
3.	To confirm Ron Paterson's availability for 4th October education session	Jonathan Christiansen	13 Sep 2019
4.	To arrange a patient experience video with Jay O'Brien / David Price	Lisa Sue	4 Oct 2019
5.	To send the draft policy "Health Care Industry Representatives in the Perioperative Setting" to the steering group. To obtain sign off from this forum.	Ulrike Gerstenberger	Completed
6.	To discuss with Matt Walker the policy for representatives	Jonathan Christiansen	13 Sep 2019
7.	To discuss with Health & Quality Safety commission the idea of a national consent form	Penny Andrew	30 Sep 2019
8.	Informed consent guidance for nursing students based on medical template	Kate Gilmour	16 Oct 2019
9.	Informed consent guidance for anaesthetic technician trainee based on medical template	Lisa Sue / Julie Bromley	16 Oct 2019
10.	To arrange with Cassie Khoo to create a graphical summary of Informed Consent guidance for students	Lisa Sue	16 Oct 2019
11.	Create a process map of elective and acute information giving and consent process	Lisa Sue	16 Oct 2019
12.	To send Lisa a copy of the current pre-op video	Kate Gilmour	6 Sep 2019

Informed Consent

16 October 2019, 11:00 to 12:00

Waitematā District Health Board
Best Care for Everyone

Chaired by: Jonathan Christiansen ***Attendees:*** Amanda Mark, Deborah Davis, Diana Ackerman, Lisa Sue, Morgan Edwards, Penny Andrew, and Ulrike Gerstenberger

Apologies: Ara Cho, Carlene Lawes, George Gorringe, Kate Gilmour, and Michael Rodgers

Minutes	
1.	**4 October education session** • Overall positive feedback from 4 Oct session. **Next steps for education and training** Agreed to ongoing education programme which will involve the combination of: • 2 education sessions per year (1 hour session with a mix of didactic teaching and interactive case discussion). The group agreed to invite Ron Paterson to one of these sessions. • Nursing will continue their in-service clinical quiz as business as usual. • Creating a mandatory online education course on Ko Awatea for the surgical registrar cohort. Content specific to informed consent of students, team care and delegation. • In-service informed consent discussions for each respective surgical department aimed for consultants. Once complete, to engage with other areas involving patient consent i.e. allied health and radiology.
2.	**Agreed next steps** • **HDC response**: Response has been submitted. No further action required until feedback received. • **Informed consent policy**: Agreed the policy is satisfactory and the only change required is clarifying the definition of student and intern. • **Consent form**: The group endorsed the current consent form and felt the introduction of tick boxes would not add additional value. Based on the suggestions from the Consumer Council, the next steps are improving the patient information to ensure effective communication and setting clear expectations of the consenting process. It was suggested that brochures alone are not the best way to engage patients, rather there is a need to explore video and digital communication platforms. Creating a webpage with all essential information and consent form sent to a patient before a procedure via digital post was recommended. • **Informed consent process**: ▪ **Student poster**: Minor changes required in terms of highlighting numbers and adding reference to the NZMJ article. ▪ **Health care representative**: A draft document was taken to Theatre Leadership Group but has not been able to progress further. Further change management required.
3.	**Any other business** • Consent form and blood transfusion audit findings: Group decided this piece of work is related to process and service improvement. This is not a legal issue therefore no further action is required from this forum. • Informed consent policy awareness poster: The group endorsed the poster as is and that no further actions are required.
4.	**Next meeting** • The group agreed that the meetings scheduled in November and December can be replaced with a meeting in February. • The next meeting: 12 February 2020, 11:00 to 12:00, CS2 Meeting room.

Actions		Owner	Due
1.	To follow up on feedback regarding nursing council guidelines on direction and delegation as per staff feedback from the October education session.	Amanda Mark	31 October 2019
2.	To co-ordinate and schedule 2 education dates for next year	Ulrike Gerstenberger	31 October 2019
3.	To plan informed consent in-service clinical quiz for nursing as business as usual	Ulrike Gerstenberger, Ara Cho	30 December 2019
4.	To arrange i3 resource to create mandatory e-Learning module for surgical registrars	Penny Andrew	31 October 2019
5.	To arrange with each respective surgical department (i.e. general surgery, orthopedics, anaesthesiology) a meeting with consultants to discuss informed consent in a similar format as with the gynaecology and obstetrics consultants	Jonathan Christiansen, Penny Andrew	12 February 2020
6.	To start discussions with Tamzin Brott about introducing informed consent to allied health	Penny Andrew	12 November 2019
7.	To amend and circulate to the steering group the informed consent policy definitions for students and interns	Amanda Mark, Penny Andrew	12 November 2019
8.	To draft a formal response to the Consumer Council regarding our next steps in response to their suggestions.	Lisa Sue, Jonathan Christiansen, Penny Andrew	31 October 2019
9.	To provide the Consumer Council with an update on progress early next year	Jonathan Christiansen, Penny Andrew	30 March 2020
10.	To action the recommended changes for the student poster and arrange printing and distribution.	Lisa Sue	18 October 2019
11.	To send a draft copy of the health care representative policy to Jonathan and Penny, who will follow this up	Ulrike Gerstenberger	18 October 2019
12.	To discuss with the respective clinical director about transfusion service improvement as a separate programme from Informed Consent	Penny Andrew	31 October 2019

Attachment 10

From: Cath Cronin (WDHB) <Cath.Cronin@waitematadhb.govt.nz>
Sent: Wednesday, 16 January 2019 1:28 p.m.
To: Stephanie Doe (WDHB); [redacted]; Jocelyn Peach (WDHB); Lyn Wardlaw (WDHB)
Cc: Meia Schmidt-Uili (WDHB)
Subject: RE: Informed Consent in Theatres

Thanks Steph

Happy for you to continue your work with the team and respond to the queries as we have agreed.

I am happy to receive recommendation regarding any change in SMO usual practice to discuss with Andrew Brant and division heads. We wouldn't implement changes to the consent process without further discussion. In my mind it was different for our junior workforce.

Happy to discuss

cath

Cath Cronin I Director Hospital Services I RN
Waitemata District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Stephanie Doe (WDHB)
Sent: Wednesday, 16 January 2019 12:12 p.m.
To: [redacted]; Jocelyn Peach (WDHB); Lyn Wardlaw (WDHB)
Cc: Cath Cronin (WDHB); Meia Schmidt-Uili (WDHB)
Subject: RE: Informed Consent in Theatres

Hi [redacted]
Yes – Diana has also distributed the policy to all the SMOs via email along with the expectations. She has also spoken to the SMOs about the requirements and expectations at the SMO meeting.
I am aware of a recent incident, which we are formally investigating, but have not yet been able to complete as the SMO is on leave until early Feb.
To date the SMOs haven't signed the form we developed – but we will follow this up with Diana when she is back from leave next week.
Also, work is commencing on the new orientation module next week (as I have a new staff member starting).
Just to note, I will be on leave from 18 Jan – 11 Feb, but please feel free to contact Meia during this time if there are any concerns. Alternatively you can contact Marianne Cameron, who is acting GM while I am away.
I will make contact with you when I am back from leave to touch base.
Kind regards
Stephanie

From: [redacted]
Sent: Wednesday, 16 January 2019 11:30 a.m.
To: Stephanie Doe (WDHB); [redacted]; Jocelyn Peach (WDHB); Lyn Wardlaw (WDHB)

Cc: Cath Cronin (WDHB)
Subject: Informed Consent in Theatres

Dear All,

Thank you again Stephanie for your efforts so far in trying to address this matter.

As you will be aware by the riskpros submitted, lack patient consent for teaching is an issue for the SMO's as well as the RMO's.

Can the SMO's be made aware of the policy and be given the form to sign [the one you sent me]as they appear to be unaware or

unconcerned of the consequences/repercussions of not adhering to the policy.

Can you or someone else who has a clear understanding of it sit down and explain it to them, the organisational risk and the risks to themselves

should a complaint be made to the HD&C.

They do not have to agree with the policy, they need to adhere to it.

Until the consent / agreement to treatment form is amended to meet the policy, could the medical staff gain consent for the teaching/junior staff

performing the operation under supervision, and document it on the form where the operation is written so it is clear to all.

I look forward to discussing this at our meeting on Tuesday 22nd January.

Kind regards,
[redacted]

Denise Poole (WDHB)

From: Cath Cronin (WDHB)
Sent: Friday, 10 May 2019 17:08
To: [redacted]
Cc: [redacted] Kathy Briant (WDHB)
Subject: Update

Follow Up Flag: Follow up
Due By: Monday, 13 May 2019 16:00
Flag Status: Completed

Hi [redacted]

I thought I would connect as finding dates to meet seem to have been pushed out. I wanted to let you know that I have starting review of the issues around informed consent and will have the outline of work to discuss when we meet.

[redacted] - I also wondered if you and [redacted] would like me to respond to the letter you sent Judy or would you prefer to talk through this when we catch up. I also have the case review from Meia.

Let me know what suits and I look forward to seeing you both soon.

Regards cath

Cath Cronin I Director Hospital Services I RN
Waitemata District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

Denise Poole (WDHB)

From: Cath Cronin (WDHB)
Sent: Tuesday, 21 May 2019 15:28
To: [redacted]
Cc: [redacted] Jocelyn Peach (WDHB); Dale Bramley (WDHB); Kathy Briant (WDHB)
Subject: RE: Informed Consent Issues

Follow Up Flag: Follow up
Due By: Wednesday, 22 May 2019 16:00
Flag Status: Completed

Categories: Meetings to be set up

Thanks [redacted]

This was our first meeting which took a little longer than planned due to leave and other conflicting diary challenges. As we agreed we will now put in a series of four weekly meetings with me and in the alternate four weeks you will meet with Lisa Sue, the project manager who will work with us through the issues. In that way you and [redacted] will have fortnightly updates. If needed I can attend the meetings fortnightly as/if needed. I am available at any time via email, text or a call to Kathy Briant on the landline below.

I have met with Kate Gilmour, Associate Director Nursing and Ulirike Gerstenberger, Clinical Nurse Director Theatres today. They will be in touch directly to start the series of education sessions you suggested [redacted]. The theatres are also commencing five weekly Friday morning education sessions so there are increasing options to connect with staff in the next months. I suggest you draft a plan for the nursing team with Kate and Ulrike in the first instance. A number of sessions could be open to all staff and we will also consider the education programme for all.

I will set up a meeting with Jonathan Christiansen, Penny Andrew, [redacted] Ulrike, Kate, you and me so we can address the issues concerning clarity of roles/expectations that you raise including internal/external presenters and what our request of the presenters would be.

I am aware that [redacted] has ongoing concerns. I have asked in my email response to her that she talks immediately to her ACCN and then to Ulrike. If that fails then she can text me. This is obviously not ideal but I can assist to intervene in the short-term while we implement sustainable change. My view is that we need to avoid rushing in to put in temporary 'fixes' and ensure that our improvements are understood by all staff, implemented and sustained over time. I have also talked to Ulrike and Kate about this today.

I will progress the review of the consent policy and form with the working group. We will address education planning together, as described above, noting that we need a comprehensive plan for all staff that aligns with our policy and expectations. We will commence our discussion to clarify our understanding of roles and consent (ie medical students, supervision etc) with Jonathan and Penny in the first instance.

I will send you answers to the original issues you raised with Judy and this will likely form the basis for our discussion with Jonathan and Penny.

I have asked Ulrike to hold all drafts of policy, guideline and memos regarding consent and bring them through the steering group so we don't pre-empt good discussion with all teams in theatre or cause any confusion.

I have suggested the Ulrike and [redacted] catch up regularly and I suggest that Ulrike and Kate join us for our meetings.

I am looking forward to working with you too.

Regards cath

Cath Cronin I Director Hospital Services I RN
Waitemata District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: [redacted]
Sent: Friday, 17 May 2019 11:15 a.m.
To: Cath Cronin (WDHB)
Cc: [redacted] Jocelyn Peach (WDHB); Dale Bramley (WDHB)
Subject: Informed Consent Issues

Hello Cath
Thank you for meeting with me and [redacted] on 14 May – the first meeting since the meeting with the Board on 17 April.
This email summarises the meeting from our recollection

As discussed, we are keen to see education for nurses, doctors and the wider multi-disciplinary team that outlines the policy and law and the obligations for those getting consent and those with patient advocacy and support roles such as nurses. We were disappointed that there is not yet a draft education plan, especially given that since the meeting we have become aware that there is a full day study day set aside next week on 21 May for SMO and nurses separately – this would have been a wonderful opportunity for education which has now been missed.

As discussed, it is important to NZNO that the initial education is offered from outside of the department, as the culture even with very senior medical and nursing staff within the department has allowed these practices of poor informed consent to go unchallenged and to flourish - so there is no confidence in an internal department led education programme. We suggested that potentially even a person from outside the DHB might be appropriate (e.g. Dr John Tait – former RANZCOG NZ Chair, CMO CCDHB who has done a lot of work in Waikato and MidCentral Womens health services). A culture shift will need to occur within the department to make it " the way things are done" - which will need to be supported from within. You have suggested that we meet with Dr Jonathan Christiansen – can you confirm this please?
[redacted] and I have agreed to further fortnightly meetings – can these please be put in the diary, as times tend to fill up quickly. We are anticipating meeting in the week of 27 May (not 27 please as I'm away from Auckland)

The education programme needs to be systematic and consistent.
We would also like to see some cultural and consumer input into the ongoing education and consent forms when these are reviewed.

Despite there being a heightened awareness within the department that concerns have been raised, breaches of consent are still occurring. [redacted] is going to send you details of a case that has occurred as recently as yesterday, so there is an urgency to review practice and provide education.

A definition of what a health professional in training is and the various roles of junior medical staff may be useful – however, even given that it is a teaching hospital, there still needs to be discussion about the role that they are taking and explicit consent if there will be teaching/examinations/procedures conducted " on the patient" –whether this is an intimate procedure or not – with particular care being taken when a procedure is invasive and especially of an intimate nature such as gynaecology.

We look forward to reaching a sustainable solution to these issues that continue to put both patients and staff at risk .
Kind regards

[redacted]

[redacted]

[redacted] | www.nzno.org.nz
New Zealand Nurses Organisation | PO Box 8921 Symonds St | Auckland 1150
11 Blake Street Ponsonby

NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI

Denise Poole (WDHB)

From: Cath Cronin (WDHB)
Sent: Tuesday, 21 May 2019 16:00
To: [redacted]
Cc: [redacted] Kathy Briant (WDHB)
Subject: Update
Attachments: Letter to [redacted] DOCX; [redacted] response March 2019 (2).docx

Follow Up Flag: Follow up
Flag Status: Completed

Categories: Meetings to be set up

Hi [redacted]

Please find a response that aims to answer the questions you posed in your letter to Dale, Judy and Sandra. I have used the draft of a response I commenced at the time but didn't table as we opted for discussion at the meeting with Judy, Dale and Sandra. I thought the letter could form the basis of the discussion with Jonathan and Penny as I'm sure there will be a need for more discussion and clarity.

I have also attached a response from Meia. If this does not answer all your queries I suggest we agenda for the meeting with Jonathan and Penny.

Please let me know if there are urgent issues still outstanding.

Kathy will be in touch to set up and confirm all our upcoming meetings.

regards cath

Cath Cronin I Director Hospital Services I RN
Waitemata District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

DRAFT - Not sent

Dear [redacted]

First of all please accept my sincerest apologies for not having responded to you earlier.

Secondly, I have reviewed the details of each of the cases whose NHI details you provided and have spoken with the relevant personnel.

The only record I could not locate was that of [redacted] which is appears to be an incorrect NHI. However this was one of three cases on the 19th September 2018, managed by the same consultant on the 19th September 2018.

In my opinion these cases illustrated examples of where the informed consent was required yet were not provided. As you will be aware, Dr Diana Ackerman has spoken with the senior medical team about expectations of informed consent. She has also progress the development of an orientation process for new junior medical staff starting with the service – this specifically includes information about informed consent requirements.

In regards to your concerns about supervision, I understand that these were addressed with the SMO team at the time by Dr Diana Ackerman. From my perspective the standard of care provided in your list of cases, including the supervision at the time appeared to be satisfactory.

Furthermore the maternity services has a robust process in place to review all adverse outcomes i.e., a multi-disciplinary team meets weekly to review all adverse outcomes and determine whether further investigation/action is required.

Once again I do appreciate your concerns for our women who have been entrusted to our care, and thank you for raising your concerns with us. I would hope that you now share the same confidence that I have in our commitment towards ensuring our women are treated respectfully and receive care that is reflective of our organisation's values.

Please don't hesitate to contact me directly either by email or phone should you have any further concerns.

Warm regards

Meia

Response to issue raised in letter from [redacted] *To be discussed in detail with meeting (Kathy will confirm date)*
Cath Cronin, Jonathan Christiansen, Penny Andrew, Kate Gilmour, Ulrike Gerstenberger, Lisa Sue, [redacted]

Informed consent

Waitemata DHB takes informed consent very seriously. We have an informed consent policy which contains detailed information regarding the application of informed consent across the DHB, including a framework for staff to work within.

As outlined in the policy, Waitemata DHB provides a learning environment where clinical teaching and learning occurs as part of day to day practice. We are a teaching institution, which provides formal learning to individuals from a wide range of professional groups. However, being a teaching institution does not remove our obligation to gain consent for students to participate in the direct care of patients in any given situation. The informed consent requirements for teaching and observation are clearly outlined in section two of the DHB's Informed Consent policy (pages 12 – 16).

The level of learner is important and there are different requirements for medical students and RMOs (both house officers and registrars). Medical students are not qualified doctors with oversight from the Medical Council of New Zealand (MCNZ) and therefore must seek at least verbal consent to participate in any routine aspect of patient care (including observation). RMOs are qualified registered medical practitioners who are employed for the purpose of providing clinical care (as outlined in their position description) and do not required the same level of consent as medical students.

Intimate (vaginal) examinations

I note [redacted] initially raised concerns approximately five years ago, which were in relation to medical students performing intimate (vaginal) examinations under anaesthesia. This concern was dealt with at the time in conjunction with the University of Auckland who have subsequently produced a paper on medical students and consent. Specifically, it was reiterated that no medical student was able to perform a vaginal examination under anaesthetic without written permission from the patient. In addition, it was also deemed that verbal consent for involvement of students in patient care (in a general sense) of any professional group was required. This information was added to the consent form.

The Waitemata DHB Informed Consent policy was amended at this time to clearly outline the requirements for student to undertake intimate examinations and prohibits multiple examinations on one patient by a group of students (please see excerpt below). Individual consent (which can be verbal for RMOs, registrars and SMOs) is required for all vaginal examinations.

2.3 Intimate Examinations

Such examinations are of critical importance and need to be properly learned by health professionals. The commonest cancers (prostate and breast) for both men and women are disclosed by such examinations.

Responsibility for eliciting the essential consent to teach these procedures rests with the supervising clinical teacher.

Multiple intimate examinations on one patient by a group of students is prohibited.

Intimate examinations by students under general anaesthetic require the same consent process i.e. the patient MUST consent for teaching BEFORE anaesthesia or pre-medication is given.

- Multiple examinations are, as in the general setting, prohibited.

Clinical teachers should use chaperones appropriately when teaching intimate examinations.

Patients have the right to have a support person present particularly during intimate examinations such as rectal or vaginal examinations.

As outlined in Stephanie's letter, [redacted] raised concern that a vaginal examination was about to be performed by a junior doctor without explicit patient consent on 14 December 2018. I note that [redacted] addressed this directly with the registrar at the time, which resulted in the examination not occurring. The service is not aware of any other incidences where vaginal examinations have been undertaken without the patient's consent. If there are concerns please raise with Cath Cronin.

Supervision of RMOs

I understand that [redacted] subsequently raised concerns about RMOs' involvement in surgical procedures. As described above RMOs are qualified doctors and part of their role is training in that specialty. In general if an RMO is supervised by the responsible SMO and experienced (for the task/procedure they are doing) and they are part of the team looking after the patient then specific written consent is not required for their involvement. Teaching and supervision in a teaching hospital are outlined in the Consent Form. We do expect that the primary operator will have introduced themselves to the patient prior to the procedure if at all possible (emergencies not withstanding) and explained their role as part of the consent process.

In our view RMOs do not need specific individual consent to participate in a procedure in theatre if they are employed by the DHB to be part of that team and it is the requirement of their role to function in that capacity. However, we expect that if an RMO undertakes a procedure without an SMO present, then the written consent and discussion should reflect that the patient understands who is doing the procedure and the level of expertise that person has.

In regards to adequacy of supervision, the level of experience, learning and competency must be judged by the SMO who is delegating the task to the RMO. The legal obligations on SMOs to adequately supervise junior medical staff are poorly defined and there is no legislation that sets out the SMOs responsibilities, but guidance is provided by the MCNZ *Good Medical Practice (2016)*, which states:

1. *"Make sure all staff for whom you are responsible for and who require supervision, including locums, less experienced colleagues and international medical graduates who are new to practice in New Zealand are properly supervised. If you are responsible for supervising staff, you should make sure you supervise at an appropriate level taking into account the work situation and the level of competence of those being supervised."*

2. *"Delegating involves asking a colleague to provide treatment or care on your behalf. When you delegate care to a colleague, you must make sure that they have the appropriate qualifications, skill and experience to provide care for the patient. Although you are not responsible for the decisions and actions of those to whom you delegate, you remain responsible for your decision to delegate and for the overall management of the patient. You should pass on complete, relevant information about patients and the treatment they need. You should also ensure that the patient is aware of who is responsible for all aspects of their care, and how information about them is being shared".*

Given this, the duty of care is with the SMO to determine the adequacy of supervision, with the expectation that their supervision would be judged by their peers. As an employer, the DHB needs to ensure that an SMO is in a position to supervise. For example, the DHB must ensure that an SMO is not rostered to work on another hospital site whilst also providing supervision to an RMO at another site. Dr Diana Ackerman (clinical director Gynaecology) has advised that she has been working with her team to ensure they are aware of these responsibilities. This includes the requirement for RMOs to talk with a patient and obtain consent for a procedure they are not able to do independently. However, as noted above, in our view as long as the Waitemata DHB consent form has been completed and the consenting doctor has explained the teaching hospital statements to the patient, separate consent is not required for a RMO to be in theatre and perform part of the procedure under supervision.

Dr Ackerman has also implemented a new process where all RMOs receive a copy of the Informed Consent policy and sign a form confirming that they have read the policy and understand their obligations and responsibilities. This process is now being undertaken at the commencement of each new run. In addition, a handbook has been developed, which includes specific information about informed consent and links to the on-line training and other resources.

If any staff member has concerns that the RMO (registrar or house officer) is not adequately experienced and/or supervised, these concerns should be raised in the briefing or debriefing, or otherwise brought to the attention of the responsible SMO at the time. It is then the SMO's responsibility to decide whether the RMO has sufficient experience and determine the level of supervision required. If nursing staff remain concerned, they need to talk with the associate clinical charge nurse, and escalate the matter to the clinical nurse director, the clinical director of the relevant speciality and/or the chief of surgery (as appropriate) at the time.

I note that [redacted] met with Dr Helen Allen (acting clinical director Obstetrics) on 8 November 2018 to discuss her concerns regarding supervision. At the meeting Dr Allen advised that she was aware of [redacted] concerns about the oversight of junior medical staff and had addressed a specific issue that had been escalated to her. Specifically, she had reiterated the requirement for appropriate supervision and oversight and requested that the lead training supervisor follow up individually with the registrar involved.

Dr Allen also felt there was an opportunity to improve the information being provided to women before they have an elective caesarean and that she had asked the midwife co-ordinator, quality to undertake a review. I understand [redacted] has participated in this review and has also provided feedback to Stephanie that there has been an improvement in the level of oversight and supervision that is being provided to junior medical staff.

Consent form

As outlined in Stephanie's letter, it was agreed that a review of the Waitemata DHB Consent Form would be undertaken and recommendations presented to the theatre leadership group for consideration.

An initial review of the form has been completed. However, it has been determined that the decision to implement any changes to the form will sit with the Director Hospital Services and Chief of Surgery (in consultation with Waitemata DHB's legal team and Chief Medical Officer), rather than the theatre leadership group. Cath has received the review and is now taking advice on the appropriate next steps. This will include consideration of re-introducing 'tick boxes' to support auditing which, I understand from the correspondence to date, is [redacted] primary concern.

Given this change in process, the revised timeframe for the completion of this action is June

Review of specific incidents

Dr Schmidt-Uili has advised that the review of NHIs provided by [redacted] has been partially completed (attached)

Review of actions

Action	Responsibility	Timeframe	Status	Commentary
Immediate action as per Director Hospital Services All RMOs working in Obstetrics and Gynaecology will be required to receive a hardcopy of the consent policy and will meet with Diana Ackerman (clinical director gynaecology) to ensure that the policy is clearly understood by the RMO. The RMO then signs a letter acknowledging this. This will be	Diana Ackerman	19 Dec 2018	**Completed**	This was initially undertaken with the team on 19 Dec 2018. A process is now in place where the chief resident discusses the policy with all RMOs and HOs at the beginning of each new run. The RMO/HO then signs the

Action	Responsibility	Timeframe	Status	Commentary
completed at handover.				letter acknowledging they understand the policy and their responsibilities.
Organise a meeting between [redacted] Diana, Adele and Lyn. Stephanie will facilitate this – but date to be confirmed, as Adele is on annual leave this week.	Stephanie Doe	Jan 2019	**Meetings with Cath in diary**	Going forward, Cath will be organising a regular time to meet with [redacted] until all actions have been completed.
Meia to meet with Diana to review the cases identified.	Meia Schmidt Uili	19 Dec 2018	**Completed**	Review is currently being completed. A formal response will be sent to [redacted] by 10 April 2019.
Meet with Debbie Eastwood and Mike Rodgers to discuss the development of the informed consent training module and the opportunity to modify and implement this across all surgical specialities.	Lyn Wardlaw	Jan 2019	**Completed**	Development of a training module was not required, as on-line training is available to Waitemata staff via Ko Awatea. Stephanie has shared the orientation book developed for Obstetrics and Gynaecology with Mike Rodgers.
Ensure that there is a clear and agreed process in place for the nursing team to escalate specific concerns about clinical practice, supervision or consent in theatre.	Ulrike Gerstenberger and Kate Gilmour	TBC	**In progress**	Existing escalation process is in place. Meeting to be scheduled with the team to reiterate process.
Meet with nursing team who work in the obstetrics and gynaecology theatres to discuss how they can support the consistent implementation of the informed consent policy and how they can escalate concerns.	Ulrike Gerstenberger and Kate Gilmour	TBC	**In progress**	Meeting with [redacted] [redacted] Kate G and Ulrike to be agreed
Complete the review of the consent form and present the recommendations to theatre leadership group.	Cath Cronin	June	**In progress**	An initial review of the consent form has been completed. The decision to implement any changes to form will sit with the Director of Hospital Services

Action	Responsibility	Timeframe	Status	Commentary
				and Chief of Surgery, rather than the theatre leadership group. The findings of the review are currently under consideration, in consultation with the Waitemata DHB legal advisor.
Develop an orientation and training package on informed consent. This will include information on the DHB policy, the consent form, documentation expectations and legislative requirements.	Diana Ackerman	28 Feb 2019	**Completed**	Orientation pack has been developed and is now in use.
Commence auditing of informed consent.	Ulrike Gerstenberger	TBC	**Yet to commence**	To be progressed following once the consent form review has been completed.

Denise Poole (WDHB)

From: Cath Cronin (WDHB)
Sent: Friday, 10 May 2019 17:08
To: [redacted]
Cc: [redacted] Kathy Briant (WDHB)
Subject: Update

Follow Up Flag: Follow up
Due By: Monday, 13 May 2019 16:00
Flag Status: Completed

Hi [redacted]

I thought I would connect as finding dates to meet seem to have been pushed out. I wanted to let you know that I have starting review of the issues around informed consent and will have the outline of work to discuss when we meet.

[redacted] - I also wondered if you and [redacted] would like me to respond to the letter you sent Judy or would you prefer to talk through this when we catch up. I also have the case review from Meia.

Let me know what suits and I look forward to seeing you both soon.

Regards cath

Cath Cronin I Director Hospital Services I RN
Waitemata District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

Attachment 12

Denise Poole (WDHB)

From: [redacted]
Sent: Wednesday, 02 October 2019 07:54
To: Jocelyn Peach (WDHB)
Cc: [redacted]
Subject: Informed Consent Education

Hello Jos,

There is a further Education session scheduled for Fri 4th Oct at 8am. The information about it says it is about the Informed Consent Poster displayed.

Whoever designed the poster is quoting different sections from the informed consent policy.

Some of the statements made do not correlate with the WDHB informed consent policy on the controlled documents section of the intranet and in fact they contradict it.

Also stated at the bottom of the poster it says it is version 19 of the policy, is this a new version that has not been published?

This is concerning as the statements are certainly not adhering to the HDC code of consumer rights and further reinforces the breaches of patients rights which are continuing to occur.

I look forward to hearing from you regarding this urgent matter

Kind regards

[redacted]

Attachment 13

Denise Poole (WDHB)

Subject: FW: med students / new 1st year reg

From: Jonathan Christiansen (WDHB)
Sent: Monday, 01 July 2019 1:29 p.m.
To: Cath Cronin (WDHB); Penny Andrew (WDHB)
Subject: RE: med students / new 1st year reg

I have reviewed the chart for [redacted] – noted as "1st year Reg performing Caesar" in the email below.

The patient was consented thoroughly by the Registrar who then performed the procedure.
Our normal consent form was completed.
All the documentation records that the SMO was present in direct supervision during the C-section.

This looks like normal practice for a teaching hospital and I can't identify any reason why we should further review this case.
Trainees must undertake a significant number of supervised procedures to gain credentialing and sign-off.

Jonathan

From: Jonathan Christiansen (WDHB)
Sent: Friday, 28 June 2019 8:45 a.m.
To: Cath Cronin (WDHB); Penny Andrew (WDHB)
Subject: RE: med students / new 1st year reg

Well in the case of the issues with the Med Students we need to work with the university to ensure that all students comply with the clear policy that consent MUST be obtained for any direct hands-on care.
We can do that through Martin and Laura, and reinforce that with the services (all DHB services) – the University Guidelines are clear that the primary responsibility/accountability for getting consent for the student is with the supervising clinician – not the student themselves.

The question on the "new" reg and the Caesarian will depend on the training level and experience of the Reg (some may have done a lot of procedures as an SHO for example), and the level of involvement of the SMO.
The Op note indicates that the SMO was the Assistant for the surgery – which would presume they are scrubbed.
There would have been consent for the C-section which in all likelihood was completed by the Reg themselves – but we will need to get the paper chart for that.

Jonathan

From: Cath Cronin (WDHB)
Sent: Friday, 28 June 2019 7:24 a.m.
To: Jonathan Christiansen (WDHB); Penny Andrew (WDHB)
Subject: FW: med students / new 1st year reg

Hi

Would you please review and update me. I will go back to [redacted]

I have asked her to send me an email or text on the day of the incident in future.

Thanks cath

Cath Cronin I Director Hospital Services I RN
Waitematā District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: [redacted]
Sent: Wednesday, 26 June 2019 1:44 p.m.
To: Cath Cronin (WDHB)
Subject: med students / new 1st year reg

Hi Cath ,
as discussed this am, 17/6 new reg with med student [redacted] 19/6 same new reg offering the med student to suture wound, 25/6 consultant letting new 1st year reg perform Caesar [redacted] 26/6 med student scrubbed in assisting [redacted] All fine if there is consent but there was none.
Med students just walk into theatre no introductions.

Regards
[redacted]