Waitematā District Health Board
Best Care for Everyone

Waitematā District Health Board

Serious Adverse Events Report

(1 July 2018 to 30 June 2019)

Corporate Quality and Risk

Waitematā
District Health Board

Best Care for Everyone

Our Promise Statement to our community is 'Best Care for Everyone'. We aim to provide care that is safe, clinically effective, focused on the individual needs of every patient and their whānau and on equity of health outcomes.

Waitematā DHB provides health services to 627,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest and one of the fastest growing DHBs in the country, and are expecting an extra 116,000 people by 2030. More than 7,500 people are employed by Waitematā DHB.

Waitematā DHB provides hospital and community services from 31 sites, including North Shore Hospital, Waitakere Hospital and the Mason Clinic. We provide child disability, forensic psychiatric services, school dental services, and alcohol and drug services to the residents of the overall Auckland region on behalf of the other DHBs.

Our staff's commitment to quality and patient safety is reflected in the excellent health outcomes of our population, with our population's life expectancy at 84.2 years (2016-18), the highest in New Zealand. Life expectancy for Māori (82.4 years) and Pacific people (77.8 years) is also among the highest in New Zealand and increasing at a faster rate than other populations. The life expectancy of Asian people in Waitematā surpassed 90 years in 2015-17 and is now 90.9 years. The European and Other population group in Waitematā have the highest life expectancy compared with any other District Health Board at 84.3 years. Our amenable mortality rate is the lowest in New Zealand, and we also have one of the lowest rates of hospital mortality of any DHB.

Our clinical teams are supported to design and implement new models of care and best practice care processes, to improve patient outcomes and experience. One of our most important recent innovations has been the introduction of Qlik Sense, a business intelligence tool that has enabled the development of clinical data dashboards. The dashboards have been developed with our clinicians and provide them with important quality and safety data. The data is available in real-time and is easy to access through a responsive exploration tool. Our 'if in doubt' adverse event reporting culture (described below), combined with our commitment to using data, enables our clinicians to learn from adverse events, identify and track improvements, and see the positive effect on health outcomes and patients' experience. In this 2018/19 serious adverse events report, we have described some of the improvement programmes that we have developed as a result of investigating and learning from adverse events.

What is a Serious Adverse Event?

An adverse event is an incident which results in unintended harm to a consumer. A serious adverse event is one which has led to significant additional treatment, is life-threatening or has led to an unexpected death or major loss of function.

Serious Adverse Event Investigation at Waitematā DHB

All serious adverse events at Waitematā DHB are investigated by a team of clinicians (e.g. doctors, nurses, midwives, allied health) and quality team staff. To ensure that investigations are impartial, these staff will not have been involved in the event.

Adverse event investigations are undertaken according to the following principles:

- Establishing the facts: what happened, to whom, when, where, how and why
- Looking at systems and processes of care delivery with a view to improvements, rather than blaming individuals
- Establishing how to reduce or eliminate a recurrence of the same type of event
- Formulating recommendations and an action plan
- Providing a report as a record of the investigation process
- Providing a means for sharing lessons from the event

Each event report is then reviewed by the Adverse Event Committee (consisting of senior allied health staff, doctors, nurses, patient experience and quality staff) to ensure that the investigation has appropriately established the facts, addressed all issues and the recommendations and actions are robust. All actions are assigned to a responsible owner and tracked to completion, which is facilitated by the Quality and Risk Team.

NB: Please note that the events discussed in this report do not include Mental Health-related events; these are reported separately via the Office of the Director of Mental Health (Ministry of Health).

Reporting Serious Adverse Events

This report is released in conjunction with the Health Quality & Safety Commission (HQSC) National Report on Serious Adverse Events. The HQSC reports on the **possible** adverse events submitted by DHBs to the HQSC for the same period prior to an investigation having been completed. Once Waitematā DHB has completed an adverse event investigation, the investigation report is approved by our Adverse Events Committee and the event is then **confirmed** with the HQSC. Sometimes, the investigation will identify that

the adverse event was not as serious as first suspected and does not meet the criteria of a serious adverse event that is reportable to the HQSC (using an agreed HQSC rating matrix).

In 2018/19, there were **39 confirmed serious adverse events** following investigations. These numbers have to be seen in the context of having been finalised in the last reporting year, however the event itself may have occurred in previous reporting years, therefore these numbers are not an accurate indication of the incidents that occurred during the 2018/19 reporting year; rather the investigations were completed in 2018/19. In addition, there are a number of possible adverse events still under investigation that, if confirmed following investigation, the details of which will be reported in the 2019/20 serious adverse event report.

Improvements to reporting

We continue to make improvements to our reporting processes. For the 2018/19 year, improvements have included a strong organisational focus on the identification and investigation of oral health adverse events developing a culture of 'if in doubt report and investigate'. Many of these events did not meet the national criteria for a serious adverse event, and therefore do not appear in this report. However this 'report and investigate' approach mirrors our organisation's overall approach which is to treat an adverse event initially as serious, to enable continuous improvements to be made to the quality and safety of the services we deliver to our community. The learning from investigating these oral health events is discussed later in this report.

In 2018/19 we completed a number of targeted adverse events training sessions to those staff involved in reviewing and investigating adverse events to reinforce our organisation's culture of 'if in doubt report and investigate'. The strength of this approach is reflected in the excellent clinical outcomes Waitematā DHB is achieving.

Overview for 2018/2019 Serious Adverse Events

In the reporting year 2018/19, Waitematā DHB reported 62 **possible** serious adverse events to the Health Quality and Safety Commission (HQSC).

During the period covered by this report Waitematā DHB **confirmed**, through investigation, **39** adverse events that had caused serious harm or death (serious adverse events). We investigated and confirmed 41 serious adverse events in 2017/18, a similar figure to the 2015/16 figure.

Each of the 39 **confirmed** serious adverse events were investigated using a systematic investigation protocol. Understanding where improvements need to be made so that we can help staff keep our patients safe and deliver quality care are the main drivers for the investigation.

The tables below outline a summary of these 39 events, as well as the associated findings and recommendations. These events have been classified into the following themes:

- Falls with major harm (24)
- Hospital acquired pressure injury (8)
- Delay / failure in follow up or treatment (5)
- General care and treatment (1)
- Delay in escalation of treatment (1)

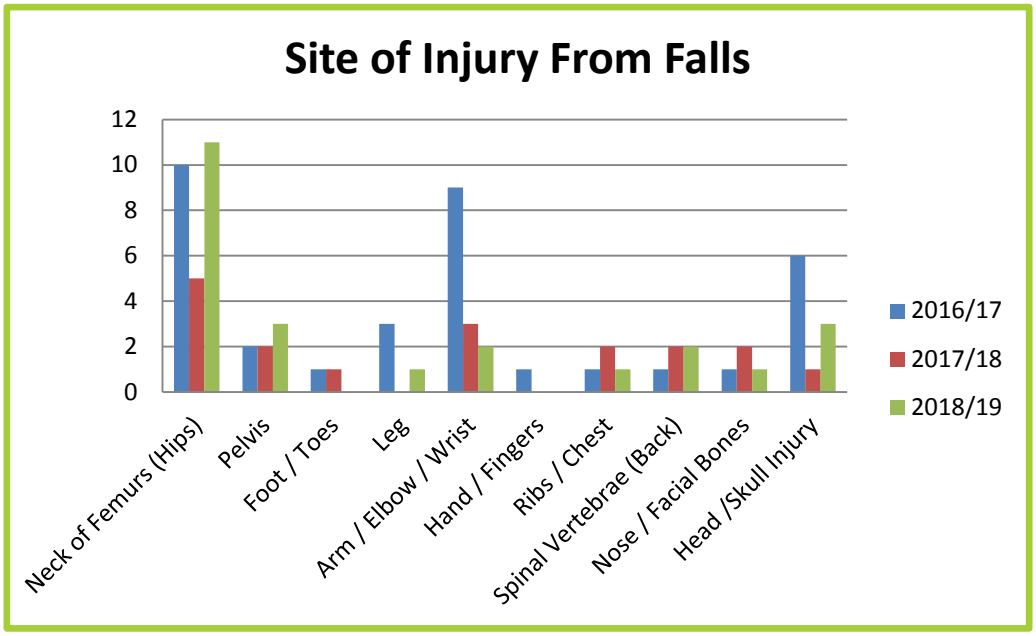
In addition to these, we also investigated and confirmed **11** incidents classified as Always Report and Review events, and **22** events related to behaviour (e.g. self-harm). Always Report and Review events are a subset of adverse events that are reported and managed in the same way as serious adverse events, irrespective of whether or not there was harm to the patient. Always Report and Review events are events that, under different circumstances, may result in serious harm or death and are preventable with strong clinical and organisational systems. Recommendations from these investigations have resulted in changes to clinical guidelines, systems, and policies and included education focused in particular areas.

Falls With Major Harm (24)

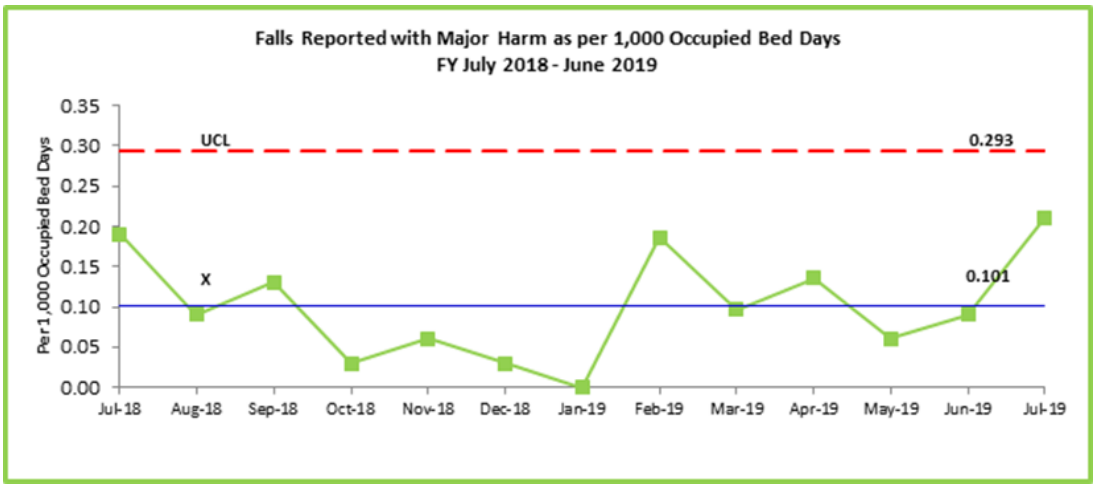
What happened?	Investigation Findings	Recommendations/Actions
24 Patients fell which resulted in serious harm. The site of injury is included in the graph following this table.	Patients often fell despite appropriate care being provided. The majority of patients had correct falls assessment completed on admission, with appropriate prevention strategies in place; however this was sometimes not updated following a change in the patient's condition. With the exception of four cases, falls prevention strategies were documented as being in place. In some instances, patient's had removed or bypassed these strategies e.g. removing personal alarm. Mobility aids were in place where required. On two occasions patients had mobilised without their aid, and for one patient their aid was not in easy reach. Many patients had cognitive issues and challenging behaviors that may have increased their risk of falling. On some occasions this risk was not recognised. Medication may have been a contributory factor a times. Many patients had multiple comorbidities with some medically deteriorating. On three occasions, individual care plans were not up to date, with some gaps in the clinical documentation. Some patients were unaccustomed to their updated mobility status. On two occasions, communication with	Education for staff on completing accurate and timely falls risk assessments and documenting falls care plans; with comprehensive auditing to be undertaken in association with the education efforts. As well as continued education, particularly around documenting checks, staff are to consider a patient attendant when fall prevention initiatives are not tolerated, and to provide the patient and their whānau with clear information on recommendations for mobilising. Physiotherapist's recommendations regarding correct equipment are to be clearly documented the rest of the team to follow. Staff have been given additional training on caring for patients with cognitive impairment, delirium and the specific care required to reduce the risk of falling. This includes when to refer for review by the specialty nurse for behaviors of concern. Appropriate monitoring must be in place following the administration of medication. Relevant physical assessment findings that could impact on a patient's safety needs to be communicated well to the rest of the team with an alert on the patient's file. Education with a follow up audit on the importance of documenting Nursing care plans particularly where changes in a patient's condition warrants alteration. Clearly discuss with patients not to attempt to mobilise for the first time without a Registered Nurse or Physiotherapist assisting. Senior staff are to discuss with their teams, appropriate and clear communication

What happened?	Investigation Findings	Recommendations/Actions
	the patient and their whānau could have been clearer. A one to one watch in place may have helped prevent one fall.	methods. Where practical, patients admitted with a fractured neck of femur are to be placed together in a four bedded room with a one to one patient watch.

The graph below compares the number and site of injury from falls with major harm for 2016/17, 2017/18, and 2018/19. This shows a similar pattern of injury site over the last three years, with a notable decrease in injuries involving arms, elbows, and wrists.



The graph below shows the rate of falls with harm per occupied bed days for 2018/19. The blue line (X) indicates a mean rate of 0.101 falls per 1,000 occupied bed days, a 37% decrease in rate when compared to a rate of 0.138 in 2017/18. The dotted red line is the upper control limited (UCL), indicating that there are no significant outliers over the course of the year. These reported adverse events will be subject to a full investigation, before they are confirmed serious adverse events.



What are we doing to reduce further falls with harm?

The newly joined Pressure Injury and Falls Prevention group continues to build on the strategies implemented in 2017/18, adding further initiatives, including:

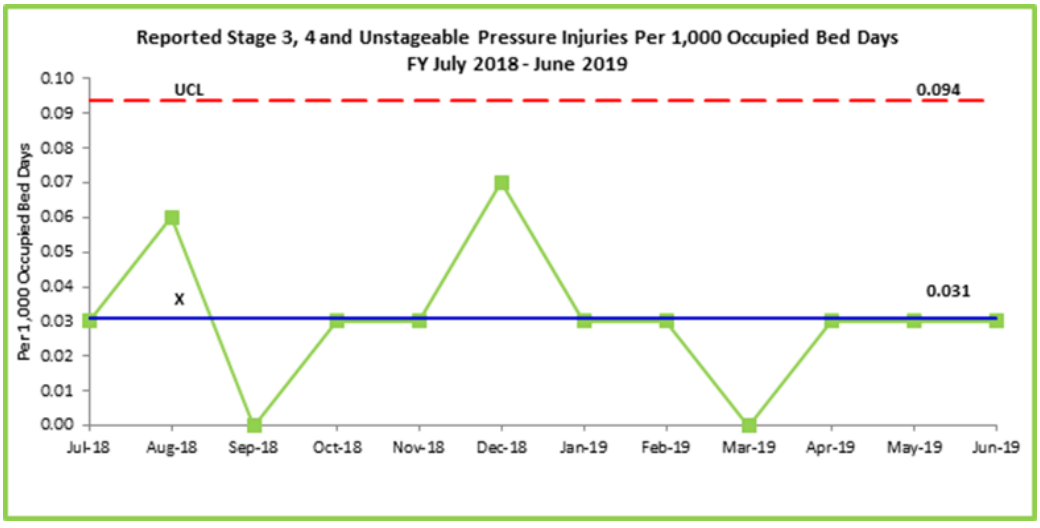
- Encouraging patients to bring their own footwear to wear in hospital as part of 'Get up, Get dressed, Get moving' which eliminates non-slip sock use and encourages review of suitable footwear in the community to prevent falls at home.
- Alert where patients have been admitted with a history of falls to ensure increased focus and support.
- Piloting removal of floor-line beds and using existing bed in a lower position to assist frail patients get out of bed at same level as at home.
- Targeted multi-disciplinary team action where patient has multiple falls in hospital.
- Review of the role of health care assistant in working with patients at risk using co-hort bed placement.
- Physiotherapy groups for patients identified at risk of falls in safe standing and safe recovery falls prevention.
- Change in falls risk assessment for elderly and psychogeriatric patient group who have risk of falls influenced by medication, shifts in centre of gravity, increased flexion at the hips and knees, a stiffer and shuffling gait, decreased proprioception, decreased righting reflexes, increased response time and decreased ability to adjust to new environment.
- Review of equipment to alert staff of patients at risk when moving unaccompanied.
- Review of environment issues e.g. grab bars in corridors.

Hospital Acquired Pressure Injury (8)

What happened	Investigation Findings	Recommendations
Eight patients developed, or had a pre-existing pressure injury further deteriorate while in hospital, the most common being to the heel.	Waterlow assessments (an estimated risk for the development of a pressure sore) and skin assessments were sometimes delayed, incomplete, or inaccurate. On two occasions the development of a pressure injury was not identified under a cast or medical device. In some cases, documentation of the care provided was incomplete. In two cases the wound care plan for existing pressure injuries was delayed, or was incomplete.	Staff to be educated through online training, staff meetings, and case studies on comprehensive assessments on admission, and further assessments when indicated. Audits to follow to ensure adherence. Staff across the inpatient services will be educated on the potential for pressure injuries under a cast, and the child policy related to pressure injuries updated. Educate staff on the importance of monitoring all vulnerable areas, and documenting the care provided. In-service training on the importance of detailed wound management care plans with senior nursing staff and pressure Injury champions monitoring patient's wounds and undertaking regular audits.

What happened	Investigation Findings	Recommendations
	On two occasions there was a lack of pressure relieving support equipment in place, and a delay in providing equipment in one other case. There was no alert system in place for children at risk of pressure injuries. Some patients in palliative care were reluctant to be turned, and in one case a pressure injury was mistaken for chronic bruising. In one case there was a delay in undertaking a dietician review. On two occasions there was no documented evidence that anti-embolism stockings had been removed every shift to observe skin integrity.	Present as a case study to reinforce the need for appropriate equipment to be in place in a timely manner. There is now a pressure injury alert sticker on the system. Liaise with Palliative Care regarding potential work that could be done at a patient's end of life to promote turns to prevent pressure injuries. Educate staff on appropriate follow up regarding the Malnutrition Universal Screening Tool score. Emphasise to staff the importance of anti-embolism stockings being removed every shift or more frequently in patients at high risk of skin breakdown to allow for skin care and assessment, and documenting this. Anti-embolism stockings are further discussed later in this report.

The graph below shows the rate of Stage 3, 4 and unstageable pressure injuries per occupied bed days for 2018/19. The blue line indicates a mean rate of 0.031 stage 3, 4 and unstageable pressure injuries per 1,000 occupied bed days, for this reporting period, a 67% decrease when compared to 2017/18 which returned a rate of 0.099. The dotted red line is the upper control limited (UCL) indicating that there are no significant outliers over the course of the year. These reported adverse events will be subject to a full investigation, before they are confirmed serious adverse events.



What are we doing to further reduce pressure injuries acquired in hospital?

The newly joined Pressure Injury and Falls Prevention group continues to build on the strategies implemented in 2017/18, adding further initiatives, including:

- Appointment of 1 FTE (full time equivalent) registered nurse (using funding from the Accident Compensation Corporation (ACC)) has allowed increased bedside focus on reduction of hospital acquired pressure injuries and target of zero stage 3 and stage 4 / unstageable pressure injuries. This funding is part of a national collaborative. The two nurses (1 FTE) are split across the North Shore and Waitakere Hospital campus.
- Restricted use of anti-embolism stockings, requiring a prescription for use.
- Review of skin care, including incontinence associated dermatitis, and identifying prevention products.
- Seek to prevent further progression through the review of assessments where pressure injuries are identified (community or hospital acquired) to ensure appropriate care and wound care plan is in place.
- Review of the pressure-relieving mattress that targets patient's heel i.e. 'off loads' heels, and sacrum i.e. has a 'seat deflate setting' to minimise pressure on the sacrum whilst sitting. The mattress covers also have visual reminders e.g. "turn 2 hourly" and "check for moisture".
- We undertook a hospital wide Pont Prevalence audit. This will be repeated in the 2019/20 year to measure improvement and celebrate success.

Delay / Failure in follow up or treatment (5)

What happened?	Investigation Findings	Recommendations
Delays in providing dental treatment resulted in extractions under general anaesthetic.	The child was seen during one appointment by a new graduate who did not seek assistance. The child was put on an incorrect recall period Fluoride varnish was not applied on the two occasions the patient was seen by ARDS. There was no on-going support provided to the family or interim treatment after a referral was made.	Every time a child is examined, all teeth present in the mouth must be checked charted. All new graduates must be provided with an identified / designated mentor. At risk preschool children must be placed on a 6 monthly recall visit unless justified otherwise. ARDS policy on fluoride varnish application must be fully implemented. While on a wait list for treatment, ARDS must make appointments to see them within 2-3 weeks in an ARDS clinic to provide interim dental care.
Uncontrolled bleeding in a patient required transfer to theatre. Temporary measures were put in place and the patient was	A vascular cause of heavy bleeding was not considered. The medical staff that saw the patient lacked experienced to suspect a vascular	A second senior medical officer on call for gynaecology to accompany junior staff on ward rounds, improving both the care and decision-making on current patients, and the education of junior staff.

What happened?	Investigation Findings	Recommendations
transferred to another DHB for further specialist treatment	cause of bleeding. Nursing staff notes were extensive and no concern was expressed. Improvement was noted daily.	Medical, nursing and midwifery staff educated on the infrequent but potentially very serious vascular causes of secondary post-partum haemorrhage.
Delayed diagnosis of Myelodysplastic syndrome	The taking of unnecessary blood tests led to the results not being checked The way the test request was labeled resulted in the lack of a visible accountable clinician Highlighted results do not discriminate between a result that is clinically high risk and one that is not within the normal range but is not clinically important. Although significantly abnormal, the results did not meet the pre-specified policy threshold to require an immediate phone call to the clinical team whilst still an inpatient or to the GP at discharge. The house officer completing the discharge did not appreciate the clinical significance of the abnormalities. Waitematā DHB's policy on acceptance of unaccepted lab tests after 3 months does not have the ability to distinguish normal or abnormal results, nor does it take account of any comments added to the results by either technicians or specialist clinicians.	Reinforce with teams that there must be a clinically valid reasons to undertake lab testing, and routine bloods. System change to allow clear visibility of the tests in all samples, which did not occur in this case. Consider alternative presentations of results that indicate clinically high risk results versus those simply just outside the normal range. Investigate an electronic solution to allow a reporting clinician to place a "flag" on any clinically abnormal or high risk test requiring follow-up. Encourage House Officers to contact the reporter to clarify any unfamiliar comments noted on lab reports. Ensure high risk or "flagged" results are escalated to Clinical Directors if not "Accepted" in a timely fashion. Encourage use of the newly available internal e-referral system for high risk results to be followed up. Investigate alternatives to the acceptance process that ensures highly abnormal results are not batch accepted/closed without further action.
Investigations failed to diagnose a cardiac tamponade before the patient passed away.	Cardiac tamponade with fatal outcome in this context is rare. Clinical notes from the referring hospital may have steered the team's attention away from a primary cardiac cause for the patient's symptoms. There were a number of plausible assumptions as to the cause of this	This case must be reviewed as a formal case review with medical registrars. That new medical registrars are supported on ward rounds in the first week of a new roster change-over. This must include reinforcement of escalation processes so that it is clear who will review patients if the senior consultant is not available. If not able to place in the Cardiology ward,

What happened?	Investigation Findings	Recommendations
	patient's recent hypotensive episodes. Cardiac tamponade was considered in the differential diagnosis however was not indicated on physical examination. The case should have been escalated earlier to a senior staff member with transfer to the Cardiology Ward.	refer to the Cardiology team for oversight / shared care. Echocardiogram within 24 hours of inter-hospital transfer following recent cardiac replacement surgery.
A patient required an Emergency Caesarean section for postpartum haemorrhage, which required a hysterectomy and resulted in ureteric injury.	There was delay in establishing that labour was obstructed. There was delay in recognising the ureteric injury.	Earlier examination by the medical team may have resulted in the caesarean section being performed earlier which may have been less complicated. When suspected, the appropriate investigations and referrals were promptly instituted. The delay would have made no difference to the outcome.

What are we doing to further reduce Delay / Failure in follow up or treatment?

A number of improvements, which will prevent failure of planned follow-up, continue to be made to the patient booking systems and processes.

These include:

- Increased visibility when an appointment is booked in the electronic record

- Increased visibility when results are available in the electronic record

- System changes to ensure follow up of referrals from General Practitioners

- Implementation of an inter-DHB electronic referral system

- Implementation of an online booking and scheduling system

Waitematā DHB is participating in the national deteriorating patient quality improvement programme. The overall aim of Waitematā DHB's Patient Deterioration Programme is to reduce harm from failure to recognise and respond to acute physical deterioration for all inpatients (including maternity and paediatrics) by July 2021.

In 2018 Waitematā DHB launched Kōrero Mai, an escalation system for deteriorating patients. When a patient or their loved one is unwell, it can be difficult for them to communicate to staff about what is happening, or staff may not understand how worried they are about their health. An 'escalation system' is a process where patients, family or whānau can escalate their concerns about their or their loved one's health to another staff member, if they feel they are not getting the care they need. Delayed recognition of, or response to, patient deterioration is an adverse event, and, although staff may always be doing their best, difficulties with communication can arise. The purpose of this co-design project (consumers and staff worked together to understand consumers' experience, and worked to design and test solutions together)

was to develop a patient, family and whānau-led escalation system for patients whose condition is deteriorating. This means that the experiences of patients, family and whānau affected by deterioration or poor communication will be investigated and used to co-design solutions with consumers.

In 2019, Waitematā DHB introduced the national Early Warning Scoring System (NZEWS) across both its acute hospitals. The system is used internationally and involves a set of physiological signs (including blood pressure and heart rate) to identify patients who are at risk of deteriorating. This system replaced an early warning system that was already being used at Waitematā DHB and now means all the DHBs in New Zealand are using the same scoring system. At the time of implementing NZEWS, Waitematā DHB also introduced a new, augmented response system, including a 24 hour, seven days a week critical care outreach service at North Shore Hospital. The DHB's electronic systems, including eVitals (electronic vital signs recording and automatic NZEWS score calculation), SmartPage (enabling rapid, structured communication between nurses and doctors) and Qlik data reporting, have enabled the smooth introduction of a large scale change project and effective monitoring of our processes to identify and manage deteriorating patients in our acute hospitals.

Delay in Escalation of Treatment (1)

What happened?	Investigation Findings	Recommendations
Severe lower gastrointestinal bleeding in a patient with Crohn's Disease	There was a failure to recognise the deterioration. There was a failure to adequately escalate the patient's condition to the consultant. There were inadequate processes to provide support for a blood transfusion reaction. There was uncertainty around whether the patient was a candidate for embolisation. The management plan that was put in place was not sufficiently specific. At the time of this incident there was no ward for complex gastrointestinal patients including patients with gastrointestinal bleeding that require multidisciplinary team (medicine and surgery) input supported by specialist nursing staff.	A working party to review and consider adaption of the protocols for management of gastrointestinal bleeding and transfusion reactions. Continue to develop and implement 'Hospital At Night' model. Incorporate blood transfusion documentation into e-prescribing. General surgery to ensure they have clear expectations about communication, documentation and escalation within their teams. Gastroenterology to ensure there is handover of appropriate patients to on call colleagues. A home ward has been assigned for gastroenterology patients requiring medical and surgical input. Intensive Care Unit to ensure they have clear expectations about communication, documentation and escalation within their team. Education sessions focusing on common clinical conditions, management of the

What happened?	Investigation Findings	Recommendations
		deteriorating patient and escalation.

What are we doing to further reduce injuries from delays in escalation of treatment?

As above, a new, augmented response system for patients who deteriorate has been introduced at both North Shore and Waitakere Hospitals. A large-scale education programme for our staff occurred prior to the introduction of the new system and a number of new patient safety processes have been put in place. This includes holding multi-disciplinary team meetings at the end of each shift to discuss patients most at risk of deteriorating across each hospital; and patients' early warning scores being displayed on ward whiteboards and in an electronic 'my patient list' available to doctors on their smart phones.

Learning From Adverse Events Week

In June this year, we had our first learning from adverse events week highlighting some of the preventative initiatives we have actioned as a DHB. Rounding out the Learning from Adverse Events Week, Heather Gunter, a nurse and mother, spoke of the tragic and avoidable death of her 15-year-old son, Matt, at another Hospital to a near full audience at the Whenua Pupuke Auditorium. Sharing these stories with DHBs around the country, Heather hopes to ultimately avoid such unnecessary deaths due to delays in escalation of treatment.

General Care and Treatment (6)

What happened?	Investigation Findings	Recommendations/Actions
Lack of Dental Care Resulting in Extensive Treatment under General Anaesthesia	ARDS (Auckland Regional Dental Service) did not have effective interaction with the family to make timely appointments. There were numerous attempts to contact the parents / caregivers but these were largely ineffective. The social circumstances of the child's family, including where the child was living, were not understood or sought. A Private practice contacted ARDS to advise urgent treatment was needed for the child. There was no active follow up by ARDS which caused a delay of almost 8 months. The setting of recall appointments was not consistent with the expected process at the time	Immediately implement strategies across all teams that support engagement with families i.e., individualised texts, email contact and phone. Ensure correct contact details (telephone number, e-mail address and home address) are checked at each visit. Complete annual audits to ensure that contact information is properly recorded and that contact with the families is documented. When children attend private contracting dentists, it would significantly benefit the child for the treatment notes to be sent back to ARDS. ARDS to ensure that setting of recall appointments is consistent with the caries risk status of children.

What are we doing to further reduce injuries in General Care and Treatment?

Improvements to the identification and investigation of oral health adverse events has led to notable service improvements; for example, improved access to correct equipment, writing and revision of policy documents, further developing staff training, support and supervision, clearer communication with and information for patients / whānau, increasing skills in finding at risk transient children, and accurate risk assessment so that children are placed on correct recall. In addition, improvements were made to existing electronic systems and processes. We are pleased to see that these improvements have already had positive benefits for current service users across our 80 plus oral health clinical facilities.

Final comment

Adverse event reporting and investigations are fundamental to enhancing patient safety and experience as well as improving the quality of care we provide. By learning from adverse events and near misses we are able to identify areas for improvement and further development, that will help our staff deliver safe, effective and person centred care. As detailed above, Waitematā DHB has made a number of system and process improvements as a result from learning from Adverse Events and continues to strive to deliver 'Best Care for Everyone'.