



## **This Issue in the Journal**

### **New Zealand's Christchurch Hospital at night: an audit of medical activity from 2230 to 0800 hours**

J Morton, Y Williams, M Philpott

Doctors' working-time reforms challenge the staff of acute hospitals to find new ways of working together to work differently, especially at night. Change requires two things. Firstly, it is necessary to have accurate information about the volumes of the medical tasks that have to be done at night, together with the competences required. Secondly, change would require a workforce willing to try new ways of working. At Christchurch Hospital, the first requirement for change has been measured and the findings are reported in this issue of the *Journal*.

### **Representative case series from New Zealand public hospital admissions in 1998—III: adverse events and death**

R Briant, J Buchanan, R Lay-Yee, P Davis

This paper reports on a reassessment of all those New Zealand Quality of Healthcare Study (NZQHS) adverse events in public hospital in 1998 where death was recorded. The nature of the original review meant that the adverse event (AE) and death were not necessarily causally related. When adverse events that were not preventable and deaths that were judged to be unrelated to the adverse event were excluded, the death rate from adverse events (AE) fell from 2.2 to 1.3 AE-preventable deaths per 1000 admissions. Therefore it is likely that extrapolations of mortality rates in the NZQHS and other similar studies have overestimated (by about one-half) the number of deaths caused by healthcare management.

### **Treating claudication in 5 words (stop smoking and keep walking) is no longer enough: an audit of risk factor management in patients prescribed exercise therapy in New Zealand**

N Kuiper, M Gordon, J Roake, D Lewis

With the aim of assessing the documentation of risk factors such as smoking, we reviewed the case notes of patients who presented to Christchurch Hospital's Vascular Outpatient Department with intermittent claudication (cramping pain caused by insufficient blood supply to the calf muscles) and who were given "Green Prescriptions" for an exercise programme. Our results show that communication (e.g. by referrers to specialist vascular services) of vascular risk factors needs improvement. Furthermore, the role of clinicians with an interest in risk factor management, and patients' understanding of their vascular risk factors, needs clarification.

## **Management of risk factors: a survey of New Zealand vascular surgeons**

H Su, M Gordon, J Roake, D Lewis

Patients with peripheral vascular disease have a high morbidity and mortality rate from complications of atherosclerosis such as acute myocardial infarction (heart attacks) and stroke. Appropriate management of the well-recognised, modifiable, cardiovascular risk factors is paramount in the overall management of these patients. Our survey asked which cardiovascular risk factors vascular surgeons in New Zealand considered important and who should manage these risk factors. There was a high response rate. The majority of vascular surgeons recognised the importance of asking patients about risk factors and believed that general practitioners need to play a pivotal role in risk factor modification. A significant proportion of vascular surgeons stated that the vascular team need to be involved in risk factor management which probably reflects the emergence of vascular surgery as an independent speciality in New Zealand with specialists capable of managing all aspects of patient care.

## **An analysis of referees and referrals to a specialist concussion clinic in New Zealand**

D Snell, L Surgenor

This study reviews the characteristics of referrals to a specialist concussion clinic in its first two years of operation. Most assessments resulted in short-term treatment, but alarmingly one-in-five cases required long-term follow-up of more than 7 months. Gender, cause of head injury, and time delays between injury and assessment significantly increased the odds of receiving long-term follow-up. Referrals for assault-related injuries were greater than expected, and men may be under-referred. The findings suggest a need to review the referral response systems and scope of the service.

## **Appropriate use of pagers in a New Zealand tertiary hospital**

R Patel, K Reilly, A Old, G Naden, S Child

The most important function an on-call house officer performs is responding to urgent medical situations. Frequent pager interruptions mean that house officers become less efficient and more prone to making mistakes, however. Anecdotal and international evidence suggests that many calls received by on-call house officers do not need immediate responses. We recorded calls to fourteen house officers over a 3-month period and found that 30% of calls were clinically appropriate and urgent; 53% of calls were clinically appropriate but not urgent; while 17% of calls were deemed inappropriate.

## **Frequency of calls to “on-call” house officer pagers at Auckland City Hospital, New Zealand**

T Chiu, A Old, G Naden, S Child

The most important function an on-call house officer performs is responding to urgent medical situations. Frequent pager interruptions mean that house officers become less efficient and more prone to making mistakes, however. We recorded over 25,000 calls to seven on-call house officer pagers over a 4-month period and calculated mean time-intervals between calls for different services. There was great variability between services and between time periods, with the highest rate just 7 minutes between calls and the lowest a mean of one call per 5 hours.

## **Ethnicity data and primary care in New Zealand: lessons from the Health Utilisation Research Alliance (HURA) study**

Health Utilisation Research Alliance (HURA)

This paper draws on experiences from the HURA study of general practices (a study undertaken to explore the relationship between ethnicity, socioeconomic deprivation, and utilisation of primary care) to discuss issues encountered in collecting and analysing ethnicity data in primary care. The paper also discusses the implications of combining general practice ethnicity data with National Health Index (NHI) ethnicity data. The study found variation in the coverage of ethnicity data achieved by general practices, as well as a level of mismatch between ethnicity data collected in general practices and that on corresponding NHI records. Overall, the findings support the need for consistent, standardised approaches to ethnicity data collection and analysis across the health sector.