INVESTIGATION REPORT

Campbelltown and Camden Hospitals
Macarthur Health Service

December 2003

HEALTH CARE
COMPLAINTS
COMMISSION

Foreword

Sometimes it is tempting to avert your gaze from a problem – particularly if it involves confronting deep seated issues within the organisation. To look away is almost always a mistake. The courageous route is to face up to it and resolve it despite the difficulties.

Liam Donaldson – CEO of the UK NHS[1]

Health care in 2003 is provided in a highly complex and pressured environment often involving the care of vulnerable seriously ill people. Community expectations are that competent and ethical professional clinicians will deliver safe and appropriate care and that they will be protected from poor care that harms. Unlike other industries where risks occur, health care is heavily reliant on people to make decisions, exercise judgement and take the action that determines the outcome for the sick or injured person.[2] Staff shortages and competencies critically affect the ability to deliver safe care.

In this environment, things can and do go wrong. Harm to patients can occur as the result of an inappropriate clinical decision being made, the failure to recognise a sign or symptom or deterioration over time, or as the result of a diagnostic or operative procedure. At times the consequences may be very serious for the patient, their family, carers and their significant others.

The Commission's experience and the research[3] show that many adverse events and problems that arise in the provision of health care are not merely attributable to one individual who was on the spot at the time the event occurred. They are often the result of a chain of errors or failures in the system of care that, unless identified and fixed, will lie latent until the circumstances occur again. Given what the health system now knows, there is no defence if effective quality and safety systems are not in place to identify risks and minimise the possibility of a reoccurrence of a known risk.

The measure of the competent organisation is the support it provides health professionals, the way it recognises the inherent risks that challenge this complex industry, and the extent to which it builds systems and practices that minimise the potential for risks. That culture depends upon knowing when things go wrong or nearly go wrong, finding the causes, and working out ways to reduce the risk of it happening again.

The findings of this investigation demonstrate that financial investment must be accompanied by planned infrastructure development including both depth and numbers in human resources. The construction of contemporary buildings designed for present day clinical care sends misleading messages to the community if they are not accompanied by adequate qualified staff who are well supported by their management and clinical leaders.

Sound clinical decision making, judgement and action relies on a critical mass of highly skilled and knowledgeable health professionals who work collaboratively in a clinical team. Essential to this are:

- trust in each other
- confidence that the clinical assessment of the patient's problem is sound
- confidence that decisions about clinical treatment and care are rational and will be carried out in an informed, organised and cooperative way
- good documentation to support all decisions made and actions taken so that patients receive safe and seamless ongoing care.

This investigation highlights the tension that currently exists between human resource management and reporting requirements necessary for a safe and high quality health care system. It also highlights tension in clinical governance principles between system and individual professional responsibilities.

James Reason says:

> *Trust is a key element of a reporting culture and this, in turn, requires the existence of a just culture – one possessing a collective understanding of where the line would be drawn between blameless and blameworthy actions. Engineering a just culture is an essential early step in creating a safe culture.*[4]

There is much work to be done across the health system in developing that *'collective understanding of where the line would be drawn between blameless and blameworthy actions'* so that individual health professionals, the community at large and the health system have an understanding of the boundaries. This investigation has brought the tension into focus.

Macarthur Health Service and South Western Sydney Area Health Service provided defensive responses to the Commission throughout the course of the investigation. This was indicative of the organisation's culture and the lack of openness in dealing with reported concerns about the safe care and treatment of patients. They did not hear the message from the nurse informants at the time of its original sending, at its first airing in the public media, nor during the course of most of this investigation. Liam Donaldson's words are prophetic. The problems were very deep seated and existed in a health care system where patients were being harmed.

The investigation and the issues raised are a unique opportunity to tackle the deep seated structural disincentives that have been hampering Macarthur Health Service and the area for many years, and to get support from the community, the Department of Health, the Minister for Health and Parliament.

ENDNOTES:

1 Quoted in "Risk Watch" (2003) Vol 1(3), newsletter from the Office of the Chief Clinical Advisor, Department of Human Services, Melbourne, September, 1.

2 Department of Health (UK) (2003) Making Amends: A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS – A Report by the Chief Medical Officer, June, 6.

3 Reason J (2000) "Human error: models and management" 320 British Medical Journal, 768 – 770.

4 Reason J (2000) op cit 768 & 769.

INVESTIGATION REPORT

CAMPBELLTOWN AND CAMDEN HOSPITALS
MACARTHUR HEALTH SERVICE

OUTLINE OF THIS REPORT

Part One	Executive summary
Part Two	Consolidated recommendations arising from the investigation.
Part Three	Introduction to the Inquiry, including the Commission's statutory authority to carry out the investigation, details of the complaint on which the investigation is based, information about the nurses who raised the complaint and information about the structure of the Macarthur Health Service.
Part Four	The method used by the Commission to conduct the investigation, including its purpose and scope, the steps used to collect information and analyse it, and how information gathered by the investigation was managed.
Part Five	The findings and recommendations of the investigation of 47 clinical incidents raised in the complaint.
Part Six	A review of claims that Macarthur Health Service used disciplinary action against four nursing staff who had reported clinical and workplace incidents.
Part Seven	A review of the adequacy of the systems for quality and safety including organisational management and clinical governance systems at Macarthur Health Service and South Western Sydney Area Health Service.

INVESTIGATION REPORT

CAMPBELLTOWN AND CAMDEN HOSPITALS
MACARTHUR HEALTH SERVICE

PART 1

Executive summary

Executive summary

The Health Care Complaints Commission

The Health Care Complaints Commission (the Commission) is an independent statutory body established in 1994 to investigate complaints about health care services in New South Wales. Where the Commission investigates complaints against health care organisations it can make comments and recommendations about how to make the health care service safer and better for patients. When it makes comments and recommendations, it provides a report to the New South Wales Department of Health. The Commission also has the power to prosecute disciplinary cases against individual registered health practitioners if grounds exist and it is in the public interest.

The complaint

This report sets out the findings and recommendations of the Commission's investigation into a complaint about Camden and Campbelltown hospitals, which are part of the Macarthur Health Service (MHS). The complaint came about after the then Minister for Health, the Honourable Craig Knowles, met with four nurses from the hospitals on 5 November 2002. The nurses made allegations about management and clinical practices at the hospitals. The Minister referred the matters to the Director-General of the NSW Department of Health for investigation. The Director-General made a formal complaint to the Commission on 18 November 2002.

The issues raised by the complaint fall into three broad categories:

- the standard of health care provided to patients
- the adequacy of systems to ensure safe and quality care – clinical governance, risk management, performance and incident reporting and investigation, training and support
- allegations that management had intimidated and disciplined nurses who reported problems and errors.

The nurse informants

Four nurses met with the Minister in November 2002 and a further three nurses came forward later in the investigation. The nurses were registered or enrolled nurses with between 13 and 30 years nursing experience, and include clinical nurse specialists and nurse unit managers. Their professional experience enabled them to identify deficiencies in patient care and to alert the management of the hospitals to problems. Their preparedness to speak out is courageous and commendable.

The nurse informants have paid a high personal price for their decisions to come forward. Some are no longer working as nurses or are not working at all. Those still working at MHS report vilification and isolation by some of their colleagues because of the criticism of the health service brought about by the investigation.

Macarthur Health Service

Campbelltown and Camden Hospitals are the two main facilities at the Macarthur Health Service. Macarthur Health Service (MHS) is part of the South Western Sydney Area Health Service (SWSAHS). MHS has experienced a significant increase in demand for services over the past decade, which has stretched available human and financial resources at all levels. A major capital works program commenced two years ago with major upgrades at both hospitals. However, despite the efforts of

management, the service has experienced great difficulty attracting adequate numbers of appropriately qualified clinical staff. There were:

- fewer resident, registrar, consultant medical staff and staff specialist doctors than other similar hospitals
- shortfalls in qualified and skilled nursing and allied health staff
- very few clinical nurse consultants and nursing education resources
- very few academic clinicians in any field
- few registrars in accredited Medical College training programs.

The essential foundations of a quality health service are clinical wisdom and clinical leadership. At MHS there were problems in this area that militated against the provision of quality care.

The investigation process

The complaint raised wide ranging issues, a total of 68 individual incidents and a large amount of information. The Commission's first task was to define the scope of the investigation. Our approach was to identify the patients in the alleged clinical incidents and focus on the systems and culture at MHS. We examined:

- the standard of care provided in 47 clinical incidents (all of the incidents where patients were able to be identified)
- clinical governance and integrated patient-focused care at MHS
- how management responded to and addressed problems of clinical care
- how management dealt with people who alerted them to the problems, including the disciplinary action taken against some of the nurse informants.

The investigation relied primarily on a review of relevant documents and records provided by the hospitals, MHS and SWSAHS and interviews with over 30 people, including the seven nurse informants, other MHS staff and managers, and SWSAHS executives and board members. All of the parties showed a high degree of cooperation in the investigation.

Experienced Commission staff carried out the investigation including senior investigators, senior managers, a solicitor and clinical advisors. The investigation was later managed by a committee made up of the Commissioner and three senior managers. An independent barrister was engaged to assist with the investigation of disciplinary action against the nurses.

The Commission appointed an expert systems review panel, which included three senior health service executives and a consumer, to review clinical governance structures and practices at MHS. The panel reviewed MHS documents and conducted group interviews with staff and managers at MHS over a period of three days.

We also convened independent expert clinical review panels to review the clinical incidents and report on the standard of care provided to the patients. Four panels were convened with 13 peer practitioners from the relevant specialty areas.

The Commission contacted the patients and families affected by the incidents and provided information sessions to assist them in understanding the process of the investigation.

MHS and SWSAHS were given an opportunity to respond to the complaint initially and as the investigation proceeded. SWSAHS was provided with an interim phase report in January 2003 and information about all of the clinical incidents in June 2003. MHS and SWSAHS provided detailed responses to a preliminary investigation report, provided to them on a confidential basis in August 2003, as required under the *Health Care Complaints Act 1993.*

The findings on clinical incidents

The investigation analysed 47 specific clinical incidents that occurred between June 1999 and February 2003. The incidents occurred in the emergency departments at Campbelltown and Camden Hospitals, the intensive care unit at Campbelltown Hospital, the operating theatre at Campbelltown, and on the medical wards at both hospitals.

The evidence obtained about the incidents strongly supported the allegations by the nurse informants about the standard of care. The clinical incidents showed variable standards of patient care and safety at both hospitals. Some examples of the clinical incidents are:

- no surgical review of a patient with very poor blood supply to her foot – an urgent surgical problem (an ischaemic foot) – for more than two days
- unacceptable delay in triage of a severely ill newborn baby
- a patient with severe chest pain was discharged from the emergency department when a bed with a cardiac monitor could not be found - she died a few hours later
- a critically ill cardiac patient who was in shock was left untreated in the emergency department for many hours
- failure to diagnose a patient with serious post birth infection (puerperal sepsis) in the emergency department
- a delay of over 12 hours in the transfer of a critically ill woman
- post operative intra-abdominal infection not diagnosed for four days
- an agitated psychotic patient who waited unsupervised in an emergency department for five hours and subsequently absconded.

The Commission found that in some incidents the care was so poor that the patients suffered serious deterioration in health. We identified the following patterns of inadequate care and treatment at the hospitals.

There was a lack of medical officers with critical care skills in the emergency departments and the intensive care unit at Campbelltown Hospital. The senior doctors who were on-call to deal with acute admissions or with clinically deteriorating patients were often working outside their areas of expertise. In many of the incidents visiting medical officers were absent from the management of their patients and did not supervise junior doctors adequately.

The hospitals have a system that sets criteria for staff to call a medical emergency team to a patient. This system should have acted as a safety net to ensure that patients were not neglected when their vital observations were deteriorating. However, there was confusion about whether the criteria were mandatory and some patients were allowed to deteriorate without appropriate clinical assessment.

The lack of an intensive care specialist doctor at Campbelltown Hospital created an unsafe environment for the treatment of critically ill patients. The lack of availability of any surgical review at Camden Hospital led to the emergency department being an unsafe environment for acutely ill surgical patients.

Documentation of care was poor in almost half of the cases reviewed, a practice that places all patients at risk.

The quality and safety system failed to ensure that all adverse events (incidents where patients suffered harm as a result of health care) were investigated, lessons learned, actions taken and outcomes evaluated. Staff were not encouraged to report safety concerns and in some cases were actively discouraged.

The Commission was concerned about the adequacy of some reviews and the critical care review committee which has been replaced.

Disciplinary action against the nurses

The Commission investigated disciplinary action taken by MHS against four nursing staff at the hospitals. Three of the nurses were employed in the operating theatres at Campbelltown Hospital. An internal MHS investigation of an incident involving the care of a child in the theatre complex in January 2002, recommended that two of the nursing staff who had intervened on behalf of the patient face disciplinary action over the way they had addressed a medical officer. Subsequently, one of the two nurses identified in that incident and a third nurse were escorted from the premises and suspended with pay when allegations of bullying, harassment and victimisation were raised with MHS management by other nursing staff. The suspension of the two nurses was continued for over two months while a staff survey of the theatre complex and an internal investigation were conducted.

A fourth nurse was disciplined over a small number of incidences where it was alleged that she had acted beyond her scope as an enrolled nurse. While the nurse did act beyond her role, the Commission found that her conduct was permitted by more senior nursing staff on the ward and she was working under difficult circumstances with significant staffing shortages.

At the conclusion of the disciplinary processes, all four nurses were given first and final warnings and the two nurses accused of bullying other nursing staff were informed they could not return to work in the theatre complex.

The Commission found that MHS management failed to properly apply the relevant personnel policies in the disciplinary action taken against the three operating theatre nurses. The breaches were:

- the investigation against the nurses was not fair, impartial or complete
- there was a lack of documentation recording the decision to suspend the nurses, a serious breach of policy given the severity of the action taken by management
- the nurses were denied procedural fairness because they were not provided with proper details of allegations made against them. Many of the allegations had little or no basis and should have never been pursued through disciplinary avenues.

We found that the approach adopted by MHS in dealing with the four nurses did not reflect a patient care focus because it did not promote a culture of learning or a willingness to share information about error and system failure. The likely consequence of management's actions, which in the case of the operating theatre nurses became widely known at the hospital, was to discourage other staff from openly and actively raising concerns about clinical care.

Systems for safety and quality

MHS and SWSAHS have had quality improvement frameworks for many years which embrace aspects of organisational management such as clinical governance, quality and safety and consumer and community participation. However, the investigation found a flawed and underdeveloped system of organisational management at MHS. It found:

- lack of structures and monitoring systems to manage risk and ensure a consistent standard of safe, high quality care for patients – known as 'clinical governance'
- ineffective incident reporting and investigation systems and a culture that does not support open disclosure of adverse events
- failure to address serious ongoing management and clinical problems which resulted in serious adverse events.

The key challenges for MHS and SWSAHS are improving the culture and clinical leadership and addressing the inadequacies in the clinical workforce at MHS.

The management structure at MHS requires immediate attention. The structure of SWSAHS divides health services into isolated sectors. The result is that there are minimal cross-area clinical networks and support systems for clinical staff working at the Camden and Campbelltown Hospitals. The organisational structure at MHS level left too few people responsible for clinical operations, a problem that was exacerbated by the inadequate number of appropriately skilled staff.

Professional barriers and the hierarchy of professions is the prevalent culture, reinforced by management's ad hoc approach to problem solving. It needs to be replaced by effective teamwork where the collective objective is providing safe care to patients.

The Commission found the following problems with quality and safety systems at MHS:

- a variability in staff reporting adverse events due to the culture and behaviour of different professional groups
- a lack of feedback from management to staff who reported issues of quality and safety
- delays by management in reviewing reports and implementing remedial action
- a failure by management to monitor and evaluate the implementation and effectiveness of any remedial action recommended
- inadequate resourcing of key quality and safety systems and personnel.

We found that MHS failed to recognise and respond to quality of patient care issues raised by the nurse informants. The credibility of the nurses was repeatedly challenged by SWSAHS and MHS during the Commission's investigation. This is not conducive to a culture that promotes safety through open discussion of adverse events.

The Commission found that management at SWSAHS and MHS made errors of judgement and failed to recognise signs of a system in distress.

Individual registered health practitioners

Another means through which the Commission can fulfil its function of facilitating the maintenance of health service and professional standards is investigating the performance of registered health practitioners. The Commission may take disciplinary action where this is warranted. Disciplinary action is never about punishing individuals. It is taken to protect the public. There are also other actions available that can be taken in the public interest where there are concerns about clinical performance including the impairment and performance programs run by the various health registration authorities.

This investigation has raised questions about the performance of individual registered health providers. The Commission is assessing these to determine if further action is warranted in the public interest. Given the very serious public health and safety issues identified early in the investigation, our primary focus was on addressing the systemic issues. It was an imperative to address these so that remedial action could be taken by the health organisations involved to ensure safe care to patients.

The Commission's detailed recommendations to address the problems found in our investigation are set out on the following pages.

Glossary of Terms

The Commission has used the following abbreviated terms throughout this report.

ASRC	Acute Services Review Committee
BP	blood pressure
CAM	Camden Hospital
CAL	chronic airways limitations
CCC	critical care committee
CCF	congestive cardiac failure
CCRC	critical care review committee
CMO	career medical officer
COPD	chronic obstructive pulmonary disease
CPR	cardio-pulmonary resuscitation
CRP	clinical review panels
CT	Campbelltown Hospital
CVP	central venous pressure
DEM	department of emergency medicine
DKA	diabetic ketoacidosis
Dx	diagnosis
ED	emergency department
EQuIP	Australian Council on Health Care Standards accreditation program standards
GCS	Glasgow coma score
GP	general practitioner
GTN	glyceryl trinitrate
HCCC	Health Care Complaints Commission
ICE	Institute for Clinical Excellence
ICU	intensive care unit
JMO	junior medical officer
KPI	key performance indicators
LMO	locum medical officer
MACS	Macarthur Ambulatory Care Service
MHS	Macarthur Health Service
MI	myocardial infarction
MVS	mitral valve stenosis
MW/MED	medical ward
NFR	not for resuscitation
O&G	obstetrics and gynaecology
OT	operating theatre
PT	patient
RCA	root cause analysis
RMO	resident medical officer
SAPS	security and patient service
SLE	systemic lupus erythematosis
SOB	shortness of breath
Surg	surgical
SWSAHS	South Western Sydney Area Health Service
TNF	transfusion
VMO	visiting medical officer
UTI	urinary tract infection

PART 2
Consolidated Recommendations

Summary of Recommendations

This is a consolidation of all the recommendations made by the Commission and contained in Parts 5, 6 and 7 of the investigation report.

PART 5

AVAILABILITY OF AND SUPERVISION BY SENIOR MEDICAL STAFF

We recommend that:

5.1 **SWSAHS and MHS identify the gaps and barriers to the active involvement of senior medical clinicians in providing safe and high quality clinical care and ongoing clinical support, guidance and supervision for less experienced clinical staff, including:**

- having an adequate number of senior clinicians across the clinical service specialties consistent with other service demands and workforce levels
- work commitments elsewhere
- geographic accessibility
- excessive demands on call back
- the impact of rostering arrangements
- VMO attitudes to attending urgent calls
- staff protocols (formal and informal) for identifying when senior medical staff should be called
- the need to urgently improve the capacity of the clinical teams to identify deteriorating or critically ill patients.

SWSAHS should advise HCCC of identified improvement strategies and evaluation strategies to monitor progress and improvement within six months.

5.2 **SWSAHS and MHS refine and implement the system for routine performance management of all senior medical clinicians. This system should be linked to:**

- credentialing and delineation of clinical privileges
- the systems for routine clinical review of care and outcomes
- review and follow up of all clinical incidents, adverse events and 'near misses'
- feedback from CMOs, RMOs and registrars
- the terms of clinicians' contracts.

5.3 **SWSAHS and MHS facilitate senior medical clinicians using team-based evaluation of care through performance indicator review, case/clinical review, quality projects and benchmarking.**

5.4 **SWSAHS and MHS work with clinicians in developing clearly defined responsibilities for clinical management, team participation, supervision, education and performance management.**

Performance expectations need to include:

- arrangements for 'on call' and circumstances where attendance at the hospital is required
- prompt attendance to assess patients with a serious or potentially serious illness
- willingness to be contacted when other clinicians need their clinical advice and support
- teaching, coordination of care, documentation in clinical records, interdisciplinary consultation and cooperation
- regular and formal ward rounds being held 'in hours' by senior medical clinicians that include all medical, nursing and allied health staff responsible for patient care
- formal multidisciplinary weekly clinical meetings being held including senior medical clinicians and all other medical, nursing and allied health staff responsible for patient care at which the treatment and care plans for selected patients are presented and discussed to improve the consistency and quality of care provided to people
- involvement in evaluating clinical care and outcomes
- spearheading the implementation of evidence based clinical practice.

5.5 **A staff specialist with qualifications in emergency medicine is appointed as a matter of urgency to Camden Hospital emergency department until the review of the service has determined its status or the clinical infrastructure has been substantially improved.**

5.6 **SWSAHS and MHS immediately change the role of the emergency department at Camden Hospital to that of a primary care centre where walk in patients can be triaged, stabilised and transferred or managed, with very limited ambulance service access for acute patients.**

5.7 **SWSAHS and MHS recruit and appoint a full time intensivist director as a matter of urgency to the ICU at Campbelltown Hospital to provide clinical leadership, coordination and supervision of patient care.**

QUALITY OF CLINICAL CARE PROVIDED BY RESIDENT MEDICAL OFFICERS, CAREER MEDICAL OFFICERS AND JUNIOR REGISTRARS

We recommend that:

5.8 **SWSAHS and MHS ensure the provision and uptake of accessible and current clinical protocols and guidelines to assist all clinicians to consistently manage both routine and high-risk clinical conditions. This may require:**

- the review of existing clinical protocols and guidelines to ensure their currency and easy availability in accessible formats across SWSAHS

- identifying gaps and working with ICE, the DOH, other area health services and the professional colleges in developing clinical guidelines/protocols for routine and high risk clinical conditions not currently in existence
- developing specific strategies to ensure that all guidelines and protocols are readily accessible, implemented, evaluated and embedded in practice and form the basis of clinical review
- developing a system for reviewing the currency of existing clinical protocols or guidelines, identifying gaps and developing new clinical protocols or guidelines on an ongoing basis, with a review/audit process to assess the impact of their implementation.

5.9 SWSAHS and MHS review and enhance the system for routine performance management of all resident medical officers and career medical officers. This system should be linked to:

- the systems for routine clinical review of care and outcomes
- review and follow up of all clinical incidents, adverse events and 'near misses'
- opportunities to rotate through acute care areas in larger hospitals to improve critical care skills
- assessment of the adequacy and appropriateness of VMO clinical leadership and supervision.

5.10 SWSAHS establish screening tools sensitive to the requirements of a particular role and clinical units and routine performance review of all locum staff to identify people with appropriate skills, knowledge and experience.

5.11 SWSAHS and MHS require as a matter of policy that RMOs and CMOs review all patients under their care on a daily basis, and clearly document the review and any changes in the patients' condition or amendments to their clinical management plan. This policy and its application should be audited as part of the regular auditing process.

QUALITY OF CLINICAL CARE PROVIDED BY NURSING STAFF

We recommend that:

5.12 SWSAHS and MHS work with associated nursing academic faculties and nursing professional colleges and organisations to support practice improvement for nursing clinicians at MHS in providing safe and high quality clinical care. There should be ongoing clinical support, guidance and supervision by nursing clinical leaders for less experienced clinical staff. These practice improvements should include:

- an adequate number of senior nursing clinicians and other nursing clinicians to service the local community demand, that is consistent with other service workforce levels, including clinical nurse educators and clinical nurse consultants
- adequate levels of clinical performance and competency, management support, appropriate accessible and proactive supervision, and resources to maintain quality of clinical practice and patient focused care

- the mechanisms to monitor nursing processes
- ensuring there are clear clinical care and treatment guidelines or protocols
- ensuring there are clear guidelines for nursing consultation, clinical support and timely decision making
- adequate communication between all members of the clinical team and a healthy team culture
- a robust preceptor system to provide support and supervision for less experienced nurses until they demonstrate adequate skill and knowledge
- opportunities to rotate through acute care areas in larger hospitals to improve critical care skills
- developing evaluation strategies to monitor progress and improvement in the provision of safe, high quality nursing care for patients.

5.13 SWSAHS and MHS review and enhance the system for routine performance management of all nursing clinicians. This system should be linked to:

- the identification of needs for ongoing development of skills and experience to provide safe and high quality care
- the systems for routine clinical review of care and outcomes
- the review and follow up of all clinical incidents, adverse events and 'near misses'.

5.14 SWSAHS and MHS develop tools that enable nursing clinicians to take a problem solving approach to developing and using standardised and individualised patient care plans. These should enable the review of the critical aspects of the care plan with particular reference to clinical observations (including neurological observations), fluid and oxygen therapy and other important aspects of care focus. These should also reflect the joint care and treatment planning and problem solving of the entire clinical team.

THE MEDICAL EMERGENCY TEAM AT MACARTHUR HEALTH SERVICE

We recommend that:

5.15 SWSAHS commission a full review of the MET system in place across SWSAHS including its application at MHS. This review should include:

- the introduction of benchmarks to establish acceptable rates for each of the key performance indicators and further analysis of the statistics currently being recorded
- clarification on the role and nature of MET call criteria (mandatory versus discretionary)
- the identification of competencies for clinical staff to join MET
- confirmation of which units and departments participate in the MET system and those that are exempt, with the reasons

- the development of protocols to ensure that in cases where MET criteria are present but MET is not called, the reason is documented, even if this occurs in a unit or department that is exempt
- increased centralisation of the administration and evaluation of the MET system to enable consistency of application and improved patient outcomes. This would involve closer links between MHS, Liverpool Hospital and other hospitals in SWSAHS and the active involvement of staff responsible for coordinating and reviewing MET processes across the area.

PATIENT DECISION MAKING AND PLANNING FOR TREATMENT AND END OF LIFE CARE

We recommend that:

5.16 **DOH finalise the policy replacing the 'Interim Guidelines for Dying with Dignity' within six months to clarify the rights and responsibilities of the community, clinicians and health organisations for decision making and planning for treatment and end of life care. The policy should include an implementation strategy for area health services.**

5.17 **SWSAHS formally re-issue instructions that all clinicians, including senior or admitting medical officers, are to follow the 'Interim Guidelines for Dying with Dignity'. The attending or admitting medical officer must:**

- initiate discussions with the patient and/or family about patient decision making and planning for treatment and end of life care
- ensure discussions occur expeditiously to allow the patient and family time to make informed decisions
- consult with members of the clinical team about the patient's decisions and the plan for treatment and end of life care
- document the content of discussions in the patient's health care records
- ensure that staff responsible for a patient's care are aware of decisions that have been made about treatment and end of life care
- document clear medical orders about resuscitation including what treatment should be started, continued, withdrawn or withheld and the reasons for it.

COMMUNICATION WITH PATIENTS AND FAMILIES

We recommend that:

5.18 **MHS provide ongoing education and training to all clinical staff to improve their skills in interpersonal communication, conflict resolution, negotiation and open disclosure to enable communication and complaints to be conducted in a sensitive and open manner with patients and families.**

COORDINATION AND CONTINUITY OF CARE

We recommend that:

5.19 **SWSAHS and MHS require, as a matter of policy, that at the completion of each patient admission the admitting medical officer documents:**

- a comprehensive clinical management plan for the patient, in consultation with the responsible senior medical officer, that is reviewed routinely as part of the clinical review process by the team
- a checklist for nursing staff that explains the monitoring requirements needed for that patient and any other critical elements of the care and treatment that need to be immediately noted and followed by nursing staff.

This should be audited as part of the routine audit of health care records.

RELATIONSHIPS AND COMMUNICATION WITHIN AND ACROSS CLINICAL TEAMS

We recommend that:

5.20 **DOH support ICE to develop a statewide program of education and training for clinicians that may be integrated into other programs or be a discrete program. The program should emphasise team based care and focus on:**

- developing and improving the relationships and communication between the individuals and professional groups that constitute clinical teams
- a safety and quality values base for behaviour in a team environment for achieving safe, quality care for patients.

5.21 **SWSAHS and MHS invest in strategies that will improve the relationships and communication between the individuals and professional groups that constitute clinical teams.**

RECOGNITION OF AND RESPONSE TO DETERIORATING OR CRITICALLY ILL PATIENTS

We recommend that:

5.22 **SWSAHS and MHS review and enhance the system for routine clinical case and incident investigation and review. As part of this review, they should consider:**

- having an expert multidisciplinary committee with an independent, experienced clinician from outside the MHS as chairperson
- establishing a commitment to and culture of open disclosure
- developing guidelines to ensure that any member having a conflict of interest in relation to a particular case will disqualify themselves from reviewing that case

- the committee becoming integrated into the broad quality and safety systems at MHS
- the committee using data from an integrated and comprehensive information system that tracks critical care incidents, adverse events and near misses through the review process to corrective actions and evaluation.

5.23 **SWSAHS and MHS develop clear protocols to ensure appropriate and timely attendance of senior medical clinicians when a patient is identified as deteriorating or has become critically ill. These protocols should include:**

- protocols for medical staff and nursing staff notifying and requesting the attendance of senior medical clinicians with clear instructions on alternative arrangements if that senior medical clinician is unavailable
- support for senior medical clinicians to ensure that they are available to respond promptly to sudden, rapid, clinical deterioration in patients and reflect this obligation in their contracts.

5.24 **SWSAHS and MHS develop clear protocols to enable staff to seek a second opinion from a senior medical clinician if they are concerned about the clinical assessment treatment and care of any patient.**

DOCUMENTATION OF TREATMENT AND CARE IN HEALTH CARE RECORDS

We recommend that:

5.25 **SWSAHS and MHS improve the quality and consistency of documentation and compliance with contemporary standards on documentation including DOH policy, the Medical Practice Regulations, accreditation standards and area health service and hospital policy. They should review all policy, guidelines, record systems, employment contracts, review and educational and audit strategies in relation to the documentation by all clinicians in patients' health care records.**

5.26 **MHS conduct quarterly random audits of health care records to assess compliance with contemporary standards on documentation. The outcomes of these audits should be reviewed by the information management committee, in collaboration with the clinical advisory council, to assess the appropriateness of documentation by all clinical staff and take action when improvements are needed.**

5.27 **SWSAHS continue to develop an area wide means of tracking patient's health care records and a policy that ensures:**

- current health care records always accompany a patient to any site in SWSAHS
- there is clear and consistent guidance about clinical team member's responsibilities regarding documentation, including the prescription and administration of drug therapy in any SWSAHS service.

NOTIFICATIONS OF DEATHS TO THE CORONER AND DECISION MAKING CONCERNING POST MORTEMS

We recommend that:

5.28 **SWSAHS develops as a matter of urgency an area-wide system for monitoring and reviewing all deaths that occur when a person is under the care of a health service. This system should include:**

- the requirement that an independent senior clinician review the circumstances of the death and the possible need for referral to the Coroner before the release of a deceased person
- an evaluation of the quality of end of life clinical decision making and care
- identifying where improvements are required in the safety and quality of care
- ensuring that appropriate referrals to the Coroner are occurring.

This information must be reported routinely to the Area Health Service Board for their review.

5.29 **SWSAHS and MHS review their policies, protocols and orientation for clinical staff to ensure that:**

- there are clearly outlined referral criteria to the Coroner with illustrative case studies available
- if there is doubt as to whether a patient's death should be reported to the Coroner, an appropriate clinician makes direct contact with the Coroner's Office to seek clarification
- there is adequate opportunity for consultation and explanations for families/next of kin when a death is reported to the Coroner
- all clinical staff have their attention drawn to the requirements of the Coroners Act 1980 through an orientation and ongoing training program covering referrals to the Coroner and the DOH guidelines in Circular No: 99/57, with input from the Office of the State Coroner where appropriate.

PATIENT TRANSFERS TO HIGHER LEVEL UNITS OR HOSPITALS

We recommend that:

5.30 **SWSAHS and MHS review and improve, as a matter of urgency, all protocols for patient transfers to higher level units and hospitals to ensure appropriate and timely transfer occurs to minimise risks to patients. This review should include:**

- the development of protocols allowing timely and unrestricted transfer of patients to appropriate critical care units within MHS
- the development of protocols allowing timely transfer of patients to Liverpool Hospital
- the development of a protocol that ensures that patients presenting at the ED with an illness potentially requiring urgent surgical intervention (such as a person presenting with the symptoms of an acute abdomen) have to obtain timely surgical review or be urgently transported to a facility that can offer this service
- undertaking routine audits of transfers to determine the number and quality of the referrals and documentation accompanying patients who are transferred to monitor and evaluate the timeliness as well as the appropriateness of the transfer of care.

PART 6

ACTION TAKEN BY MACARTHUR HEALTH SERVICE AGAINST NURSING STAFF

We recommend that:

6.1 The NSW Department of Health (DOH) reviews the disciplinary action and processes taken by Macarthur Health Service (MHS) against the four nurses who underwent formal disciplinary action as a matter of urgency.

6.2 South Western Sydney Area Health Service (SWSAHS) and MHS offer to engage in mediation with the nursing staff who raised concerns with the DOH to try to resolve their complaints and concerns.

6.3 The Institute for Clinical Excellence (ICE) work with DOH to incorporate the application of clinical governance and the requirements of a culture focused on quality and safety into DOH's statewide human resources framework.

6.4 DOH develop and support the use of a statewide education and training package for area health services to educate senior health service managers in grievance, performance management and disciplinary procedures. The package should be linked to quality and safety frameworks to ensure consistency in the application of policies and procedures.

6.5 SWSAHS reviews and further develops all human relations policies, procedures and training relating to taking disciplinary action, suspension, grievances and performance management of staff and the application of these to make sure that:

- all senior managers have education and training in the application of performance management procedures and disciplinary procedures, with an emphasis on incorporating clinical governance and quality and safety frameworks into such procedures
- there is ongoing monitoring by SWSAHS of all disciplinary action of MHS staff until SWSAHS is satisfied that senior managers at MHS have a thorough understanding of disciplinary policies and procedures and apply these consistently, according procedural fairness at all times
- there is appropriate consideration of principles of clinical governance, the requirements of a culture focused on quality and safety, and the need for a safe, supportive and fair environment for incident reporting
- there is procedural fairness at all points in the decision making
- there is clarity about the factors to be taken into account when deciding whether a staff member's continuing presence at work compromises or prejudices the health service, other staff or patients
- there is a process of consultation with human resources personnel, the employee's direct supervisor and the employee, where practicable, before a decision to suspend is made and the reasons for suspension and all steps in the suspension process are clearly recorded.

PART 7

CLINICAL GOVERNANCE

We recommend that:

7.1 **DOH continue to support clinical governance in the health system and work with ICE to assist SWSAHS and other area health services to further develop and implement clinical governance to foster cultures that are patient centered and safety focused. This should include the initiatives outlined in:**

- the Safety Improvement Program
- the Clinical Governance Development Program
- the Patient Flow and Safety Collaborative: Towards a Safer Culture Project.

7.2 **SWSAHS, with support from DOH, develops a strategic recruitment plan that addresses incentives to attract and retain competent clinical leaders and managers and clinical staff to meet the needs of the community. The plan may include the creation of 'centres of excellence' including research opportunities and clinical specialisation linked to academic centres.**

7.3 **SWSAHS reflect the strategic importance of the quality framework in budget processes. This resource alignment should continue until DOH is satisfied the framework has been embedded across the health system.**

PERFORMANCE MANAGEMENT AT MHS

7.4 **SWSAHS work with MHS to continue the development of robust performance and clinical review and auditing systems to measure variation in unit performance, care and outcomes across units and services within the acute care continuum that can be benchmarked within the area and externally with other like services. The results should be conveyed to the staff in the organisation.**

INTERNAL AUDITS AT MHS

7.5 **MHS strengthen the links between the annual quality audits and organisational planning and review processes.**

INCIDENT REPORTING SYSTEMS

7.6 **DOH review the policy framework and best practice guidelines for the Development of Health Services Grievance Management Systems (Circular 99-45) and work with area health services to:**

- clarify the overlap and boundaries of the quality and safety systems such as incident management systems, performance management systems, grievance systems and disciplinary systems

- develop integrated processes for reporting issues or concerns that may be incidents or grievances, or for staff members raising questions about the health, conduct or performance of other individual staff members, managers or clinical teams
- develop clear channels that provide a local means for staff to raise grievances or concerns of safety
- outline the mechanisms and need for all staff to follow the organisation's reporting systems clearly and consistently.

7.7 **DOH continue to develop the proposal to introduce a safety climate survey tool to identify baseline information in relation to the perceptions of frontline staff, Boards, Area Executives and middle management about attitudes and commitment to safety. This tool should be used across the NSW health system and allow benchmarking of results across health services.**

7.8 **DOH, in collaboration with ICE and area health services, identify models and performance indicators for incident reporting and corrective action systems to enable monitoring and benchmarking by staff, management, health services and the community of:**

- the identification and preparation of reportable incident briefs to DOH
- the timeliness of reporting, review and implementation of corrective action
- the adequacy of the review process and recommendations
- report back to staff and the care team
- the evaluation of improvements achieved.

7.9 **SWSAHS and MHS implement appropriate facilitative and integrated mechanisms for all staff to report all incidents, issues, concerns and views. These mechanisms should:**

- take into account differing and traditional behaviours of different professional groups
- make it clear that this reporting is necessary to enhance access to information about these risk identifiers so that clinicians and managers may make more informed decisions for the continuous improvement of the assessment, care and treatment provided to patients.

7.10 **SWSAHS and MHS review the problem reporting system to ensure that incident reporting has the clear objective and effect of assisting learning and improving the quality and safety of care provided to patients across MHS. They also need to identify the gaps and remove the barriers to open and safe reporting and feedback for staff that were identified in this investigation.**

7.11 **SWSAHS and MHS conduct routine monitoring through a reliable and valid climate survey of staff satisfaction with the incident reporting system to determine if the changes in culture, policy and practice around the incident reporting system have been successful. The survey should include:**

- staff satisfaction with the openness of the reporting system and the safeguards that enable them to report issues freely without fear or favour
- staff satisfaction with the feedback mechanisms through the incident reporting system to inform them of progress, action and outcomes in relation to each report and the method and timing of feedback.

CONSUMER COMPLAINT MANAGEMENT

7.12 **DOH work with the HCCC and area health servicesto review and improve the NSW guidelines for responding to and managing consumer complaints.**

These guidelines should:

- include the principles of open disclosure at the local health service level, based upon the work of the Turning Wrongs into Rights Project
- recognise that consumer complaints are consumer reported incidents
- integrate reporting and recommendations for action arising from complaints with the incident reporting and management system, enabling the quality and safety issues raised in the complaint to be reviewed and acted upon
- develop consumer feedback mechanisms that will enable consumers and other stakeholders to know the progress, action and outcomes for each complaint.

7.13 **An additional patient support officer be employed by the HCCC to work exclusively in the MHS region to help rebuild the community's confidence in their health service and more effectively resolve care related concerns.**

7.14 **MHS appoint a senior staff member who is part of the quality improvement team to be responsible for investigating and resolving complaints.**

RISK ASSESSMENT AND MANAGEMENT

We recommend that:

7.15 **DOH work in collaboration with ICE to develop tools and models to enable the health system to apply the Australian and New Zealand Standard on Risk Management across corporate and clinical governance structures.**

7.16 **SWSAHS apply the standard on risk management across their entire corporate and clinical governance frameworks.**

SERVICE PLANNING AND CHANGE MANAGEMENT

We recommend that:

7.17 **SWSAHS and MHS review the planning processes at MHS to ensure consistency, compatibility and usefulness of planning tools across each internal level and with external stakeholders. Each measurement indicator used at each level should be overtly linked with the Department of Health's four strategic directions to:**

- show how each level is working towards broader health system goals
- facilitate reporting on progress towards the broader health system goals
- justify funding proposals to achieve the broader health system goals.

7.18 DOH review the role delineation of health services to incorporate a risk assessment / evaluation tool linked to the broader system of clinical risk management. This will assist area health services to assess current services and plan for new services linked to the role delineation of organisations and units. This tool should be available to the community to help them understand the reasons for service levels.

7.19 SWSAHS and MHS develop an area wide clinical services plan and models of care that:

- minimise the duplication of services that require 24-hour coverage and back-up support, where time and transport availability make this clinically supportable
- build a robust change management plan
- incorporate mechanisms to ensure the community and staff have the opportunity to actively participate in the debate and discussion around the development of this plan
- clearly outline the roles of both hospitals for staff and the community
- clearly outline what services will be developed where
- include a teaching and research component linked to overall strategies for service and health improvement
- once settled, incorporate strategies for promoting the role of both hospitals in a positive light, with active promotion of the individual identity of each hospital with its local community.

7.20 MHS develop active change management strategies to support and assist staff in dealing with the impact of change at Camden Hospital medical ward.

7.21 The maternity service at Camden Hospital should continue to develop as a low risk primary health care model.

7.22 SWSAHS and MHS maintain a close monitoring role on the re-introduction of maternity services at Camden to identify and minimise risks for families who may wish to use the service.

7.23 DOH, SWSAHS and MHS actively facilitate a program of staff involvement, development and support to review and enable the requisite cultural change that must accompany service development and change of the magnitude being seen in MHS.

LEADERSHIP, MANAGEMENT AND ORGANISATIONAL CULTURE

We recommend that:

7.24 SWSAHS and MHS work collaboratively, using the model of best practice for operating theatres developed by DOH, to:

- develop and implement clear, objective and achievable performance goals for the operating theatre teams
- ensure a commitment by management of the necessary support to enable benchmarking across the area and with health services across the state.

7.25 **SWSAHS and MHS invest strongly in an ongoing program of team-building for all clinical teams that has a clear set of objectives that have been negotiated with the involvement of the clinical teams themselves. The program should include a conflict resolution strategy that can be implemented to deal with situations where there are differing opinions within a clinical team.**

They should also immediately invest in working with the operating theatre team at Campbelltown Hospital to ensure that the clinical team shares values and approaches to consumer focused care, support and advocacy, the roles of the different clinical team members and attitudes to flexibility, initiative, innovation and cooperation without compromising professional principles.

7.26 **SWSAHS and MHS immediately review existing clinical leadership and management structures and positions to:**

- ensure that all clinical teams have clinical leaders and managers with the appropriate mix of knowledge, skills and experience to undertake their role
- provide support and supervision from across the area and externally where necessary
- identify where there are gaps in supporting existing clinical team leaders and managers undertake the necessary further development that may be required or enable a dignified transfer to a more appropriate negotiated position.

7.27 **SWSAHS and MHS develop a clear focus on systematically identifying and celebrating positive achievements as well as identifying areas of deficiency and improvement.**

7.28 **SWSAHS and MHS need to consider the role delineation of Camden Hospital, within the area health service.**

ORGANISATIONAL STRUCTURE

We recommend that:

7.29 **SWSAHS review the way that clinical services and clinical support services are organised across the area and:**

- harness the resources of the area to achieve integration and more consistency in clinical service planning and care provision across the entire area health service
- develop connections and support from outside SWSAHS from tertiary educational facilities, health professional colleges and associations, and other area health services while local clinical leadership and resources are being developed
- enable a more functional resource allocation process that is driven by consumer needs and contemporary clinical standards.

7.30 **SWSAHS and MHS review the organisational structure, accountability and reporting lines of staff at MHS, with particular emphasis on the accountability and reporting lines of staff at Camden Hospital, to support staff and patient care and immediately appoint a site manager at Camden Hospital.**

WHISTLEBLOWER ISSUES

We recommend that:

7.31 **The Health Care Complaints Act 1993, the Health Services Act 1997 and the health professional registration Acts be amended to provide for mandatory reporting by health practitioners of unsafe conduct, performance and impairment on the part of health providers or management.**

7.32 **The Health Care Complaints Act 1993 be amended to protect the identity of complainants in certain circumstances and to provide whistleblower protections for health practitioners in both the public and private sectors.**

7.33 **Health professional registration boards and health professional associations actively encourage the reporting of unsafe practices on the part of health providers or management and reflect this in their professional codes of conduct, practice and ethics.**

7.34 **DOH work with ICE to publish and disseminate information to private and public health care providers about:**

- the importance of reporting unsafe practices on the part of health providers or management
- the positive contribution of reporting to quality improvement
- the need for a safe reporting culture
- the options available to report, including to the Commission
- what health professionals can do about patient safety concerns if they are not satisfied by management responses.

IMPLEMENTATION OF THE RECOMMENDATIONS OF THIS REPORT

We recommend that:

7.35 **DOH coordinate the oversight of the implementation of the recommendations in this report by the team commissioned to oversight the implementation of the recommendations in the review commissioned by the DOH.**

Contents

3.1 THE HEALTH CARE COMPLAINTS COMMISSION 26

3.2 BACKGROUND TO THE COMPLAINT 26

3.3 THE COMPLAINT 27

3.4 SUMMARY OF ISSUES 28

3.5 PARTIES TO THE COMPLAINT 29

3.6 NURSE INFORMANTS 29

3.7 INDIVIDUAL REGISTERED HEALTH PRACTITIONERS 29

3.8 HEALTH SERVICES IN MACARTHUR 30

PART 3
Introduction

Introduction

3.1 THE HEALTH CARE COMPLAINTS COMMISSION

The Health Care Complaints Commission (the Commission) is a statutory body that acts in the public interest by investigating, monitoring, reviewing and resolving complaints about health care services.

Under the *Health Care Complaints Act 1993* (the Act), complaints may be made to the Commission about the professional conduct of a health practitioner or a health service that affects the clinical management or care of an individual client (s.7).

The Commission's primary responsibility is to ensure protection of the public. Thus the Act requires the Commission to investigate a complaint if it raises a significant issue of public health or safety or raises a significant question as to the appropriate care or treatment of a client by a health service provider (s.23).

Where the Commission investigates an individual health practitioner, our options at the end of the investigation process are to terminate the matter; prosecute; recommend or intervene in disciplinary action; make comments to the practitioner; or refer the complaint to the Director of Public Prosecutions (s.39). The practitioner must be given the opportunity to comment before any of these actions (other than termination) are determined (s.40). Complaints and investigations into registered health practitioners also require consultation with the appropriate registration authority.

Where the Commission investigates a health organisation – a health care provider that is not a natural person – the Commission may terminate the matter, make recommendations or comments to the health organisation or refer the matter to the Director of Public Prosecutions (s.42). Before making recommendations or comments, the Commission must inform the health organisation of the substance of the grounds for its proposed action and give the organisation the opportunity to make submissions (s.43).

Where the Commission makes recommendations or comments, we must also report to the Director-General of the Department of Health, including the reasons for our conclusions and the reasons for any recommended action (s.42).

This report concerns the Commission's investigation into a complaint formally made by the Director-General of the New South Wales Department of Health about standards of care at Campbelltown and Camden Hospitals. The hospitals are part of Macarthur Health Service and are under the governance of South Western Sydney Area Health Service.

3.2 BACKGROUND TO THE COMPLAINT

On 5 November 2002 the then Minister for Health, the Honourable Craig Knowles, met with four nursing staff from MHS about their concerns over the clinical management and care provided to patients at Campbelltown and Camden Hospitals and the response of hospital management to their concerns. The nursing staff are current or former staff of Campbelltown and Camden Hospitals.

After this meeting, the Minister referred the matters raised by the nurses to the Director-General, Ms Robyn Kruk, for investigation. The Director-General asked the department's Director of Audit to conduct this investigation.

On 12 November 2002, the Director of Audit provided an interim report to the Director-General. In this report, the Director advised that her investigative staff had interviewed five nursing staff, reviewed documentation relating to allegations that had been made by the nurses and made certain recommendations. The Director recommended that the department institute a full investigation and, if evidence was obtained of clinical negligence or malpractice, refer the matter to the Commission.

3.3 THE COMPLAINT

On 18 November 2002 the Director-General made a complaint to the Commission regarding allegations by a number of staff concerning management and clinical practices at the Campbelltown and Camden Hospitals. Staff linked these practices to a number of deaths. The department advised it was obtaining further information from the staff who raised the matter which would be made available to the Commission.

Attached to the letter of complaint was a memorandum from the Minister to the Director-General dated 5 November 2002, a memorandum from the Director of Audit to the Director-General dated 12 November 2002, and the names of the nursing staff who had met with the Minister.

The Minister's memorandum

The memorandum from the Minister dated 5 November 2002 advised the Director-General as follows:

- Discussions took place with five people (four nurses and a support person) who made a range of allegations concerning Campbelltown Hospital.
- The allegations relate to mismanagement, negligence, patient neglect and a failure by the critical care committee to properly oversee the clinical performance of the hospital over a period of some years.
- The allegations involve senior members of staff at Campbelltown Hospital, Macarthur Health Service and the Area Health Service ignoring concerns or doing little to have concerns addressed.
- It was asserted that the hospital's performance had declined under the leadership of the Chief Executive Officer of Macarthur Health Service, and the culture of the organisation made it difficult to have concerns investigated.

The Director of Audit's memorandum

The memorandum from the Director of Audit to the Director-General provided a summary overview of the department's findings and recommended follow-up action. It advised that:

- Four of the five people who met with the Minister had been interviewed and statements had been obtained from two other persons.
- The people interviewed provided cogent and persuasive reports on what appeared to be long standing clinical and management performance problems, poor processes, and specific adverse incidents that reflect badly on both hospitals and the clinical governance of SWSAHS and its Board.
- The complainant nurses have had a range of responsibilities at Campbelltown Hospital and extensive nursing experience.
- The allegations raise a number of significant matters including:
  - an apparent lack of adequate quality and safety systems at hospital level
  - an apparent lack of clinical governance, risk management and performance monitoring at Area level
  - a culture that does not support open disclosure of errors and adverse events
  - an apparent failure to address serious ongoing management and clinical problems that has resulted in serious adverse events.

The memorandum made a number of recommendations including follow-up investigation of the allegations and a review of clinical practice and quality management at both Campbelltown and Camden Hospitals.

The statutory declaration

On 21 November 2002 the Director of Audit (as delegate of the Director-General) provided a statutory declaration to the Commission verifying the complaint. A statutory declaration is a requirement under the Act (s.23(3)).

The declaration states:

'I have received statements and evidence from seven nurses concerning clinical and nursing practice at Camden and Campbelltown Hospitals. It has been alleged that Camden and Campbelltown Hospitals:

- *lack adequate quality and safety systems*
- *lack effective clinical governance, risk management or performance monitoring by South Western Sydney Area Health Service*
- *have ineffective incident reporting or investigation systems*
- *have a culture that does not support open disclosure of errors or adverse events*
- *have a management that minimises incident reporting by bullying, intimidating and disciplining nurses who do report adverse incidents*
- *have failed in a number of instances to report appropriately to the Coroner*
- *have inadequate systems to monitor performance and to respond to performance issues*
- *have ineffective training, support and performance management to assist staff to meet the demands of their responsibilities*
- *have failed to address serious ongoing management and clinical problems which have resulted in serious adverse events.'*

The Commission determined that the complaint required investigation because it raised a significant issue of public health and safety and a significant question as to the appropriate care or treatment provided to clients by a health service provider (s.19 and s.23).

3.4 SUMMARY OF ISSUES

The issues raised in the complaint essentially concern the quality and safety of the health care delivered to the Macarthur community by the two hospitals.

They can be categorised into three broad areas:

- The standard of health care provided to patients.
- The adequacy of systems to ensure safe and quality care – that is, clinical governance, risk management, performance and incident monitoring, training and support –
- Management that minimises incident reporting by bullying, intimidating and disciplining staff who report problems and errors.

3.5 PARTIES TO THE COMPLAINT

The complainant for the purposes of the Act and the Commission's investigation is the Director-General of the Department of Health, not the nurses who initially raised the issues.

The health service providers identified in the complaint are:

- Campbelltown Hospital
- Camden Hospital
- Macarthur Health Service as the health service responsible for the two hospitals
- South Western Sydney Area Health Service as the area health service that has overall responsibility for Macarthur Health Service and the two hospitals.

3.6 NURSE INFORMANTS

The four nurses who met with the Minister were subsequently and separately interviewed by the Department of Health and by the Commission. The nurses are all registered or enrolled nurses with between 13 and 30 years nursing experience. They are current or former staff of Campbelltown and Camden Hospitals and include clinical nurse specialists and nurse unit managers. In this report they are referred to as Nurses N1, N2, N3 and N4.

A further three nurses from the hospitals were interviewed by the department and subsequently assisted the Commission in its investigation. In this report they are referred to as Nurses N5, N6 and N7.

The nurses' level of experience enabled them to identify deficiencies in patient care and to alert the management of the hospitals and MHS to the problems. Their concern for patient care and delivery of quality health services and their preparedness to speak out is courageous and commendable.

3.7 INDIVIDUAL REGISTERED HEALTH PRACTITIONERS

The Commission acts in the public interest by facilitating the maintenance of standards of health services. We do this by investigating and making comments and recommendations when required. We also provide an independent mechanism for assessing whether the prosecution of disciplinary action should be taken against individual health practitioners. Disciplinary action is never taken to punish individuals. It is taken to protect the public.[1] There are also other actions available that can be taken in the public interest where there are concerns about clinical performance including the impairment and performance programs run by the various health registration authorities.

The Health Care Complaints Act 1993 imposes requirements to ensure procedural fairness before disciplinary action is taken. The investigation of clinical incidents primarily adopted audit and document review methodologies. Given the very serious public health and safety issues identified early in the investigation, the Commission's primary focus was on addressing the systemic issues. It was an imperative to address these so that remedial action could be taken by the health organisations involved to ensure safe care to patients.

The investigation has, however, raised questions about the performance of individual registered health providers. The Commission is assessing these to determine if further action is warranted in the public interest.

Health Care Complaints Commission v Litchfield (1997) 41 NSWLR 630

3.8 HEALTH SERVICES IN MACARTHUR

The Macarthur region

The Macarthur region covers three local government areas: Campbelltown, Camden and Wollondilly.

Approximately half the population is 25 years or younger, with 29% of the community being born overseas. Twelve percent (12%) of the population in the area serviced by MHS speak a language other than English at home and 21% of the population are either unemployed or not in the labour force. One point nine percent (1.9%) of the community identifies as Aboriginal or Torres Strait Islander – this is the highest percentage within Sydney metropolitan local government areas.

Campbelltown has seen rapid growth, fuelled since its nomination in 1968 as a major growth area for the expansion of Sydney under the concept of satellite towns. The availability of less expensive land has seen many first home buyers settle in the area, and some large public housing estates have been an important part of Campbelltown's rapid growth.

The demographics and the ongoing development of the area present real challenges to the delivery of responsive and quality health care services.

South West Sydney Area Health Service (SWSAHS)

SWSAHS is constituted under the *Health Services Act 1997.* Area health services facilitate the conduct of public hospitals and other health institutions and provide health services for residents of their areas. Their purpose is to provide relief to sick and injured persons through the provision of care or treatment and to promote, protect and maintain the health of the community.

SWSAHS is the largest area health service in New South Wales with an estimated 2001 population of nearly 798,000 people stretching from Fairfield and Bankstown in the north to Moss Vale and Bundanoon in the south.

The total number of staff employed as at 30 June 2002 was 7,382. This included a nursing workforce of 3,155 and a medical and support staff workforce of 2,254. Total government funding for the 2001/2002 financial year was $643 million with 133,425 hospital admissions and 46,437 inpatient operations during the year (SWSAHS annual report 2001/2002).

Macarthur Health Service (MHS)

MHS was created in 1998 and includes Campbelltown, Camden and Wollondilly within SWSAHS. Campbelltown and Camden Hospitals are the two main health facilities within MHS but there are also a number of smaller and more specialised community facilities.

MHS was structured along clinical lines with directorates consisting of maternal and child health services, mental health services, aged care and rehabilitation services, acute services and ambulatory care services, irrespective of where those services were located. That is, hospital-based and community-based services were run as an integrated service across various locations. This meant that the two hospitals effectively became one hospital on two sites.

MHS current activity levels are approximately 105,000 occupied bed days per year and 460,000 non in patient services per year for a population of approximately 227,000 with a projected population growth of 4% per year.

Camden and Campbelltown Hospitals

Camden Hospital was established in 1899 while Campbelltown Hospital, now a major metropolitan teaching hospital, opened in 1977. They are separated by a 20 minute car journey.

The broad direction of MHS has been to develop the two hospitals as complementary to each other rather than duplicating a wide range of services in close geographic proximity. For instance in the early 1990s, the children's ward at Camden Hospital was transferred to Campbelltown Hospital.

While the two hospitals share the same visiting medical officers (VMOs), the development of other infrastructure, particularly the availability of medical registrars and staff specialists who provide 24 hour services, has largely taken place at Campbelltown. This has resulted in some changes to the role of Camden Hospital. For example, since 2001 surgery at Camden Hospital has been restricted to patients requiring day surgery and in 2002 a decision was made to admit acute medical patients to Campbelltown Hospital only.

Today Campbelltown is the larger facility with a broad range of acute elective and emergency services provided by visiting specialist doctors. Camden Hospital now provides some acute medical services, palliative care, rehabilitation, day only surgical services and emergency care.

Area health services are required to develop functional and strategic plans to ensure appropriate provision of clinical services. Known as 'role delineation', this process involves identifying the level of core and support services required, with level 1 being the lowest and level 5 the highest. 'Core services' are emergency, medical, surgical, maternal and child, integrated community and hospital services and community based health services. 'Support services' are pathology, pharmacy, diagnostic imaging, nuclear medicine, anaesthetics, intensive care, coronary care and operating suite.

Under this process, Campbelltown Hospital was recently upgraded from a 191 bed, level 3 hospital to a 320 bed, level 5 one. Camden Hospital is designated an 84 bed, level 3 hospital. MHS embarked on a significant capital works program to accommodate these changes. The program also included establishing a cancer therapy centre providing chemotherapy and radiation services to 120 patients a day.

In the 2001/2002 financial year there were 5,796 hospital admissions and 3,016 inpatient operations at Camden Hospital. In the same period there were 21,194 hospital admissions and 10,391 inpatient operations at Campbelltown Hospital.

Contents

4.1 SCOPE OF INVESTIGATION 34

4.2 THE INVESTIGATION TEAM 34

4.3 THE INVESTIGATION MODEL 35

4.4 RESPONSES TO THE COMPLAINT 40

PART 4

The investigation process

The investigation process

4.1 SCOPE OF INVESTIGATION

As outlined in the previous sections, in November 2002 the Commission commenced an investigation into a complaint made by the Director-General of the Department of Health about standards of health care at Campbelltown and Camden Hospitals.

The initial complaint and additional information provided by the nurse informants disclosed the following areas of concern:

- the standard of care provided in the identified clinical incidents
- the quality and safety of care provided by MHS
- clinical governance and integrated patient focused care
- management response to problems of clinical care, including dealings with people who alerted them to the problems.

Given the wide-ranging nature of the allegations and the very serious public health and safety issues, the Commission decided the most appropriate investigation strategy was initially to focus on systems issues and the culture at Macarthur Health Service.

4.2 THE INVESTIGATION TEAM

Experienced Commission investigators, senior managers, a solicitor and clinical advisers carried out the investigation. An independent barrister was engaged to assist with the investigation of disciplinary action against the nurses. A retired general physician and visiting medical officer were engaged to review all incidents concerning VMOs to provide an additional review.

A steering committee was later established comprising the Commissioner, the Assistant Commissioner, Complaint Resolution, the Manager, Legal Services and the Director, Partnerships, Quality and Development Services.

The role of the steering committee was to:

- manage and direct the investigation
- ensure the progress of the investigation
- ensure the investigation was appropriately resourced
- deal with stakeholder issues
- decide on how to deal with strategic issues
- make decisions relating to the progress of each phase of the investigation
- ensure that a quality product was delivered.

It was also established to deal with any possible perception of bias raised by MHS staff concerns that the Commissioner knew the General Manager of MHS.

4.3 THE INVESTIGATION MODEL

As summarised above, the complaint raised concerns about health care standards and processes to ensure safe and quality care. In accordance with our strategy of focusing on the systemic issues raised by the complaint, the investigation focused on:

- exploring in detail adverse events that had been identified in the complaint and by the nurse informants
- reviewing clinical governance structures, processes and practices within the hospitals, MHS and SWSAHS.

As is explained below, the Commission obtained information relating to these two aspects. An interim report was prepared in January 2003. This was followed by a review of the identified adverse incidents in June and a preliminary investigation report in August.

Adverse events

The information provided by the informants and others identified 71 specific incidents in which it was alleged that the hospitals had not provided an adequate standard of care. Three incidents were duplicates so we considered 68 incidents. The informants were able to provide patient names and medical record numbers for some incidents. For other incidents they were able to provide information such as the date, hospital department or some unusual characteristic. We obtained assistance from MHS and the informants to identify the patients in as many incidents as possible. Patients were identified in 47 incidents so it was these 47 incidents that were investigated. These incidents occurred between June 1999 and February 2003.

The incidents occurred in the emergency departments at Campbelltown and Camden Hospitals, the intensive care unit at Campbelltown Hospital, the operating theatre at Campbelltown, and on the medical wards at both hospitals.

We did not investigate the other 21 reported incidents because we could not identify the patient. This prevented us from being able to obtain medical records or other information.

The Commission's investigation is not a prevalence study of incidents occurrence. Nor does it seek to comparatively measure the hospital's performance. It does, however, utilise specific incidents to make conclusions about the systems and culture existing within MHS.

Primary information sources

Our investigation primarily relied on documentation and interviews. The documentation we obtained from MHS and SWSAHS includes:

- incident, review, audit, annual, Coroner and management reports
- medical records relevant to the incidents
- personnel files
- policy, procedure and protocol documents for delivery of health care services, education and training of staff and disciplining of staff
- minutes of meetings including quality committees
- climate surveys
- previous MHS review reports.

The Commission conducted interviews with over thirty people including:

- the CEO and staff of SWSAHS
- the General Manager and other managers at MHS
- the chairman of the SWSAHS clinical advisory committee
- the complaints officer at MHS
- the seven nurse informants.

We also considered the report of 'The review of standards of patient care at Macarthur Health Service' commissioned by the Department during the course of the investigation.

We researched international, national and state standards and policies for quality, safety, clinical governance, risk management and performance monitoring.

Privacy and confidentiality

As part of the investigation we obtained medical and employment records of a range of people including patients, MHS employees, other persons and the nurse informants. Under the *Health Care Complaints Act 1993* and the *Privacy and Personal Information Protection Act 1998* the Commission can collect and use this information where necessary as part of an investigation. However, the Commission also has obligations under the laws to protect the privacy of personal information. We are mindful that the information is highly sensitive and disclosure of identifying information, such as the names of patients, is neither necessary nor desirable. Accordingly, in this report individual patients, health providers and the nurse informants are identified by codes.

Advisory panels

As is usual practice in Commission investigations, external clinical advisers were engaged to provide independent assessment of the issues. Two types of panel were established - a systems review panel and a series of clinical review panels.

Systems review panel

A systems review panel was initiated to provide a review of the adequacy of systems in place at MHS to support clinicians in the delivery of safe, high quality care to patients. The systems review panel was made up of experts from around Australia with Commission staff as facilitators. The panel was assisted by Dr C H Pain, Area Director, Medical and Clinical Services, SWSAHS.

The members of the panel were:

- Associate Professor John Cartmill, Sydney University and Nepean Hospital, Chairperson of ErroMed a human factors training organisation that specialises in safety in health.
- Associate Professor Kaye Challinger, Chief Executive Officer, Royal Adelaide Hospital and member, Australian Council for Quality and Safety in Health Care.
- Ms Janette du Buisson Perrine, consumer representative, SWSAHS.
- Dr Michael Walsh, Chief Executive Officer, Bayside Health, Victoria and deputy chairperson, Australian Council for Quality and Safety in Health Care.

The panel was also assisted by:

- Ms Sarah Crawford, Senior Project Officer, Partnerships, Quality and Development Services, HCCC.
- Mr Bruce Greetham, Director, Partnerships, Quality and Development Services, HCCC.

The panel's terms of reference were to examine and review clinical governance structures, processes and practices at Campbelltown and Camden Hospitals and to look at the links with MHS and SWSAHS. This included reviewing:

- the impact of the organisation's culture and its approach to safety and quality, including its responsiveness to staff, consumer and other stakeholder complaints and concerns
- the systems for ensuring safe, high quality patient care at individual and organisational levels
- human resource policies and practices relating to staff performance, in particular those promoting the safety and quality of clinical practice.

The review considered:

- integrated risk management systems, including risk and adverse event processes
- planning and testing of management systems, clinical standards and practitioner coverage for new, upgraded or expanded services
- internal policy, guideline and benchmark development, implementation and review processes, and the relationship with external developments.

The review team initially examined documentation such as quality reports and policies at MHS to gain an understanding of the system of clinical governance. They then spent three days at MHS interviewing staff and managers in the units where the incidents occurred – Campbelltown operating theatres, Camden emergency department and Camden medical wards. The discussions were designed to identify individual and organisational reactions to the incidents, staff awareness of policies and attitudes to reporting incidents, and to identify proactive systems at MHS to monitor trends and prompt management action. The systems review team also interviewed relevant senior executives at MHS and SWSAHS and members of the SWSAHS board.

The panel reviewed some of the clinical incidents to examine their implications and impact on quality and safety. They also considered the findings and recommendations in the preliminary investigation report.

Clinical review panels

Each of the clinical incidents was reviewed by a clinical review panel made up of peer practitioners from relevant clinical areas of practice. The practitioners were from a number of facilities, including teaching and district hospitals, and provided a wide coverage of views and a range of perspectives on the appropriate clinical standards and whether there was a departure from those standards.

Emergency department incidents

Emergency department incidents were reviewed by a panel of six practitioners. There were three emergency department directors - two from metropolitan teaching hospitals and one from a metropolitan district hospital - and three nurse unit managers from the same hospitals as the directors.

The members of this panel were:

- Ms Lucy Caswell, RN, Nursing Unit Manager, St Vincents Hospital.
- Dr Brian Collits, Director of Emergency Medicine, Manly Hospital.
- Dr Giordian Fulde, Director of Emergency Medicine, St Vincents Hospital.
- Dr Tony Joseph, Director of Emergency Medicine, Royal North Shore Hospital.
- Ms Leigh Kirkwood, RN, Clinical Nurse Educator, Manly Hospital.
- Ms Karen Steenbergen, RN, Nurse Unit Manager, Royal North Shore Hospital.

Medical ward incidents

Medical ward incidents were reviewed by a panel made up of a career medical officer from a metropolitan district hospital, a physician from a metropolitan teaching hospital, a nursing unit manager from the medical ward of a metropolitan district hospital, and a clinical nurse specialist from a metropolitan district hospital.

The members of this panel were:

- Mr Andrew Marrett, RN, Medical Ward, Mona Vale Hospital.
- Dr Michael Pannetta, Career Medical Officer and General Practitioner, Hornsby Hospital.
- Ms Jo Le Ray, RN, Nurse Unit Manager, Medical Division, Gosford Hospital.
- Dr George Skowronski, Intensivist and Physician, St. George Hospital.

Intensive care unit incidents

Intensive care unit incidents were reviewed by Dr George Skowronski.

Operating theatre incidents

Operating theatre incidents were reviewed by a surgeon, an anaesthetist and a nursing unit manager from the operating theatre of a metropolitan teaching hospital.

The members of this panel were:

- Ms Joanne Bancroft, Nurse Unit Manager, Operating Theatres, Westmead Hospital.
- Dr Richard Halliwell, Staff Anaesthetist, Westmead Hospital.
- Dr John Swinnen, Surgeon, Westmead Hospital.

Panel assessment

Each incident was reviewed after the panel members had had the opportunity to review the relevant documents for a period of days beforehand. At least two practitioners from each panel carefully examined the material for each incident, except for the intensive care unit incidents. Their views were then explained to and tested by the wider panel. The opinions recorded in the incident summaries are those adopted by the panels.

For each incident, the panel members were asked to form an opinion on:

- whether the allegations made were substantiated
- the issues identified by the Commission
- whether in their opinion the care was safe or unsafe
- whether in their opinion the care was acceptable or unacceptable
- whether or not the care was patient focused
- whether or not the care was effective
- any positive aspects of care
- the management response from the hospitals or MHS to the incident and whether it was adequate or inadequate.

At the end of the review, seven of the panel members met to identify any recurring themes and make any comments and suggestions that would help us prepare our recommendations. This group was made up of the emergency department reviewers and Dr Skowronski.

We collated the information provided by the panels incident by incident and recorded it as data to be analysed and presented in the preliminary investigation report and our final report. We also noted the panel discussions on any of the broader issues or recurring themes arising from the incidents.

The panels also reviewed and considered the s.43 submissions made by SWSAHS in response to the preliminary report to see if their opinions on the incidents needed to be changed. We followed a similar process to the one outlined above.

The same clinical panels were convened and facilitated by Commission staff. A few days before the panel was convened, each panel member was sent the information seen previously as well as the SWSAHS response to the preliminary report.

For each incident, the panel members were asked to form an opinion on:

- whether the SWSAHS response raised any dispute about the facts
- whether the SWSAHS response raised any dispute about the Commission's findings
- whether their view was changed in light of the SWSAHS response.

Each panel met separately and then as a combined group where their views were shared and tested by the wider panel.

The wider panel was also asked to reflect on the Commission's preliminary report and any systems and human factor issues arising from the clinical incidents. Commission staff recorded the panel's views.

The clinical panel's views about the standard of care provided in each clinical incident and the systems issues suggested by the incidents were taken into account by the Commission when making our final findings and recommendations. For the preliminary report, the Commission's views about the issues in the clinical incidents and the substantiation of these issues were determined by the Acting Commissioner and Director, Partnerships, Quality and Development Services. The Commission's final views about the issues in the clinical incidents were determined by the Assistant Commissioner, Complaint Resolution.

4.4 RESPONSES TO THE COMPLAINT

The respondents

The Commission formally sought the views of SWSAHS and MHS at several stages of the investigation: at the outset, in response to the interim report in January 2003, in response to the preliminary assessment of clinical incidents in June 2003 and in response to the preliminary investigation report in August 2003.

We also received a submission from Macarthur Medical Staff Council which we took into account before finalising the Commission's views.

Management and staff at MHS were advised that the investigation would involve identifying areas of excellence and opportunities for improvement as well as dealing with the public health and safety concerns raised in the complaint. We gave relevant parties opportunities to comment on our processes and initial findings and on preliminary drafts of our reports. This included meeting with the nurse informants once we had formed our preliminary views to discuss those views with them.

South West Sydney Area Health Service

SWSAHS provided a detailed response to the Commission's proposed findings, comments and recommendations in our preliminary investigation report. SWSAHS raised some concerns about aspects of the investigation and summarised their position as follows:

> *'SWSAHS has always acknowledged that this investigation includes a number of cases where errors of a serious nature were made. These are cases that are deeply distressing for both the families involved and for clinicians that delivered care. We have never denied that these incidents occurred.*
>
> *It is an unfortunate fact that adverse events do occur throughout the health system. This includes events such as the errors reviewed in this investigation. It is accepted throughout the health system that the best response to events of this kind is to conduct objective, fair and balanced investigations and learn from errors made in a blame free environment. This is in fact what had been occurring at Campbelltown and Camden Hospitals, with increasing success.*
>
> *SWSAHS and Macarthur Health Service accept a number of the findings and remain concerned about others. There are numerous findings and recommendations that we consider are not supported by evidence. These are all discussed at length within our response.*
>
> *SWSAHS and Macarthur Health Service have both worked enthusiastically to improve the quality of care provided over the last few years, despite difficulties in attracting quality clinical staff at all levels. This work will continue.'*

The Department of Health

Action was taken by the Director-General following receipt of the Commission's preliminary investigation report in August 2003. This action included:

- commissioning a review, under s.122 of the *Health Services Act 1997*, of the standards of patient care and services at MHS by the Chairperson of the Institute for Clinical Excellence, Professor Bruce Barraclough, and an expert review team

- replacing the Chief Executive Officer of SWSAHS and the General Manager of MHS
- establishing a committee to coordinate the implementation of the s.122 review.

Patients, families and carers

Senior Commission officers and clinical advisers contacted patients and families affected by the clinical incidents to provide information and answer questions about the investigation. Several meetings were held with patients and their families to provide information. The Commission remains willing to follow up with other patients and families at the conclusion of this investigation.

Contents

5.1 INTRODUCTION 44

5.2 SUMMARY OF INCIDENTS REVIEWED 47

5.3 AVAILABILITY OF AND SUPERVISION BY SENIOR MEDICAL STAFF 55

5.4 QUALITY OF CLINICAL CARE PROVIDED BY RESIDENT MEDICAL OFFICERS, CAREER MEDICAL OFFICERS AND JUNIOR REGISTRARS 61

5.5 QUALITY OF CLINICAL CARE PROVIDED BY VISITING MEDICAL OFFICERS 68

5.6 QUALITY OF CLINICAL CARE PROVIDED BY NURSING STAFF 75

5.7 THE MEDICAL EMERGENCY TEAM (MET) AT MACARTHUR HEALTH SERVICE 84

5.8 PATIENT DECISION MAKING AND PLANNING FOR TREATMENT AND END OF LIFE CARE 91

5.9 COMMUNICATION WITH PATIENTS AND FAMILIES 97

5.10 COORDINATION AND CONTINUITY OF CARE 101

5.11 RELATIONSHIPS AND COMMUNICATION WITHIN AND ACROSS CLINICAL TEAMS 105

5.12 RECOGNITION OF AND RESPONSE TO DETERIORATING OR CRITICALLY ILL PATIENTS 111

5.13 DOCUMENTATION OF TREATMENT AND CARE IN HEALTH CARE RECORDS 118

5.14 NOTIFICATIONS OF DEATHS TO THE CORONER AND DECISION MAKING CONCERNING POST MORTEMS 121

5.15 PATIENT TRANSFER TO HIGHER LEVEL UNITS OR HOSPITALS 128

5.16 MANAGEMENT RESPONSE TO ADVERSE EVENTS 132

5.17 OUR CONCLUSIONS 139

PART 5

Investigation of clinical incidents

Investigation of clinical incidents

5.1 INTRODUCTION

Section 7 of the *Health Care Complaints Act 1993* says that complaints can be made to the Health Care Complaints Commission concerning issues which affect the clinical management or care of an individual client. In accordance with the Act, we focused our attention on clinical incidents where individual clients could be identified.

This part of the report details the Commission's views after an analysis of 47 clinical incidents. The reports and summary analyses of each clinical incident are in Appendix A. In considering the clinical incidents as a whole, we identified 14 issues as common themes. Our views in relation to these issues are set out below. We acknowledge that, during the course of our investigation, MHS continued to work towards making their quality and safety systems effective. These clinical incidents give an insight into how the systems were working at the time they occurred.

The analysis of issues informs the Commission's findings and recommendations in relation to the heads of complaint.

These were:

- a lack of effective clinical governance, risk management or performance monitoring
- an ineffective incident reporting or investigation system
- a failure in a number of instances to report appropriately to the coroner
- inadequate systems to monitor performance and respond to performance issues
- ineffective training, support and performance management to assist staff to meet the demands of their responsibilities
- a culture that does not support open disclosure of errors or adverse events
- a failure to address serious and ongoing management and clinical problems which has resulted in serious adverse events.

The investigation of the Director-General's complaint included an examination of all of the specific clinical incidents identified by the nurse informants. It was not possible to investigate the clinical events brought forward by the nurse informants at the time of preparing our final report. The number of incidents we investigated has provided a sufficient basis to make appropriate findings, comments and recommendations in relation to the issues which impact on the clinical management of individual health consumers and which were raised in the complaint.

We analysed the information provided by the informants and identified 71 specific incidents in which it was alleged that the hospitals had not provided an adequate standard of care. Three incidents were duplicates so 68 incidents were considered. Details of the 68 incidents are contained in Appendix A. The informants were able to provide patient names and medical record numbers for some incidents. For other incidents they were able to provide information such as the date, hospital department or some unusual characteristic. We obtained assistance from the Macarthur Health Service (MHS) and the informants to identify the patients in as many incidents as possible. Patients were identified in 47 incidents so it was these 47 incidents that were investigated. A summary of the 47 incidents and the Commission's findings are contained in Table 5.1.

As discussed elsewhere, the Commission's investigation is not a prevalence study of adverse events. Nor does it seek to comparatively measure the hospitals' performance. The Commission is usually afforded the opportunity of investigating one clinical incident raised by a complaint. We are able to make findings and recommendations in relation to an individual incident aimed at preventing recurrence. In reviewing the 47 incidents at MHS, the Commission has been able to make findings in relation to each incident. Our analysis has also been strengthened by the number of incidents in this investigation where similar issues are identified.

We did not investigate the other 21 reported incidents because we could not identify the patient. This prevented us from being able to obtain medical records or other information to test the allegations.

Identifying the issues

At the start of our investigation, we analysed each incident and identified the issues of possible concern. We considered the allegations made by the informants, internal medical advice and the other information we obtained. Some incidents raised up to ten issues of concern whereas others raised only one issue of concern.

We categorised the issues we identified to provide our analysis with some structure and to allow a systems analysis to take place based on patterns in problems occurring.

From an analysis of the 47 incidents, we identified 14 categories of issues. These categories are:

- Availability of and supervision by senior medical staff
- Quality of clinical care provided by resident medical officers, career medical officers and junior registrars
- Quality of clinical care provided by visiting medical officers
- Quality of clinical care provided by nursing staff
- The medical emergency team (MET) at Macarthur Health Service
- Patient decision making and planning for treatment and end of life care
- Communication with patients and families
- Coordination and continuity of care
- Relationships and communication within and across clinical teams
- Recognition of and response to deteriorating or critically ill patients
- Documentation of treatment and care in health care records
- Notifications of deaths to the Coroner and decision making concerning post mortems
- Patient transfer to higher level units or hospitals
- Management response to adverse events, including incident reporting.

The issues are not standard data categories used elsewhere to evaluate quality and safety in health care. They are a list of issues and areas distilled from the information to describe clusters of similar concerns occurring across the reported incidents.

As some of the issues may overlap, there is some repetition of information in this part of the report. For example, an absence of nursing observations in the medical records of a patient may be recorded as a concern about the quality of nursing care and a concern about documentation in the records. Because an overlap may occur, care is required in reaching statistical conclusions. It is one reason why a quantitative analysis of the issues cannot be relied upon in coming to a conclusion.

Evaluating the incidents

We obtained the opinion of clinical review panels (CRPs) to help us evaluate the issues and then formed a preliminary view about whether each issue was substantiated, partially substantiated, not substantiated or that there was insufficient information to make a finding. We also made comments and recommendations about each issue. We provided SWSAHS with the CRPs views in June 2003 and sought a preliminary response in relation to them. After further analysis we formally advised SWSAHS of the Commission's views in August 2003. SWSAHS made s.43 submissions in relation to the 47 incidents in October 2003. The Commission obtained a further opinion from the CRPs after providing them with the SWSAHS response. The SWSAHS submissions and the CRP opinions were taken into account in forming the Commission's findings and comments.

The reports in Appendix A include:

- a description of each case
- the allegations raised by the informants
- the issues identified by the Commission
- the location of the incidents
- the opinions of the clinical review panels
- our views and comments on the incident.

We have also included case studies to highlight the issues and their implications for patient care. To make sense, they needed to contain detailed medical information and are therefore quite lengthy.

The incidents we investigated represent a very small sample of overall adverse incidents reported to the management of MHS. The MHS critical care review committee (CCRC) or other review body had previously reviewed some of the adverse events.

It is important to note that the 47 incidents examined occurred between 1999-2003, a period of 5 years. During that time there were 104,602 admissions to Campbelltown and Camden Hospitals and 172,982 presentations to the emergency departments. During this time, staffing levels were not comparative to other equivalent facilities. *The Health Care Complaints Act,1993* precludes the Commission from making any recommendations about resources. The findings and recommendations are very clearly focused on recommendations which will improve the quality and safety of health care provided to patients by MHS.

5.2 SUMMARY OF INCIDENTS REVIEWED

Table 5.1 gives an overview of the clinical incidents reviewed. It briefly describes the clinical incidents and the issues identified by the Commission. It also indicates whether or not the Commission found there were quality and safety concerns. Quality and safety concern is a shortened descriptor of the Commission identifying an inadequate standard of care in the area of health service delivery described by the issue. The numbers are not sequential as only the incidents where patients could be identified have been included. Further details about the individual incidents are in Appendix A of this report.

Table 5.1 – Summary of incidents and issues identified by the Commission

HCCC No	Date of incident	Brief description of incident	Issues identified by HCCC	Quality and Safety Concerns
1	Qtr 1, 2002	Management of 10 year old child who had a significant anaesthetic risk factor.	Relationships and communication within and across clinical teams	Yes
			Coordination and continuity of care	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Management response to adverse events, including incident reporting	Yes
			Communication with patients and families	Yes
			Availability of and supervision by senior medical staff	Yes
2	Qtr 4, 2001	Patient with delay in arranging surgical review for ischaemic foot.	Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Relationships and communication within and across clinical teams	Yes
			Quality of clinical care provided by visiting medical officers	Yes
			Quality of clinical care provided by nursing staff	Yes
			Management response to adverse events, including incident reporting	Yes
			Patient transfer to higher level units or hospitals	Yes
			Availability of and supervision by senior medical staff	Yes
			Coordination and continuity of care	Yes
3	Qtr 4, 2002	Patient had wrong breast removed	Patient transfer to higher level units or hospitals	Yes
			Communication with patients and families	Yes
			Documentation of treatment and care in health care records	Yes
			Quality of clinical care provided by visiting medical officers	Yes
			Quality of clinical care provided by nursing staff	Yes
4	Qtr 4, 2001	Patient with inappropriate management of septic knee	Management response to adverse events, including incident reporting	Yes
			Availability of and supervision by senior medical staff	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
5	Qtr 2, 2001	Unacceptable delay in triage of severely ill newborn baby.	Quality of clinical care provided by nursing staff	Yes
			Availability of and supervision by senior medical staff	Yes
			Patient transfer to higher level units or hospitals	No
			Recognition and response to critically ill patients	No
			Management response to adverse events, including incident reporting	Yes
7	Qtr 1, 2001	Patient fell off the operating theatre table	Relationships and communication within and across clinical teams	Yes
			Management response to adverse events, including incident reporting	Yes
			Communication with patients and families	No
			Quality of clinical care provided by nursing staff	Yes
			Quality of clinical care provided by visiting medical officers	Yes

HCCC No	Date of incident	Brief description of incident	Issues identified by HCCC	Quality and Safety Concerns
10	Qtr 4, 2001	Inadequate resuscitation provided	Documentation of treatment and care in health care records	Yes
			Patient decision making and planning for treatment, and end of life care	Yes
			Recognition and response to critically ill patients	Yes
			Quality of clinical care provided by nursing staff	Yes
			Availability of and supervision by senior medical staff	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
11	Qtr 3, 2002	Failure to call MET team when a patient's initial systolic blood pressure was recorded at 80. Repeat manual reading was recorded as 100/60.	Management response to adverse events, including incident reporting	Yes
			The Medical Emergency Team (MET) at Macarthur Health Service	No
			Quality of clinical care provided by nursing staff	No
12	Qtr 3, 2002	Uncertain cause of death of 87 year old patient.	Documentation of treatment and care in health care records	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	No
			Quality of clinical care provided by nursing staff	No
			Management response to adverse events, including incident reporting	Yes
			Notifications of deaths to the Coroner and decision making around post mortem	Yes
			The Medical Emergency Team (MET) at Macarthur Health Service	No
13	Qtr 3, 2002	Management of patient's blood pressure and utilisation of MET	Management response to adverse events, including incident reporting	Yes
			The Medical Emergency Team (MET) at Macarthur Health Service	Yes
14	Qtr 3, 2002	Management of 88 year old woman with chronic illnesses	Quality of clinical care provided by visiting medical officers	No
			Management response to adverse events, including incident reporting	No
			Patient decision making and planning for treatment, and end of life care	Yes
			Documentation of treatment and care in health care records	Yes
			Quality of clinical care provided by nursing staff	Yes
15	Qtr 4, 2001	Patient with chest pain discharged from Emergency Department	Notifications of deaths to the Coroner and decision making around post mortem	Yes
			Quality of clinical care provided by visiting medical officers	Yes
			Communication with patients and families	Yes
			Management response to adverse events, including incident reporting	Yes
			Documentation of treatment and care in health care records	Yes
			Patient transfer to higher level units or hospitals	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
16	Qtr 3, 2001	Failure to recognise 55 year old woman with shortness of breath and general feeling of unwellness some days after mitral valve replacement who was critically unwell	Coordination and continuity of care	Yes
			Quality of clinical care provided by nursing staff	Yes
			Recognition and response to critically ill patients	Yes
			Relationships and communication within and across clinical teams	Yes
			The Medical Emergency Team (MET) at Macarthur Health Service	Yes
			Management response to adverse events, including incident reporting	Yes
			Patient transfer to higher level units or hospitals	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Documentation of treatment and care in health care records	Yes
			Availability of and supervision by senior medical staff	Yes

HCCC No	Date of incident	Brief description of incident	Issues identified by HCCC	Quality and Safety Concerns
17	Qtr 3, 2002	82 year old woman not resuscitated despite the absence of not for resuscitation order	Patient decision making and planning for treatment, and end of life care	Yes
			The Medical Emergency Team (MET) at Macarthur Health Service	Yes
			Documentation of treatment and care in health care records	Yes
			Availability of and supervision by senior medical staff	No
			Notifications of deaths to the Coroner and decision making around post mortem	No
			Management response to adverse events, including incident reporting	Yes
18	Qtr 1, 2001	Failure to diagnose puerperal sepsis in a woman seven days post partum	Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Quality of clinical care provided by visiting medical officers	Yes
			Quality of clinical care provided by nursing staff	Yes
			Documentation of treatment and care in health care records	Yes
			Recognition and response to critically ill patients	Yes
19	Qtr 3, 2002	MET not called for patient with systolic blood pressure of 88 and 85.	The Medical Emergency Team (MET) at Macarthur Health Service	Yes
			Documentation of treatment and care in health care records	No
			Management response to adverse events, including incident reporting	Yes
21	Qtr 3, 2002	Failure to manage myocardial infarction identified by GP after ECG and pathology	Communication with patients and families	Yes
			Relationships and communication within and across clinical teams	Yes
			Quality of clinical care provided by visiting medical officers	Yes
			Quality of clinical care provided by nursing staff	Yes
			Patient decision making and planning for treatment, and end of life care	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Documentation of treatment and care in health care records	Yes
			The Medical Emergency Team (MET) at Macarthur Health Service	Yes
			Coordination and continuity of care	Yes
22	Qtr 2, 2001	Difference of opinion between emergency department and Mental Health staff over management of patient with psychiatric condition in emergency department	Management response to adverse events, including incident reporting	Yes
			Availability of and supervision by senior medical staff	Yes
			Relationships and communication within and across clinical teams	Yes
23	Qtr 4, 2001	Post discharge death after thoracic aortic aneurysm diagnosed as urinary tract infection	Availability of and supervision by senior medical staff	Yes
			Management response to adverse events, including incident reporting	Yes
			Coordination and continuity of care	Yes
			Relationships and communication within and across clinical teams	Yes
			Notifications of deaths to the Coroner and decision making around post mortem	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
24	Qtr 1, 2002	Locum CMO falsely recorded an examination of an elderly patient following a fall	Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Management response to adverse events, including incident reporting	Yes

HCCC No	Date of incident	Brief description of incident	Issues identified by HCCC	Quality and Safety Concerns
26	Qtr 1, 2002	Elderly patient with a low gastro-intestinal bleed inappropriately removed at Camden Hospital without a surgical review or an active management plan	Quality of clinical care provided by visiting medical officers	Yes
			Patient decision making and planning for treatment, and end of life care	Yes
			Coordination and continuity of care	Yes
			Management response to adverse events, including incident reporting	Yes
			Availability of and supervision by senior medical staff	Yes
			The Medical Emergency Team (MET) at Macarthur Health Service	Yes
			Patient transfer to higher level units or hospitals	Yes
30	Qtr 3, 2000	Inadequate assessment of 38 year old woman with complex health problems presenting with chest pain.	Recognition and response to critically ill patients	No
			Coordination and continuity of care	No
			Availability of and supervision by senior medical staff	No
			Quality of clinical care provided by nursing staff	Yes
			Quality of clinical care provided by visiting medical officers	No
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Management response to adverse events, including incident reporting	No
			Notifications of deaths to the Coroner and decision making around post mortem	Yes
33	Qtr 4, 2001	Patient suffering overdose of medication required more intensive care than was provided.	Patient transfer to higher level units or hospitals	Yes
			Availability of and supervision by senior medical staff	Yes
			Quality of clinical care provided by visiting medical officers	Yes
			Quality of clinical care provided by nursing staff	No
			Management response to adverse events, including incident reporting	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Recognition and response to critically ill patients	Yes
34	Qtr 2, 2001	Significantly delayed surgical review complicates the care of an elderly patient with a perforated duodenal ulcer	Management response to adverse events, including incident reporting	Yes
			Quality of clinical care provided by nursing staff	Yes
			Recognition and response to critically ill patients	Yes
			The Medical Emergency Team (MET) at Macarthur Health Service	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Documentation of treatment and care in health care records	Yes
			Patient transfer to higher level units or hospitals	Yes
			Availability of and supervision by senior medical staff	Yes
35	Qtr 4, 2002	Over 12 hour delay in transfer for critically ill woman	Relationships and communication within and across clinical teams	Yes
			Availability of and supervision by senior medical staff	No
			Patient transfer to higher level units or hospitals	Yes
36	Qtr 1, 2003	Delay in Emergency Department for woman with small bowel obstruction.	Patient transfer to higher level units or hospitals	No
			Documentation of treatment and care in health care records	Yes
			Quality of clinical care provided by visiting medical officers	No

HCCC No	Date of incident	Brief description of incident	Issues identified by HCCC	Quality and Safety Concerns
37	Qtr 1, 2003	Patient classified as an acute surgical emergency kept at Camden Emergency Department and not transferred to Campbelltown or to another hospital when Campbelltown Code Red, despite requests by nursing staff to transfer patient.	Documentation of treatment and care in health care records	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Quality of clinical care provided by visiting medical officers	Yes
			Patient transfer to higher level units or hospitals	Yes
			Patient decision making and planning for treatment, and end of life care	Yes
38	Qtr 1, 2003	Inappropriate admission and inadequate management of a man with significant medical conditions and presentation with acute abdominal pain.	Documentation of treatment and care in health care records	Yes
			Quality of clinical care provided by nursing staff	Yes
			Relationships and communication within and across clinical teams	Yes
			Coordination and continuity of care	Yes
			Recognition and response to critically ill patients	Yes
			Quality of clinical care provided by visiting medical officers	Ye
			Patient transfer to higher level units or hospitals	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
39	Qtr 1, 2003	Management of patient with a post operation laparoscopic complication - intra abdominal infection.	Patient transfer to higher level units or hospitals	Yes
			Management response to adverse events, including incident reporting	Yes
			Notifications of deaths to the Coroner and decision making around post mortem	No
			Quality of clinical care provided by visiting medical officers	Yes
			Communication with patients and families	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Relationships and communication within and across clinical teams	Yes
			Recognition and response to critically ill patients	Yes
			Availability of and supervision by senior medical staff	Yes
40	Qtr 4, 2002	Appropriate care provided to elderly person needing emergency surgery.	Coordination and continuity of care	No
			Patient transfer to higher level units or hospitals	No
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	No
41	Qtr 2, 2002	Delay in obtaining medical review for person with anxiety relating to acute prolonged respiratory distress.	Coordination and continuity of care	Yes
			The Medical Emergency Team (MET) at Macarthur Health Service	Yes
			Quality of clinical care provided by nursing staff	Yes
			Management response to adverse events, including incident reporting	Yes

HCCC No	Date of incident	Brief description of incident	Issues identified by HCCC	Quality and Safety Concerns
42	Qtr 2, 2002	Uncoordinated care of elderly person with post operation infection.	Communication with patients and families	Yes
			Availability of and supervision by senior medical staff	Yes
			Coordination and continuity of care	Yes
			Quality of clinical care provided by visiting medical officers	Yes
			Notifications of deaths to the Coroner and decision making around post mortem	Yes
			Quality of clinical care provided by nursing staff	Yes
			Patient decision making and planning for treatment, and end of life care	Yes
			Documentation of treatment and care in health care records	Yes
43	Qtr 2, 2002	Allegation that a medical officer without sufficient skill attempted to administer an epidural then a general anaesthetic to woman having caesarean section.	Relationships and communication within and across clinical teams	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Management response to adverse events, including incident reporting	Yes
44	Qtr 2, 1999	Delayed transfer of a young woman 34 weeks gestation suffering respiratory distress	Management response to adverse events, including incident reporting	Yes
			The Medical Emergency Team (MET) at Macarthur Health Service	Yes
			Quality of clinical care provided by visiting medical officers	Yes
			Availability of and supervision by senior medical staff	Yes
45	Qtr 2, 2002	Under triage of patient and "just in time" progress through ED and transfer to a teaching hospital.	Management response to adverse events, including incident reporting	No
			Quality of clinical care provided by nursing staff	Yes
			Patient transfer to higher level units or hospitals	Yes
46	Qtr 1, 2001	Young woman with asthma required specialist ICU care	Quality of clinical care provided by nursing staff	Yes
			Recognition and response to critically ill patients	Yes
			Documentation of treatment and care in health care records	Yes
			Communication with patients and families	No
			Availability of and supervision by senior medical staff	Yes
			Notifications of deaths to the Coroner and decision making around post mortem	No
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
59	Qtr 2, 2001	Suicidal patient not adequately supervised or managed and inappropriately discharged some time after he attempted to hang himself in Emergency Department.	Availability of and supervision by senior medical staff	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Quality of clinical care provided by nursing staff	Yes
			Relationships and communication within and across clinical teams	No
			Quality of clinical care provided by visiting medical officers	Yes
			Management response to adverse events, including incident reporting	Yes

HCCC No	Date of incident	Brief description of incident	Issues identified by HCCC	Quality and Safety Concerns
60	Qtr 2, 2001	Psychiatric registrar refused to assess patient ready for discharge from ICU causing bed blockage.	Quality of clinical care provided by visiting medical officers	No
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Management response to adverse events, including incident reporting	Yes
			Availability of and supervision by senior medical staff	No
61	Qtr 2, 2002	Management of patient with cardiac condition - carer support needed.	Patient decision making and planning for treatment, and end of life care	No
			Communication with patients and families	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	No
			Coordination and continuity of care	No
62	Qtr 3, 2002	MET not called when 81 year old women with severe chronic pulmonary disease had systolic blood pressure of 88.	The Medical Emergency Team (MET) at Macarthur Health Service	Yes
63	Qtr 3, 1999	Critically ill patient admitted to ICU, condition deteriorated over a number of days, delayed transfer to another hospital despite numerous requests by nurses to transfer.	Patient transfer to higher level units or hospitals	Yes
			Documentation of treatment and care in health care records	Yes
			Availability of and supervision by senior medical staff	No
65	Qtr 2, 2001	No diagnosis, after 9 hours in Emergency Department for woman after overdose, incorrect treatment for hypertension, delay in putting in central line.	Availability of and supervision by senior medical staff	Yes
			Management response to adverse events, including incident reporting	Yes
			Relationships and communication within and across clinical teams	Yes
			Quality of clinical care provided by visiting medical officers	Yes
			The Medical Emergency Team (MET) at Macarthur Health Service	Yes
			Documentation of treatment and care in health care records	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
66	Qtr 3, 2001	Woman with symptoms of fulminant pregnancy induced hypertension not managed as a critical patient.	Management response to adverse events, including incident reporting	Yes
			Documentation of treatment and care in health care records	Yes
			Quality of clinical care provided by nursing staff	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Availability of and supervision by senior medical staff	Yes
			Recognition and response to critically ill patients	Yes
67	Qtr 4, 2001	Man known to have meningitis not managed after initial assessment.	Quality of clinical care provided by visiting medical officers	Yes
			Documentation of treatment and care in health care records	Yes
			Management response to adverse events, including incident reporting	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Quality of clinical care provided by nursing staff	Yes

HCCC No	Date of incident	Brief description of incident	Issues identified by HCCC	Quality and Safety Concerns
68	Qtr 4, 2001	Poor end of life care for critically unwell 81 year old patient and family.	Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Quality of clinical care provided by visiting medical officers	Yes
			Documentation of treatment and care in health care records	Yes
			Documentation of treatment and care in health care records	Yes
			Patient decision making and planning for treatment, and end of life care	Yes
			The Medical Emergency Team (MET) at Macarthur Health Service	Yes
			Quality of clinical care provided by nursing staff	No
69	Qtr 4, 2001	Failure to respond to the critical clinical deterioration of a patient, lack of end of life planning, and failure to refer to the Coroner or conduct an autopsy	Management response to adverse events, including incident reporting	Yes
			The Medical Emergency Team (MET) at Macarthur Health Service	Yes
			Quality of clinical care provided by nursing staff	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Recognition and response to critically ill patients	Yes
			Documentation of treatment and care in health care records	Yes
			Relationships and communication within and across clinical teams	Yes
			Notifications of deaths to the Coroner and decision making around post mortem	Yes
			Patient decision making and planning for treatment, and end of life care	Yes
			Quality of clinical care provided by visiting medical officers	Yes
70	Qtr 4, 2001	Adequacy of management of 42 year old woman with a mental illness and multiple physical conditions.	Management response to adverse events, including incident reporting	Yes
			Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Yes
			Quality of clinical care provided by nursing staff	Yes
			Coordination and continuity of care	Yes

5.3 AVAILABILITY OF AND SUPERVISION BY SENIOR MEDICAL STAFF

Introduction

We examined the medical records of the 47 patients identified in the incidents and identified the availability of and supervision by senior medical staff as a possible concern in 23 incidents. Eighteen incidents (or 78% of cases where we had identified it as a possible issue) involved unacceptable standards of medical care to patients because a visiting medical officer (VMO), experienced registrar or staff specialist was not available for the direct care of patients and/or to supervise junior medical staff.

Out of a total of 47 incidents, this issue was substantiated or partially substantiated in 38% of cases. These were incidents 1, 2, 4, 5, 10, 16, 22, 23, 26, 33, 34, 39, 42, 44, 46, 59, 65 and 66. These incidents occurred from 1999 to 2003, with most occurring in 2001. There was one incident in 1999, one in 2000, 14 in 2001, 3 in 2002 and one in 2003.

Patients are admitted to hospital under the care of a doctor, usually a VMO. VMOs are accredited to practice in the facility and to undertake defined clinical care. Because they also maintain a private practice in addition to the care of hospital inpatients, hospitals need to have clear expectations of the availability of VMOs to ensure patient safety.

Most of the substantiated incidents related to VMO availability. No incident involved the availability of a staff specialist, but their availability as an alternative may have been an option. The unacceptable care related to four categories of medical practice.

These categories were:

- delays in attendance
- failure to advise VMO of documentation in clinical records
- coordinated care
- supervision of more junior medical officers.

The broad issues raised relate to the unavailability of VMOs to review patients in the emergency departments (ED) and medical wards at both Campbelltown and Camden Hospitals. The patients were often critically ill or deteriorating clinically and had only one medical review by doctors with inadequate experience and clinical competence to do such reviews.

The lack of VMO availability related to inadequate VMO cover, failure to notify the VMO, failure to attend at all, or failure to attend in a timely fashion – see incidents 33 and 66.

CASE STUDY

Case Study – Incident 2

No surgical review of a patient with an ischaemic foot for more than two days in Camden Hospital

Mrs I was an 83 year old woman who was admitted to Camden Hospital in late 2001 following a fall. She was in hospital awaiting a bed in a nursing home. Eleven days after her admission a registered nurse recorded in the patient notes that Mrs I's right foot was purple. She added, 'Resident Medical Officer to review patient'.

The RMO reviewed Mrs I one hour later but made no reference to her right foot. A further review by the RMO one hour later still made no reference to Mrs I's foot.

The following day (Day 12) a CMO, recorded a diagnosis of 'ischaemic right foot' along with a note that the VMO surgeon on-call, 'will see patient this week asap.' Camden Hospital operates as an acute hospital without emergency surgical services being available within the hospital.

The next day (Day 13) another doctor reviewed Mrs I, confirmed the diagnosis of 'ischaemic right foot' and contacted the admitting VMO physician, a gastroenterologist, who agreed that Mrs I should be transferred to Campbelltown Hospital for review by a surgeon. Later on Day 13, Mrs I's family arranged a private surgical consultation at 1800 hours by a consultant surgeon, who arranged for Mrs I's immediate transfer to St Vincent's Hospital.

A registered nurse submitted a 'problem report' and an email to the MHS Director of Health Services reporting that she had encountered resistance from the doctors on Day 13 about the need for an urgent transfer for surgical review. In particular, the nurse identified that the systems in MHS provided no channel of communication for nurses to report urgent clinical concerns about medical management that is adversely affecting patient safety.

The case was reviewed four months later by the MHS acute services critical care review committee (ASCCRC).

They made three recommendations:

- request explanations from medical team re: lack of action on findings
- vascular surgeon informed of importance of attending consults requested within a short period of time
- develop guidelines for nursing staff to put into action to prevent recurrence of constant delays in treatment.

MHS did not provide evidence which showed the recommendations of the ASCCRC had been implemented.

Our findings

The Commission found:

1. The care provided to Mrs I was unsafe and inadequate. There were serious breaches of the minimum standard of care in relation to assessment, investigation, treatment and care as follows:
   - the care team's communication was ineffective over 57 hours from the time the ischaemic foot was first recorded in the patient notes
   - the RMO who reviewed Mrs I on Day 11 should have examined her foot and noted the findings of assessment and a management plan in her medical record
   - nursing staff should have contacted the RMO to request an urgent examination when the RMO appeared not to have examined Mrs I's foot
   - nursing staff failed to make a record of the concerns expressed by Mrs I's family on Day 11 about her foot
   - on Day 12 the CMO diagnosed 'ischaemic right foot' which is an urgent surgical problem but did not order an urgent plan of action

- the VMO surgeon on call gave a contradictory response to the CMO on Day 12 saying he will see the patient 'this week asap'. He had not reviewed Mrs I by the time she was transferred 24 hours later. This was an inadequate response to an urgent surgical problem
- with her history of transcient ischaemic attacks and immobility, Mrs I should have been given prophylactic anticoagulant medication
- medical staff should have been more alert to the possibility of arterial embolus in view of Mrs I's atrial fibrillation
- there is no record until Day 6 of any formal admission or medical examination of Mrs I's hospital stay. This is unacceptable
- Mrs I was admitted under a physician, but the records do not show any leadership by him in her care and treatment
- there was no medical management plan documented in Mrs I's notes. There should have been a documented plan for the management of Mrs I's ischaemic foot as soon as it was discovered
- the nursing staff should have implemented an 'extremities observation chart' earlier than Day 13 and they should have recorded observations every hour instead of once only at 1330 hours.

2. The scope of the recommendations by the acute services critical care review committee was inadequate given the critical systems failures.

3. The factors contributing to the poor care warranted immediate review and corrective action. An opportunity to improve safety was lost by the failure of the incident review system to follow up the actions recommended by the ASCCRC.

4. The submission to the Commission by MHS and SWSAHS was inappropriate in that it suggested that the level of care provided to Mrs I was adequate because she was a social admission and only in Camden Hospital awaiting a nursing home bed. The submission displays a defensive attitude, a failure to recognise serious problems in care and an inability to use the review of an adverse event to modify safety systems within the hospital.

Our conclusions and comments

We have identified significant issues in the clinical incidents examined relating to the availability of and supervision by senior medical staff, particularly VMOs, that have impacted adversely on the care and treatment provided to patients.

Inadequate VMO cover was a particularly relevant issue for the surgical specialities. There were a number of incidents where patients with acute surgical presentations to Camden Hospital ED were not reviewed by the surgical team for extended periods and were eventually transferred in a critical condition to either Campbelltown or Liverpool Hospital with very poor outcomes – see incident 34. In one instance, a surgeon was in theatre at another hospital while rostered on call for Camden or Campbelltown Hospitals and required for an urgent surgical attendance. In other cases the unavailability of VMOs meant that surgical and medical reviews and assessments, and subsequent judgments on the need for patient transfer, were made by RMOs and CMOs.

In the cases reviewed, the intensive care unit (ICU) was without specialist intensivist cover and relied on locum ICU staff or medical officers with limited levels of ICU experience to carry out difficult resuscitation and coordinate complex intensive care management.

Psychiatric VMO and registrar review in ED appears to have been quite inadequate because of the poor relationship that seems to have existed between the ED team and the mental health services at MHS at the time – see incident 22. This has sought to be addressed by the agreement made between the mental health services and the ED in April 2003 and increased rostering of psychiatric registrar cover. The outcomes of this are yet to be reviewed.

The lack of VMO and specialist availability left a vacuum of clinical leadership that has had significant implications for the maintenance of clinical standards and patient outcomes at both hospitals.

It is expressed by:

- the failure of VMOs to show leadership and to expect good practice in relation to clear and comprehensive patient clinical management plans
- a lack of supervision for all levels of medical officers, particularly RMOs and CMOs, who have struggled to recognise the deteriorating and critically ill patient
- a culture that appears to have existed in both hospitals in which complex medical assessments and management decisions are made with no reference to the nominated VMO who should have been responsible for coordinating and supervising patients' clinical treatment and care.

There is a substantial discrepancy between the findings of MHS and the Commission regarding the appropriateness of care in a number of the incidents. This raises questions about the thoroughness and reliability of the MHS review process, particularly if the process is being used as a basis for identifying deficiencies and opportunities for improvement in clinical practice and the treatment and care provided to patients. For effective improvement to take place, the system for identifying gaps and barriers to safe quality care must be sound.

Since the introduction of strategies to improve the efficiency and quality of service in June 2002, there have been two incidents - incidents 42, 39 – that relate to the availability of VMOs, staff specialists or experienced registrars. The effectiveness of strategies implemented to date needs to be evaluated.

In 2002 there was a plan to audit the performance of all staff specialists and VMOs and to review VMO appointment criteria. The Commission recognises that the performance management process and the five yearly re-appointment process includes requirements for the production of evidence of satisfactory past performance.

A causal factor for unsatisfactory performance by RMOs and CMOs and adverse outcomes for patients is the lack of direct supervision and leadership by VMOs and other senior medical staff. The public interest demands that AHSs develop their own systems to capture performance information about individual clinicians. Since the complaint was made, MHS has employed an Associate Professor to head the Department of Medicine who has begun to target performance management and conduct audits of VMO leadership and care. The Commission also notes that thirty new VMO and staff specialists have been appointed but is unsure in what period of time. These two actions are likely to significantly improve the availability and leadership of VMOs.

While the availability of VMOs was one of the issues identified, the Commission recognises workforce shortages in urban fringe areas, the difficulty in building medical leadership and infrastructure at the rate required to meet local service demand and redevelopment, and the difficulties inherent in the building process.

Our recommendations

We recommend that:

5.1 SWSAHS and MHS identify the gaps and barriers to the active involvement of senior medical clinicians in providing safe and high quality clinical care and ongoing clinical support, guidance and supervision for less experienced clinical staff, including:

- having an adequate number of senior clinicians across the clinical service specialties consistent with other service demands and workforce levels
- work commitments elsewhere
- geographic accessibility
- excessive demands on call back
- impact of rostering arrangements
- VMO attitudes to attending urgent calls
- staff protocols (formal and informal) for identifying when senior medical staff should be called
- the need to urgently improve the capacity of the clinical teams to identify deteriorating or critically ill patients.

SWSAHS should advise the HCCC of identified improvement strategies and evaluation strategies to monitor progress and improvement within six months.

5.2 SWSAHS and MHS refine and implement the system for routine performance management of all senior medical clinicians. This system should be linked to:

- credentialing and delineation of clinical privileges
- the systems for routine clinical review of care and outcomes
- review and follow up of all clinical incidents, adverse events and 'near misses'
- feedback from CMOs, RMOs and registrars
- the terms of clinicians' contracts.

5.3 SWSAHS and MHS facilitate senior medical clinicians using team-based evaluation of care through performance indicator review, case/clinical review, quality projects and benchmarking.

5.4 SWSAHS and MHS work with clinicians in developing clearly defined responsibilities for clinical management, team participation, supervision, education and performance management. Performance expectations need to include:

- arrangements for 'on call' and circumstances where attendance at the hospital is required
- prompt attendance to assess patients with a serious or potentially serious illness
- willingness to be contacted when other clinicians require their clinical advice and support
- teaching, coordination of care, documentation in clinical records, interdisciplinary consultation and cooperation

- regular and formal ward rounds being held 'in hours' by senior medical clinicians that include all medical, nursing and allied health staff responsible for patient care
- formal multidisciplinary weekly clinical meetings being held including senior medical clinicians and all other medical, nursing and allied health staff responsible for patient care at which the treatment and care plans for selected patients are presented and discussed to improve the consistency and quality of care provided to people
- involvement in evaluating clinical care and outcomes
- spearheading the implementation of evidence based clinical practice.

5.5 A staff specialist with qualifications in emergency medicine is appointed as a matter of urgency to Camden Hospital emergency department until the review of the service has determined its status or the clinical infrastructure has been substantially improved.

5.6 SWSAHS and MHS immediately change the role of the emergency department at Camden Hospital to that of a primary care centre where walk in patients can be triaged, stabilised and transferred or managed, with very limited ambulance service access available for acute patients.

5.7 SWSAHS and MHS recruit and appoint a full time intensivist director as a matter of urgency to the ICU at Campbelltown Hospital to provide clinical leadership, coordination and supervision of patient care.

5.4 QUALITY OF CLINICAL CARE PROVIDED BY RESIDENT MEDICAL OFFICERS, CAREER MEDICAL OFFICERS AND JUNIOR REGISTRARS

Introduction

Of the 47 clinical incidents examined, the Commission identified the quality of clinical care provided by resident medical officers, career medical officers and junior registrars as a possible issue in 28 instances. Of those 28 instances, we found that 26 involved departures from acceptable standards of medical care provided by RMOs or CMOs.

Out of a total of 47 incidents this issue was substantiated in 55% of cases. These were incidents 1, 2, 4, 10,15, 16, 18, 21, 23, 24, 30, 33, 34, 37, 38, 39, 43, 46, 59, 60, 65, 66, 67, 68, 69 and 70. The 26 incidents of concern occurred from 2000 to 2003, with the majority occurring in 2001. There was one incident in 2000, 18 incidents in 2001, four in 2002 and three in 2003.

From the information available, it was not possible for us to distinguish whether a number of entries in the medical record were made by an RMO or a CMO.

The incidents occurred at both Campbelltown and Camden Hospitals and related to four categories of medical practice.

These categories were:

- assessment and treatment planning
- documentation in clinical records
- clinical performance or competence
- overall treatment and care.

Assessment and treatment planning includes competent clinical assessment and the development of appropriate treatment and care plans. These plans are individualised to patients' needs and are skill based and linked to knowledge. Satisfactory performance in these areas by less experienced clinicians requires support, education and supervision from and by proficient clinicians, such as staff specialists and VMOs. We noted the apparent lack of support and supervision provided to RMOs and CMOs at the two hospitals, particularly in assessment and treatment planning. Deficiencies in some of the incidents related to investigation, diagnosis and treatment planning to address a patient's clinical condition which led to inadequate or unsafe care being provided.

Case Study – Incident 38

Failure to recognise and treat deteriorating clinical symptoms, and failure to transfer to a tertiary hospital.

Mr SD, 70 years of age, presented at Camden emergency department (ED) at 2235 hours in early 2003 with severe abdominal pain, abdominal distension, and increased colostomy activity for the preceding 3 hours. His past history included a colostomy secondary to bowel resection for cancer of the rectum in 1998, and mild chronic airway limitation (CAL).

Mr SD was triaged as category 4 requiring him to be medically reviewed in 60 minutes. The triage nurse noted Mr SD 'was not in any obvious distress' at 2235 hours. However, he was given buscopan and maxalon followed by morphine for severe pain at 2320 hours, and the triage category was not changed. There is no record of the time Mr SD was seen by the ED locum – it may have been around 2320 hours. The differential diagnoses for the abdominal pain were obstruction, ischaemia and gastritis. Both bowel obstruction and bowel ischaemia warranted prompt surgical review.

The ED locum ordered chest and abdominal x-rays, IV fluids and routine pathology tests. A surgical review was noted for the morning. No contact was made with a surgeon or VMO that evening. At 2245 hours the patient's BP was 155/100, O2 saturation was 100% on 3L O2. His temperature was 35.7C and PR 76 bpm. Because of the severity of Mr SD's abdominal pain he required morphine on 3 occasions - at 2355 hours, 0102 hours, and 0445 hours. No instructions were given to nursing staff about monitoring Mr SD's condition.

Although nursing staff were aware that Mr SD was experiencing extreme pain, there is no indication that they were responding to a provisional diagnoses of bowel ischaemia or bowel obstruction. No vital observations were recorded by nursing staff between 0200 hours and 0600 hours. At 0200 hours the O2 saturation had dropped to 98% on 6L of O2, his PR had increased from 76 to 95 bpm, and his BP was 123/68mm. A nursing note at 0500 hours states that Mr SD was awake most of the night. He was complaining of pain and given morphine.

For the next seven hours there was no further PR recorded in the vital observation chart in ED. There was no record of any medical examination of Mr SD from his admission at 2200 hours until 1130 the following morning. Sometime after 0600 hours the ED locum on duty the following morning noted that the abdominal x-ray showed 2 dilated loops of bowel and faecal loading. Mr SD's WCC was 14,800 with neutrophilia of 10,900.

At 0835 hours, having noted the abdominal x-ray results, the ED locum attempted to transfer Mr SD to Campbelltown Hospital.

The transfer arrangements were ceased when the ED locum was made aware that the surgeon was in Camden Hospitals day surgery theatre. The surgeon was contacted at around 0900 hours and was informed of Mr SD's admission.

The record notes that the surgeon would review Mr SD later that morning. The surgeon has stated he was told that Mr SD's condition was stable. At 1030 hours a nurse's record states that Mr SD 'suddenly began to lose consciousness'. Mr SD's BP at 1044 hours was 55/30. No pulse,

respiration, or O2 saturation rates were recorded at this time. At 1110 hours his O2 saturation level was 88% on room air and his BP was 71/49.

The first entry in the medical record after this deterioration was at 1130 hours when it was recorded that Mr SD was cyanosed and had no BP. Haemaccel 500ml was given IV as well as 0.5mg of adrenalin. The surgeon attended ED from the day surgery theatre at around 1130 hours. Although he did not write in the notes himself, it is noted that he made a provisional diagnosis of ischaemic bowel and started IV ceftriaxone, gentamycin, and flagyl.

The surgeon went back to the day surgery unit and returned to see Mr SD at 1200 hours when he requested Mr SD be transferred to Campbelltown ICU for surgery. Mr SD was started on an adrenalin infusion, O2, ventolin, and atrovent. Blood cultures were sent to pathology.

At 1237 hours, a nursing entry states that the paramedics were booked 'asap'. Careflight arrived at around 1330 hours and found Mr SD in septic shock and under-resuscitated. Mr SD was intubated by them and stabilised. He was transferred to Campbelltown Hospital where it was clear that the patient required tertiary hospital facilities and care. Mr SD was then transferred to Liverpool Hospital at 2100 hours where he later died.

Our findings

The Commission found that the care provided to Mr SD was unsafe and inadequate for the following reasons:

- there was a lack of prompt surgical review on admission in view of Mr SD's abdominal pain
- there was a failure to notify the VMO after Mr SD presented at ED
- there was a failure to appropriately review and monitor Mr SD's condition from the time of his admission to ED
- there was inappropriate administration of 4 doses of narcotic analgesia without a clear diagnosis
- there was a failure to give clear instructions to nurses about Mr SD's monitoring requirements
- prompt transfer of Mr SD to an appropriate facility given his clear surgical signs and symptoms was not done
- a clear management plan was not developed and implemented
- Mr SD's condition was not reviewed
- nursing staff failed to take vital observations of Mr SD over 4 hours, between 0200 hours and 0600 hours, despite the provisional diagnosis of ischaemic bowel and bowel obstruction and despite Mr SD needing three doses of morphine
- nursing notes are not in chronological order. Between 0200 hours and 1110 hours, no PR is recorded. There are only two temperatures recorded in over 12 hours, and the respiratory rate was only appropriately taken after Mr SD's condition deteriorated
- there was a lack of coordinated care and a plan for the care of Mr SD given his provisional diagnosis
- there was poor communication between the treating team as indicated by a lack of directions
- given the clinical presentation of Mr SD, arrangements to transfer him to an appropriate tertiary hospital were critically delayed.

CASE STUDY • CASE STUDY • CASE STUDY

It does not appear that management was made aware of any concerns about the clinical care given to Mr SD in early 2003. However, in response to concerns about Mr SD's care identified by the Commission, MHS reviewed his case in June 2003. Management failed to identify or accept the significant and serious problems in the care of Mr SD. Management found that the main issue 'concerned the appropriateness of initial transfer to Campbelltown Hospital (from Camden Hospital).' Management advised that 'transfer guidelines do exist and the Review Team has taken steps to ensure that these guidelines are readily available and understood by staff in Camden Emergency Department.'

When the case was later reviewed by the Department of Surgery, clinical issues were noted and issues relating to system or causal factors identified. Corrective measures were proposed which are aligned with those suggested by the Commission's Clinical Review Panel.

While it is recognised that CMOs may be relatively experienced practitioners, the ultimate responsibility for coordinating and supervising patient management rests with the VMO or staff specialist under whom the patient has been admitted. In incidents where the level of knowledge, skill, judgment or care of the attending RMO or CMO was inadequate, a causal factor for this unsatisfactory care and treatment was the level of leadership and commitment demonstrated by the VMOs.

CASE STUDY • CASE STUDY • CASE STUDY

Case Study – Incident 65

Inappropriate medical management of a young woman following an overdose of IV Amphetamine

Ms CA, a 26 year old woman, was admitted to the emergency department of Campbelltown Hospital in May 2001. She had taken an overdose of intravenous 'speed'. She was complaining of chest pain, diarrhoea and abdominal pain. She brought her 2 year old child with her. She was seen promptly at 0630 hours and triaged priority 2. She was given Valium, Maxolon and Buscopan and Oxygen therapy. She was noted to be hypotensive with a BP of 69/25 at 0700 hours.

An IV cannula was inserted through which was administered a fluid challenge, a litre of normal saline commenced at 0650 hours, and a further litre commenced at 0900 hours. Her blood pressure was unresponsive to this treatment and a litre of Haemaccel was commenced at 1030 hours.

At 1115 hours her BP was noted to be 59/44. Ms CA was given 3 bolus doses of IV Aramine in an attempt to elevate the blood pressure also without benefit.

Colloid and crystalloid fluid resuscitation continued throughout the day to a total of over 5 litres of fluid but her blood pressure which was well monitored by the nursing staff in ED remained unresponsive. Although the medical records do note a lack of urine output, no indwelling urinary catheter was inserted to closely monitor urine output until 1400 hours. The possibility of septicaemia was mentioned in the records (the patient having injected) but no antibiotic therapy was given.

Ms CA was transferred to ICU 10 hours after admission at 1620 hours, where a central line was inserted at 1920 hours and an inotrope infusion of Noradrenaline commenced. From 1420 hours until commencement of a Noradrenaline infusion at 1920 in ICU Ms CA's systolic BP remained less than 80. At 2200 hours although still hypotensive her blood pressure had begun to improve and antibiotics were commenced. She remained on the infusion for 2 days until it was weaned and ceased. Ms CA was discharged home from ICU 3 days after admission. It does not appear that the VMO was contacted at the time of Ms CA's admission. A VMO reviewed the patient for the first time on day 3 just prior to her discharge.

The case was reviewed by the Critical Care Review Committee. The recommendations outlined in a memo 10 months after the incident were:

- need to improve documentation of nursing and medical staff (ED & ICU), via education, staff meeting and ongoing reviews. Consideration should be given to integrated notes in ED for medical and nursing staff. A standard format should be developed for both medical and nursing
- need to ensure medical staff clearly document plan of care and evaluation of strategies implemented
- development of an education program including case presentations
- development of policy regarding IV Aramine.

Our findings

The Commission found:

1. The care provided to Ms CA to be unsafe and inadequate for the following reasons:
   - there was a failure to instigate the appropriate medical treatment in the circumstances
   - this patient was markedly under-resuscitated for a prolonged period in ED
   - Aramine was an inappropriate choice of inotrope and the insertion of the central line for inotropic support should have occurred much earlier
   - the prolonged low blood pressure could have resulted in renal impairment
   - VMO input and therefore senior clinical support in this case did not occur due to an apparent failure of the clinical staff in ED to notify the VMO of the admission
   - there was a failure of medical staff attending the patient in ED to adequately document the management
2. The medical records in this case were extremely difficult to follow as the nursing and medical notes were not integrated.
3. The Critical Care Review Committee did not identify all of the causal factors and its recommendations were inadequate.
4. MHS provided no evidence of the implementation or evaluation of the recommendations of the committee.

Our conclusions and comments

We identified significant issues relating to patient care by RMOs or CMOs that were not identified by the MHS review process. The degree, number and nature of deficiencies in the care provided in the small number of cases we reviewed raises questions about the reliability of reviews conducted by MHS.

The majority of instances occurred in 2001. This pre-dates the recent recruitment of most of the staff specialists including a number of director positions.

Since the introduction of strategies to improve the efficiency and quality of service in June 2002, there have been three further incidents identified - incidents 12, 38 and 39 - that relate to the quality of care provided by RMOs and CMOs.

There are a number of causal factors for the unsatisfactory performance by RMOs and CMOs. These include the lack of direct supervision and leadership by VMOs and the lack of a chain of command to ensure appropriate and safe assessment, treatment and care is provided to patients. MHS has comparatively fewer resident, registrar and consultant medical staff than other similar hospitals. This has to be one of the main factors affecting their performance. The low numbers of registrars in particular means medical officers are working with higher caseloads.

We are also concerned about the impact of the high usage of LMOs and the risks in continuity and consistency of care.

Our recommendations

We recommend that:

5.8 SWSAHS and MHS ensure the provision and uptake of accessible and current clinical protocols and guidelines to assist all clinicians to consistently manage both routine and high-risk clinical conditions. This may require:

- the review of existing clinical protocols and guidelines to ensure their currency and easy availability in accessible formats across SWSAHS
- identifying gaps and working with ICE, the DOH, other area health services and the professional colleges in developing clinical guidelines/protocols for routine and high risk clinical conditions not currently in existence
- developing specific strategies to ensure that all guidelines and protocols are readily accessible, implemented, evaluated and embedded in practice and form the basis of clinical review
- developing a system for reviewing the currency of existing clinical protocols or guidelines, identifying gaps and developing new clinical protocols or guidelines on an ongoing basis, with a review/audit process to assess the impact of their implementation.

5.9 SWSAHS and MHS review and enhance the system for routine performance management of all resident medical officers and career medical officers. This system should be linked to:

- the systems for routine clinical review of care and outcomes
- review and follow up of all clinical incidents, adverse events and 'near misses'
- opportunities to rotate through acute care areas in larger hospitals to improve critical care skills
- assessment of the adequacy and appropriateness of VMO clinical leadership and supervision.

5.10 SWSAHS establish screening tools sensitive to the requirements of a particular role and clinical units and routine performance review of all locum staff to identify people with appropriate skills, knowledge and experience.

5.11 SWSAHS and MHS require as a matter of policy that RMOs and CMOs review all patients under their care on a daily basis and clearly document the review and any changes in the patients' condition or amendments to their clinical management plan. This policy and its application should be audited as part of the regular auditing process.

5.5 QUALITY OF CLINICAL CARE PROVIDED BY VISITING MEDICAL OFFICERS

Introduction

Of the 47 clinical incidents examined, the Commission identified the quality of clinical care provided by visiting medical officers (VMOs) as a possible issue in 20 incidents or 43%. We identified 18 incidents of patient care where there were significant departures from acceptable standards of clinical care provided by VMOs. Of the 20 incidents where the issue was identified we found inadequate care by VMOs in 18 cases or 90%.

Out of a total of 47 incidents, this issue was substantiated or partially substantiated in 38% of cases. These were incidents 2, 3, 7, 15, 18, 21, 26, 33, 37, 38, 39, 42, 44, 59, 65, 67, 68, 69. The 20 incidents occurred between 1999 and 2003. There was one incident in 1999, one in 2000, ten in 2001, five in 2002 and three in 2003.

The incidents were identified at both Campbelltown and Camden Hospitals and were related to five categories of medical practice.

These categories were:

- assessment and treatment planning
- documentation in clinical records
- clinical performance or competence
- overall treatment and care
- the supervision of more junior medical officers.

CASE STUDY • CASE STUDY • CASE STUDY

Case Study – Incident 18

Failure to diagnose puerperal sepsis in a patient in the emergency department of Campbelltown Hospital

Mrs B was a 40 year old married mother of four children. In January 2001, six days after the birth of her fourth child, she presented to the emergency department (ED) at Campbelltown Hospital but was sent home with a diagnosis of 'flu'. Campbelltown Hospital is unable to locate the records of that ED visit however the electronic triage system recorded 'fevers, rigors, general aches and pains. Onset of symptoms 3 days ago. BP 100/69, pulse 106 and temperature 39.4.'

The following day, (Day 2) she went to the after hours GP service at Campbelltown Hospital feeling hot and sweaty with total body pain and a swollen right arm. Her temperature was 36.8 and her BP was 70/50. The general practitioner wrote *'? septic ? cause'* and sent Mrs B to the ED at Campbelltown Hospital.

Mrs B was triaged at 21:27 and seen by a JMO at 2150 hours. Her temperature was 35.7 degrees, pulse rate 107 and blood pressure 91/47. She gave a history of having had a fever of 39, rigors, watery diarrhoea, right and left arm and right leg swelling and generalised pain. She was given 1 litre of normal saline immediately.

A nursing entry before medical review stated, *'patient looked unwell. Pale and diaphoretic. Patient tachycardic and hypotensive. Awaits medical review'.* The JMO in the ED diagnosed possible myositis secondary to viral infection and ordered a broad range of tests including blood culture. Mrs B was given pethidine 25mgs and morphine 5mgs for pain while still in ED.

Over the four hours that she was in ED, her BP and pulse rate were recorded each hour for the first two hours. The VMO physician, a gastroenterologist, was notified of Mrs B's admission at 20 minutes past midnight - three hours after she arrived. The medical records state, *'For admission under - notified and aware'.* There is no indication of any management plan and no antibiotics were ordered.

Mrs B had an unsettled night and walked unsteadily to the shower in the morning. She was reviewed by the VMO at 1015 hours on 6 January 2001 at which time her blood pressure was unrecordable, her temperature was 34.4 and her pulse rate was 120-150 beats/minute. She was drowsy and in septic shock. The VMO response was to call the CMO from ICU, to review the patient with him. Care appears to have been handed to the registrar CMO. Mrs B was transferred to ICU at 1340 hours after receiving haemacel on the ward. She remained profoundly shocked. An adrenalin infusion was commenced. The CMO had many attempts to insert an arterial line unsuccessfully. Another VMO contacted Liverpool Hospital Careflight to organise urgent transfer. A septic work-up was performed and antibiotics were started. There is no record of what antibiotics were administered.

Before transfer, an obstetrician/gynaecologist and a surgical registrar reviewed Mrs B. She was transferred to Liverpool Hospital by helicopter but died at 1700 hours.

Blood cultures and post mortem diagnosed streptococcus pyogenes septicaemia. She had died of puerperal sepsis.

The director of the ED provided a report to the Coroner identifying the following three factors in relation to her presentation to the ED on Day 1:

- she presented with non-specific symptoms
- the potential significance of presenting one week post partum was not appreciated
- an obstetric and gynaecological consultation may have lead to her condition being accurately diagnosed sooner.

In relation to Mrs B's presentation on Day 2, the director of ED identifies the following factors:

- the failure to administer antibiotics
- her admission to a medical ward instead of an O&G service
- the failure to fully recognise the importance of her recent delivery
- the failure to obtain an O&G consultation.

The Macarthur Perinatal Mortality and Morbidity Committee reviewed the case after seven weeks and recommended that:

- the emergency department undertake educational seminars held with a staff specialist lecture, highlighting pre and post delivery complications including postnatal infection and sepsis

- a procedure be put in place that all patients presenting with signs of generalised illness within six weeks of delivery have a mandatory obstetric and gynaecology consultation before discharge.

These recommendations were implemented by the director of ED.

Mrs B's husband, Mr B, made additional inquiries to MHS two months after her death. MHS responded to Mr B by organising a meeting with the medical staff who had cared for his wife. They also organised for the Area Director of Medical Services for South West Sydney to assist Mr B to obtain answers to his questions.

SWSAHS provided a report to the Commission dated 22 May 2003 in which they formally requested that we undertake an investigation of the care and management of Mrs B at Campbelltown Hospital. In this report they pointed out a number of initiatives and improvements that have taken place at MHS since 2001.

Our findings

The Commission found:

1. The care provided to Mrs B was unsafe and inadequate for the following reasons:
   - there was a failure to recognise signs of possible critical illness in a patient seven days post partum at the time of her second presentation on Day 2
   - there was a failure to review Mrs B in the light of her presentation to ED the previous day with fever of 39.4 degrees, rigor and tachycardia
   - there was incomplete medical admission and assessment
   - there was no management plan
   - antibiotics should have been ordered immediately after the collection of the blood for culture
   - there was no communication with nursing staff about vital observation requirements
   - narcotic analgesia was given on two occasions in ED without a clear diagnosis being made
   - there was no registrar/specialist review following the narcotic administration
   - no septic work-up was organised in the ED
   - there was no VMO involvement in Mrs B's management plan
   - there was no prompt review by a VMO in spite of Mrs B being seven days post partum, very unwell and having required pethidine for atypical pain
   - there was failure to promptly organise the transfer of Mrs B to Liverpool Hospital when she was reviewed by him at 1015 hours on Day 3
   - there was a failure to prescribe antibiotics in a timely fashion
   - Mrs B was inadequately monitored in ED with only three sets of vital observations documented by nurses during the four hours in ED
   - there was a lack of response by nurses to Mrs B's deteriorating medical condition on the medical ward from 0145 hours to 1015 hours on Day 3.

CASE STUDY

2. In relation to the MHS management response to this incident, we note with approval the prompt implementation of appropriate procedures by the director of ED. However the requirement for post partum women to have an O&G consultation should be at the time of presentation not, as suggested, before discharge. In the case of Mrs B, she was admitted rather than discharged and became critically ill without being seen by an O&G.

CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY

Case Study – Incident 39

Post operative intra-abdominal infection not diagnosed for three days in Campbelltown Hospital

Mrs X, a 61 year old woman, was admitted to Campbelltown Hospital in early 2003 for a laparoscopic cholecystectomy (removal of her gall bladder by 'key hole' surgery). Mrs X had been on the waiting list for her surgery for eight months.

The operation started at 2015 hours on the 'emergency' operating list. The procedure was more difficult than expected because Mrs X's gall bladder had adhered to her duodenum and her liver. It contained multiple gallstones and pus. The laparoscopic procedure lasted for three hours and was not converted to an open surgical procedure. The pathology report described the removed gallbladder as 'ragged and partially opened'.

The following morning (Day 2) Mrs X was pale, sweaty, hypotensive 80/50, tachycardic 110 bpm and had not passed urine. The only remedial action taken was blood pressure monitoring and commencement on intravenous therapy. Blood pathology tests were taken at 1020 hours and showed a WCC 35,600 and creatinine of 166. Oxygen saturation at 1300 hours was 91% falling to 88% at 2100 hours. The surgeon saw Mrs X and recommended free fluids and chest physiotherapy.

On the afternoon of Day 2, Mrs X complained of severe abdominal pain which required morphine 10 mg.

The following day (Day 3) a MET was called at 0915 hours in response to a pulse rate of 136 bpm. Basal lung collapse and pulmonary embolism were suspected. A chest X-ray and Clexane were ordered. The surgeon reviewed Mrs X at 1020 hours and ordered removal of the drain, free fluids and medical review. Her tachycardia persisted throughout the day and was 150 at 1550 hours. The cardiology team saw Mrs X at 1715 hours and noted her persistent tachycardia but did not think that it was due to a heart problem.

A little later, an RMO examined Mrs X because she was short of breath and continued to complain of upper abdominal pain. Her heart rate was 132 and her oxygen saturation was 93% - 95% on 50% oxygen at 8 l/m by mask. The white cell count from blood taken at 0810 hours was 28.3. Arterial blood gasses taken at 1655 hours showed a pH of 7.31 with a base excess of –5. The RMO discussed Mrs X with the surgical registrar and concluded that she had a likely pulmonary embolism. There was no VQ scan or contrast CT angiogram to confirm or exclude this diagnosis. There was no differential diagnosis of intra abdominal sepsis.

Another MET was called at 2100 hours because Mrs X had a heart rate of 150 – 160, cold periphery, right sided abdominal tenderness and rebound. Mrs X was transferred to ICU at 2220 hours. She was reviewed some time later by the surgical registrar who wrote 'feels better. Tachicardia 144. Transfuse 2 units. Repeat Hb tomorrow'.

Mrs X continued to be short of breath and to complain of abdominal pain. She was given 10 mg of morphine at 0030 hours on Day 4. Arterial blood gasses at 0618 hours showed a pH of 7.24 with a base excess of -6. Her urine output remained poor and her heart rate stayed elevated.

At 0530 hours on Day 4, Mrs X continued to desaturate to 91% on room air. Her pulse rate was 150 and her urinary output had reduced. At 0545 hours she was noted to be drowsy, sweaty and complaining of abdominal pain. At 0620 hours Mrs X's blood gases showed her to be markedly acidotic.

She was reviewed by the surgical team before 0830 hours. She was tachycardic - 140 bpm. For the first time abdominal CT was suggested.

At 0830 hours on Day 4, the ICU registrar for the first time mentioned sepsis and Mrs X was sent for an urgent CT scan of her abdomen. The surgeon who had performed Mrs X's surgery saw her at 1700 hours and noted that the CT showed free fluid in the pelvis and under the liver. Gentamycin was administered. There was no suggestion of the need for a laparotomy at this review.

On the morning of Day 5, Mrs X was noted to be 'unwell'. Her blood pressure was 90/-, her heart rate was 130 and her oxygen saturation was 93% on oxygen by mask. She was peripherally shut down and sweaty. Mrs X was seen again by the surgeon and the possibility of sepsis and intra-abdominal collection was raised. It was planned to resuscitate her and take her to the operating theatre for exploratory laparotomy. At about 0900 hours Mrs X appeared to be about to arrest.

A retrieval team from Careflight arrived at about 1115 hours. They planned to intubate Mrs X before transport. However during the intubation she vomited and aspirated into her lungs. Her lungs were sucked out and she was put on a ventilator. Noradrenaline was started and intravenous fluid resuscitation was given. At 1400 hours Mrs X was transferred to Liverpool Hospital.

Mrs X died that same day. Her husband, Mr X, was told that she had died of aspiration pneumonia. The death of Mrs X was not referred to the Coroner.

The case was initially referred to the acute services review team for review. They started an investigation but, after discussion between the General Manager, Medical Director of Health Services, Area Patient Safety Officer and Director of Nursing & Acute Services, it was decided to establish a team to undertake a root cause analysis, with involvement of the Director of Liverpool ICU.

The root cause analysis conducted by MHS came to the following conclusions about the systemic failures in the care of Mrs X:

- the operating theatre was scheduled late. The scheduling decision made by theatre staff led to the operation being postponed over 48 hours until late on a weekend evening. This contributed to the immediate post-op period coinciding with a time of minimal staffing levels

- a significant deterioration in the patient's clinical condition was not recognised
- a Carepath was not used and therefore variances were not recognised
- the immediate post-op period occurred during the middle of the night
- no criteria exist for sending patients to ICU post-op following unexpected, extended abdominal surgery after hours
- the failure to recognise a critically ill patient was due to the increased workload on the surgical registrar as the patient became unwell on a Sunday when there is only one surgical registrar on duty. The patient was unwell on change-over day, that is the one day of the year when combined change-over occurs
- a surgical focus masked medically based problems
- there were no formal criteria for transfer of patients to a tertiary hospital at that time.

Mrs X's husband, Mr X, complained to MHS about her care. The management of MHS wrote back to Mr X and senior staff from MHS met with Mr X on two occasions to provide feedback on the issues he had raised and to give feedback on the outcome of the root cause analysis.

In February 2001 a surgical audit was started in MHS that reviews all general surgical cases at Campbelltown Hospital.

Our findings

The Commission found:

1. The care provided to Mrs X was unsafe and inadequate for the following reasons:
   - the facts suggest that Mrs X died from a major intra-abdominal complication of her laparoscopic cholecystectomy
   - Mrs X was a relatively healthy patient who had waited eight months for a straightforward elective procedure. It was not appropriate for her to undergo surgery on a Saturday night as an emergency procedure. Only life saving surgery should be done as an emergency procedure
   - there appears to be a lack of appropriate process for identifying cases that will be done as emergency surgery
   - the decision to persist with a laparoscopic procedure for three hours rather than an open procedure was inappropriate
   - it was apparent from Mrs X's clinical picture on the first day post-op that she was very sick. The MET call was appropriate but there was a delay in recognising how ill the patient was and proactively investigating the cause
   - there was a failure to recognise the serious nature of Mrs X's post-operative state and to intervene appropriately
   - investigations were not done to confirm the diagnosis of possible pulmonary embolism
   - ICU failed to diagnose post-operative intra-abdominal sepsis of which there were clear signs.

CASE STUDY • CASE STUDY

2. The death of Mrs X should have been reported to the Coroner even though she died at Liverpool Hospital. The attention of the Coroner should be drawn to this case immediately.
3. Mr X objected to the letter from the General Manager of MHS following the death of his wife explaining what had happened.
4. MHS initiated their own root cause analysis investigation of this case. MHS has given us a timetable of actions to be implemented in 2003 to rectify the systemic problems identified.
5. In recognition of the need to improve the complaints management system (including the quality of written responses) the MHS has begun a process whereby members of the Macarthur Health Community Council review complaints.
6. The ICU at Campbelltown Hospital is not adequately staffed. It does not have a director or permanent staff. It operates, particularly at holiday time, with locums and part time staff. The ICU staff lack emergency medicine or anaesthetic training and are therefore not equipped to adequately diagnose and resuscitate the critically ill patient.

Our conclusions and comments

We identified significant shortcomings in the quality of care provided to a selection of patients by some VMOs and in the support and supervision provided by these VMOs to CMOs and RMOs. The degree and number of deficiencies identified in the care provided to these patients raises serious questions about the reliability of the clinical review systems used at MHS at the time.

There was a lack of critical care skills in the Emergency Departments and the ICU at Campbelltown Hospital. The senior doctors who were on-call to deal with acute admissions or with clinically deteriorating patients were working outside their areas of expertise, a probable reflection of the difficulties in recruitment experienced by MHS. Senior doctors were also absent from the management of their patients and did not supervise junior doctors adequately.

Since the introduction of strategies to improve the efficiency and quality of service in June 2002, there have been four further incidents– incidents 3, 21, 42 and 38 - that relate to the quality of care provided by VMOs. In 2002 there was a plan to audit performance of all staff specialists and VMOs and review VMO appointment criteria. The outcome of the review is not known. However, in light of the investigation of a very small sample of incidents, the credentialing process may be improved by a review of past clinical performance of prospective VMOs.

We also identified a link between unsatisfactory performance by RMOs or CMOs, adverse outcomes for patients, and the lack of direct supervision and leadership of the VMO.

The recommendations in 5.3 are also relevant in this section.

5.6 QUALITY OF CLINICAL CARE PROVIDED BY NURSING STAFF

Introduction

Of the 47 incidents examined, the Commission identified 25 where there were possible issues with the quality of the nursing care given. Of the 25, it was subsequently found to be the case in 21 (84%) cases.

Out of a total of 47 incidents, this issue was substantiated or partially substantiated in 45% of cases. These were incidents 2, 3, 5, 7, 10, 14, 16, 18, 21, 30, 34, 38, 41, 42, 45, 46, 59, 66, 67, 69 and 70. These incidents occurred between June 1999 and January 2003 with most occurring in 2001. One incident occurred in 2001, 13 in 2001, 6 in 2002 and 1 in 2003. Incidents occurred at both Camden and Campbelltown Hospitals.

CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY

Case Study – Incident 5

New born not seen for 102 minutes in emergency department

In mid 2001, a ten day old baby was taken to Campbelltown Hospital ED by his family. He had been suffering with a cough, runny nose and vomiting. The family presented at 1907 hours but were not seen until 2049 hours, 102 minutes later. It is understood that the family approached the desk on three occasions requesting attention. By the time the baby was seen by the triage nurse, he was tachypnoeic, inactive and had blue lips. His oxygen saturation levels were 91%, heart rate was 145 bpm and respiratory rate was 60 bpm. Despite these vital signs he was triaged at category 2, to be seen within ten minutes. Ten minutes later the baby was transferred to the observation ward from where he was taken almost immediately to the resuscitation room.

The paediatric registrar attended and diagnosed severe bronchiolitis with carbon dioxide retention. Oxygen was administered and saturation levels increased to 97%. At 2130 hours, a chest x-ray revealed over inflation of the lungs and some left peri hilar atelectasis was suspected.

At some point the registrar telephoned the paediatric VMO (time not recorded). An IV cannula was inserted and 30 mls of bolus normal saline was administered. Following discussion with the VMO, the registrar outlined a care plan including administration of intravenous ampicillin and gentamicin, repeat arterial blood gases, transfer by newborn emergency transfer service (NETS) for continuous positive airways pressure, nil by mouth and N/2 saline 170 ml/kg, at 15 mls/hour. Capillary gases were pH 7.364 p02 57.9; pCOs 54.7, BE 4.7 and HCO3 31.1.

MHS later advised the Commission that the VMO did not attend the hospital because it was felt that ventilation was not absolutely indicated and the registrar had instituted appropriate management.

At 2155 hours the baby had a respiratory rate of 104/min with tracheal tug.

At 2200 hours the baby was transferred to the special care nursery. On arrival he was described as pink, tachypnoeic with intercostal recession, active and crying. Head box oxygen insitu Fi02 70%, respiratory rate 68, temperature 36.5 and oxygen saturations 100%. BSL was 4.3 mmmol/L.

At 2344 hours the registrar contacted NETS and it was agreed to transfer the baby to an ICU bed in a childrens hospital.

At 0038 NETS arrived and assessed the baby. He was pink and warm in an incubator with head box oxygen 78%. His saturation was 98-100% with increased respiratory rate and chest recession. Reduction in ambient oxygen increased his respiratory effort and it was noted that handling caused increased distress. Consequently, a decision was made to intubate and ventilate before transporting him to a childrens hospital. At 0402 hours, 9 hours after initial presentation at the emergency department, the baby was stabilised and transferred to the ICU at a childrens hospital.

The baby remained intubated in the ICU of a childrens hospital for 2 days. He was then extubated and transferred to the ward.

On the day of the incident, the paediatric registrar completed a problem form reporting the delay in triage. Clinical staff acted quickly. Within five days the MHS internal reviewers had advised the clerk to immediately inform triage of any neonate presentations to ED and recommended the development of a policy for neonates. Six days after the incident, a meeting was held to develop strategies to ensure appropriate triaging of paediatric patients. Key parties were involved including the MHS paediatrician and the Director of Emergency Medicine.

Ten days after the incident the Director of Emergency Medicine confirmed the following changes were underway:

- neonates to be triaged within15 minutes of presentation
- upon initial clerk registration, any neonates to be brought to the attention of triage nurse immediately
- reorganisation and simplification of paediatric resuscitation protocols and procedures
- the ED paediatrician provided inservices to CMOs and RMOs
- inservices for nursing staff were planned on identifying potentially ill infants.

Despite the initial changes, a formal policy on triage of neonates was not authorised for 15 months. In September 2002, MHS triage procedures were authorised in the form of work instructions stating *'Patients are seen by triage nurse first and then directed to clerk for registration. Family members will be encouraged to give information at the registration desk whilst the patient is waiting for triage.'* The work instruction states that infants 1 to 8 weeks are to be triaged in less than ten minutes and are not to be given a triage category of 3 or higher. Children 8 weeks to 10 years are not to be given a triage category of 4 or higher.

During the 15 month period between the incident and the issuing of the MHS triage procedures, a number of staff remained unclear as to the triage policy on neonates, babies and children. Patients also continued to be seen by the clerk before triage.

The Commission has copies of emails dated July and August 2002 from senior staff at Campbelltown and Camden Hospitals which state *'we don't have formal policies re triaging paediatrics… informal policies are to triage children higher than adults and never less than level 4.'* The emails also confirm that, as late as August 2002, patients at Camden Hospital ED continued to be seen by the clerk before triaging.

MHS did not initiate any fact finding to ascertain the cause of the delay in triaging this critically ill neonate or the reason the baby was triaged at category 2 rather than 1 when he was

tachypnoeic, cyanotic and inactive. In its response to the Commission, MHS considered the triaging of this baby at category 2 appropriate. MHS added that the baby was however treated immediately ie as a category 1.

In July 2003, MHS advised the Commission of the introduction of strategies in addition to the triage procedures.

These included:

- the appointment of a staff specialist paediatrician to work in the emergency department
- the introduction of a clinical initiative nurse program (CIP) in July 2002 to improve management in the ED. CIP nurses are rostered to cover morning and evening shifts, seven days a week
- since October 2002, 48 nurses from Campbelltown ED have attended training in triage
- the start of the enhanced emergency service satisfaction project in late 2002 aimed at reducing the waiting times for children in ED
- the opening in December 2002 of a dedicated area for paediatric patients in Campbelltown ED
- data collection on paediatric patients who 'did not wait' indicating a 50 % reduction between August 2002 and February 2003.

In October 2003, the Department of Paediatrics at MHS advised us that since this incident a number of quality initiatives have been introduced. Based on information obtained from audits over the last five years, the following changes have been instituted:

- notes of every child seen in ED are kept for independent audit by a senior staff member the next working day
- extended hours consultant (staff specialist) evening cover from early 2002 ensuring staff specialist or senior registrar coverage until 9 or 10 pm, 3-4 evenings per week
- 24 hour paediatric registrar cover from early 2003
- joint audit meeting with NETS, held on an occasional basis to discuss possible problem cases.

They also offered us access to their files recording all transfers and deaths.

Our findings

The Commission acknowledges the changes outlined by MHS and the Department of Paediatrics, but found:

1. The care provided to the newborn baby was unsafe and inadequate for the following reasons:
   - the family remained in ED unattended for 102 minutes during which time the baby became critically ill
   - the baby was assessed at category 2 instead of category 1.
   - the baby was not examined personally by the responsible doctor despite his critical condition. The serious condition of the baby required the input of an experienced paediatrician, irrespective of whether immediate intubation was assessed as necessary.

CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY

2. In relation to the action taken by MHS in response to this adverse incident:

   - MHS failed to conduct any form of fact finding to ascertain why a neonate was not triaged until 102 minutes after presentation
   - MHS failed to investigate the circumstances occurring before triage or confirm that the family had made repeated requests for assistance
   - clinical staff acted quickly to devise triage guidelines for neonates, babies and children, however these were not formally introduced into MHS policy until 15 months after the event. Staff remained unclear on the procedures for managing paediatric presentations
   - MHS did not alter the process whereby all patients are seen by clerical staff before triaging until 15 months after the incident in apparent disregard of the issue being drawn to management's attention
   - the management response in 2001-02 was inadequate. It failed to put in place measures to prevent further incidents of inadequate care. The changes promulgated by management after notification of the complaint to the Commission are far more likely to reduce the risk of further incidents. Of particular note is the collection of data which is capable of evaluating whether or not policy changes have been implemented and whether the policy is meeting the stated objectives. The Commission approves of such an approach.

CASE STUDY • CASE STUDY • CASE STUDY

Case Study – Incident 70

Management of patient suffering acute psychotic episodes

Ms E, aged 42 years, had a complex medical history relating to brittle insulin dependent diabetes, epilepsy, asthma, and viral encephalitis (1993) percipitating organic psychosis/personality disorder with mild cognitive impairment, hypothyroidism and osteoarthritis. We reviewed medical records relating to three of Ms E's admissions to Campbelltown Hospital - in December 2001, in July 2002 and in December 2002.

Our investigation of the care of Ms E during these admissions is based on a ASCCR memo dated 14 March 2002 indicating that a review of Mrs E's medical record, for an unspecified problem arising during an unspecified admission period, had occurred. The recommendation of the ASCCR was to 'Increase awareness of importance of good medical records.' It appears that significant issues relating to the care of Ms E were not recognised.

Ms E was taken to Campbelltown Hospital ED by ambulance at 0335 hours in December 2001 after cutting her right wrist with a razor blade. Ms E described auditory hallucinations to the triage nurse. She had cut her right wrist in response to these auditory commands.

Ms E was triaged at Level 3 which required that she be medically assessed within 30 minutes. This did not occur for 1 hour 30 minutes. In the meantime, Ms E had absconded from ED at around 0455 hours and was found walking along the road. Although she was attempting to run away, she

was persuaded to return to ED where she was seen by the ED/CMO locum within ten minutes of her return and was prescribed antipsychotic medication. A Schedule II admission was completed.

It is noted that Ms E's blood glucose level (BGL) was taken around 2$^{1}/_{2}$ hours after admission and repeated at intervals of 2 hours, 2$^{1}/_{2}$ hours and 2$^{1}/_{2}$ hours until 1330 hours. Ms E was comprehensively assessed by a psychiatric registrar at 1015 hours – the provisional diagnosis was organic psychosis secondary to encephalitis and ? borderline personality traits. The registrar noted that the VMO would be contacted but there is no record that this occurred. The VMO visited Ms E about 22$^{1}/_{2}$ hours after admission.

Although admission was requested, no emergency bed was available in the psychiatric unit, Waratah House, despite Ms E being acutely psychotic. Her transfer occurred 13 hours after presenting at ED. Ms E was discharged 74 days later.

Ms E presented to Campbelltown Hospital ED in July 2002 at 0048 hours in the company of her husband. She gave a history of relapse of auditory hallucinations that told her to hurt/cut herself. She was also reluctant to sleep due to bad dreams. She was triaged Level 4 requiring that she be assessed within 60 minutes. Despite being acutely psychotic, only one nursing vital observation taken at 0050 hours is recorded for the 5 hours 22 minutes Ms E was in ED. Although well known to the hospital and presenting with symptoms of acute psychosis involving self-harm and a history of wandering away, a decision was made to accept Ms E's 'guarantee not to self harm' and allow her to wait in the waiting area of the ED under the supervision of her husband. When seen by a doctor, it appears that despite confirming the command auditory hallucinations to self-harm, Ms E stayed in the waiting room. There is no evidence that her BSL was taken in ED despite her history of being a diabetic with poor control.

An unidentified doctor saw her at 0230 hours - the provisional diagnosis appears to be 'Psychosis' and the treatment plan was to 'Inform psychiatric reg'. About two hours later, a psychiatric registrar comprehensively examined Ms E. The registrar observed that Ms E was highly agitated, was rocking and unable to cope with the voices. During the assessment she tried to scratch herself with a small pair of scissors and resisted having them taken from her. The diagnosis was organic related psychosis, organic related psychiatric disease and borderline personality disorder. It was decided that her safety could not be guaranteed at home and a Schedule II admission was completed. The registrar contacted the VMO who advised admission to the subacute ward as a category C security risk. Ms E was transferred to Waratah House two hours later, at 0600 hours, where she stayed for 35 days.

Ms E was brought by ambulance to Campbelltown Hospital ED in December 2002 at 1806 hours having experienced a hypoglycaemic episode. She was unconscious when initially attended by ambulance officers who commenced an infusion of dextrose in normal saline IV. On arrival at ED Ms E was drowsy but rouseable. She was triaged as level 3, requiring to be seen by a doctor within 30 minutes. A doctor conducted a thorough assessment one hour and 15 minutes later at 1920 hours and prepared and implemented a management plan for Mrs E's care and treatment. This included BSL levels being taken within two hourly intervals.

However after the initial medical assessment at 1920 hours, there was no further medical review in the ED and no medical review until 0135 hours more than 3 hours after Mrs E arrived in ICU despite her complex history, drowsiness and unresponsive pupils on admission. MHS explained that the ICU medical officer was attending a patient for whom a MET was called. This case

illustrates the impact on patient care in ED, ICU and the MET availability when MET personnel are drawn from the ICU. According to information provided to the Commission, the problem is recognised by MHS, medical staff and nursing staff and the solution requires quantitative and qualitative, as well as resource, initiatives.

Our findings

The Commission found:

1. The care provided to Ms E was unsafe and inadequate for the following reasons:

   Admission December 2001

   - it was inappropriate for an agitated psychotic patient to wait 1½ hours in an ED to be assessed and appropriately treated by a medical officer. During this time Ms E left the ED in a psychotic state increasing the risk of harm to herself or others
   - Ms E was under triaged as Category 3
   - while it is noted that Ms E remained in ED for 13 hours because a bed was not available, the delay was inappropriate given Ms E was clearly psychotic. Emergency admissions to psychiatric units must prioritise and facilitate admission of the acutely agitated psychotic patient
   - no nursing vital observations were recorded on the ED observation chart for almost nine hours, from 0750 to 1635 hours. This is a poor reflection on nursing clinical practice and documentation
   - there was no medical direction given to nursing staff about the need for regular monitoring. However, it is expected that a competent RN would have been aware of the need to monitor the patient and make records.

   Admission July 2002

   - Ms E was under-triaged at Category 4 when she was clearly too acutely psychotic to wait for medical assessment and treatment
   - it was an unacceptable risk and inappropriate to allow an acutely psychotic patient to wait in a general waiting area. She was clearly agitated and intent on self harm by the time she was reviewed by the psychiatric registrar
   - there was a poor admission assessment by the ED doctor and no systematic review of Ms E by ED staff
   - only one nursing observation was recorded on the ED vital observation chart
   - despite a history of poor diabetic control, there is no evidence that Ms E's BSL was taken in ED
   - there were no medical directions given to nursing staff about the need for regular monitoring. However, it is expected that a competent RN would have been aware of the need to monitor the patient and make records
   - there was an unacceptable delay of four hours after being reviewed in ED and transfer to Waratah House.

CASE STUDY • CASE STUDY

Admission December 2002

- although the admission assessment by the MO was appropriate and a good management plan was prepared, there is no evidence of a review of Mrs E after admission at 1920 hours and an ICU registrar review from 2220 until 0135 hours. This was in spite of drowsiness and having unresponsive pupils on presentation
- the VMO was not contacted
- the ICU registrar was contacted by ED staff at 2220 hours and was due to review Mrs E in ED. However, the ICU registrar failed to attend and the patient was transferred to ICU at 0135 hours.

2. In 2002 the CCRC reviewed the medical notes of the patient. The recommendation was to increase the awareness of the importance of good medical records. The Commission is of the view that the review undertaken by the CCRC was inadequate. We have found significant clinical issues. In its s.43 submission SWSAHS noted the Commission's view. We are uncertain whether this is an acknowledgement by SWSAHS of the Commission's finding.

Our conclusions and comments

Thirteen of the incidents raised questions about the performance or competence of the nursing staff, including the failure to recognise unwell, deteriorating or seriously ill patients.

Fifteen of the incidents showed instances or a combination of poor (1), inadequate (8) or no vital observations (8) being taken or recorded. However, in one case, while reviewers found 'poor observations throughout' on the patient's admission, the patient was found to have been triaged well.

In fifteen of the incidents there was poor documentation or a total lack of expected documentation. In a number of cases documentation, or the lack of it, was found to be unacceptable.

In sixteen of the incidents the standard of nursing care was found to be unsatisfactory. This included a lack of teamwork, a lack of effective communication, a failure to call a MET or NET and a lack of continuity of care. In one case the care was 'just within normal limits'.

The review of 25 cases point to worrying indicators in nursing care during that period of time including:

- a lack of attention to nursing standards
- poor quality documentation by nurses in the health care records
- ineffective or poor supervision of inexperienced nurses by senior nurses
- inadequate resources to support quality nursing care
- management systems that failed to enable reporting of unsatisfactory clinical practice, adverse events or 'near misses'
- management systems that failed to provide prompt and constructive feedback on the results of investigations of adverse events, clinical incidents and unsatisfactory performance.

Since 1999, MHS has taken the following action to specifically address the inadequate nursing standards.

These actions include:

- lunchtime educational sessions about MET – March 2000
- education for staff in non-critical care areas in MET calls – began in 2001 and ongoing
- development of a code blue/MET call process and introduction of mandatory notification of VMOs in ED – March 2002
- guidelines for documentation implemented and assessment forms located at bedside in ED - April 2002
- advanced clinical nurse program for ED triage nurses, Campbelltown and Camden Hospitals - April to June 2003
- rotation of volunteer ED staff between Campbelltown and Camden Hospitals - July 2002
- employment of clinical nurse specialist and clerical support officer for acute services review team - December 2002
- diabetic ketoacidosis (DKA) care path completed and implemented - February 2003
- employment of ED support officer and ED clinical initiatives nurse to enhance patient/staff safety and security - February 2003
- a service agreement signed between emergency department and mental health services - April 2003.

In its s.43 submission to the Commission, SWSAHS raised a number of system issues which would affect the quality of nursing services. These include the difficulty in attracting nurses to work in critical care, the under resourcing in nursing infrastructure, particularly Clinical Nurse Consultants and Clinical Nurse Educators. The Commission accepts this submission. The *Health Care Complaints Act 1993* precludes the Commission from making any recommendation in relation to resources. A number of recommendations are made however.

The Commission also considers that a 24 hour on-site psychiatric registrar was required and the on call arrangements in place at the time were not working effectively. Even though MHS had recognised the need for an on-site registrar in late 2001, this was not in place at the time.

Our investigation showed that between June 1999 and January 2003 there were incidents of inadequate standards of nursing care provided in the emergency departments of Campbelltown and Camden Hospitals, the intensive care units and, to a lesser degree, in the medical wards and operating theatres.

The main areas in need of improvement are the:

- competency and performance in aspects of nursing practice, including the recognition and assessment of deteriorating or critically ill patients
- maintenance of quality documentation of general and vital observations, clinical incidents and adverse events by nurses
- relationship and communication between all members of the clinical team, including other nurses, medical staff and allied health staff
- implementation of a coordinated patient management plan that is focused on individual patient needs and clinical condition.

Our recommendations

We recommend that:

5.12 SWSAHS and MHS work with associated nursing academic faculties and nursing professional colleges and organisations to support practice improvement for nursing clinicians at MHS in providing safe and high quality clinical care. There should be ongoing clinical support, guidance and supervision by nursing clinical leaders for less experienced clinical staff. These practice improvements should include:

- an adequate number of senior nursing clinicians and other nursing clinicians to service the local community demand, that is consistent with other service workforce levels, including clinical nurse educators and clinical nurse consultants
- adequate levels of clinical performance and competency, management support, appropriate accessible and proactive supervision, and resources to maintain quality of clinical practice and patient focused care
- the mechanisms to monitor nursing processes
- ensuring there are clear clinical care and treatment guidelines or protocols
- ensuring there are clear guidelines for nursing consultation, clinical support and timely decision making
- adequate communication between all members of the clinical team and a healthy team culture
- a robust preceptor system to provide support and supervision for less experienced nurses until they demonstrate adequate skill and knowledge
- opportunities to rotate through acute care areas in larger hospitals to improve critical care skills
- developing evaluation strategies to monitor progress and improvement in the provision of safe, high quality nursing care for patients.

5.13 SWSAHS and MHS review and enhance the system for routine performance management of all nursing clinicians. This system should be linked to:

- the identification of needs for ongoing development of skills and experience to provide safe and high quality care
- the systems for routine clinical review of care and outcomes
- review and follow up of all clinical incidents, adverse events and 'near misses'.

5.14 SWSAHS and MHS develop tools that enable nursing clinicians to take a problem solving approach to developing and using standardised and individualised patient care plans. These should enable the review of the critical aspects of the care plan with particular reference to clinical observations (including neurological observations), fluid and oxygen therapy and other important aspects of care focus. These should also reflect the joint care and treatment planning and problem solving of the entire clinical team.

5.7 THE MEDICAL EMERGENCY TEAM (MET) AT MACARTHUR HEALTH SERVICE

Introduction

In the 47 clinical incidents reviewed, the Commission identified the use of the medical emergency team (MET) as a possible issue in 15 cases. Of these 15 cases, we found it was an issue in 13 (87%) cases.

Out of a total of 47 cases, we found there were concerns about the use of MET in 28% of cases. These were incidents 13, 16, 17, 19, 21, 26, 34, 41, 44, 62, 65, 68, 69. The 13 incidents occurred between 1999 and 2002 with one case occurring in 1999, four in 2001, and seven in 2002. Incidents occurred at both Camden and Campbelltown Hospitals.

In July 1996 the cardiac arrest team at Campbelltown Hospital was replaced by the medical emergency team (MET). The MET system originated in Australia and aims to improve patient outcomes. It uses early warning criteria to trigger early and critical intervention to meet patient emergency needs. Early intervention has been found to reduce the likelihood of serious complications and death. Regular tracking of MET interventions is essential to ensure the effectiveness of the system, identify potentially preventable events, and implement strategies to improve patient care. A MET can also help ward staff that may have limited experience of acute care.

The effectiveness of the MET system depends on staff awareness of MET criteria. Any staff member can call a MET if the patient meets the clinical indicators or if they are concerned about them. The criteria identify clinical indicators such as level of blood pressure, respiratory rate, pulse rate, oxygen saturation levels and neurological function that warrant MET intervention. For example this could be systolic blood pressure <90, pulse rate <40 or >140, or respiratory rate of <5 or >36.

Details of the MET system are included in the MHS Clinical Manual, laminates attached to staff identification and flipcharts that document emergency procedures to be followed by staff and are located in all wards. Staff are also made aware of the MET system through annual inservice for representatives from each ward, annual inservice to nursing staff, discussion of MET in nursing orientation and one-off education sessions as required.

The proponents of the MET system in SWSAHS recognise that the specificity of the criteria is likely to result in an overcall rate. This is considered an acceptable part of the system and it is essential that staff are not made to feel they should not have called a MET.

According to the information provided by MHS, the composition of the MET teams is:

Campbelltown Hospital

- ICU medical officer
- ICU registered nurse
- department of emergency medicine medical officer
- medical registrar or paediatric registrar
- after hours hospital manager.

Camden Hospital

- Emergency department career medical officer
- ED registered nurse
- after hours hospital manager
- SAPS officer.

Each member of the MET is experienced in or has undergone training in the SWSAHS advanced resuscitation course or in postgraduate critical care. A high level of experience is crucial to the provision of effective resuscitation.

Campbelltown ICU and Camden ED do not participate in the MET system because staff would effectively be calling themselves. ED staff at Campbelltown Hospital only call MET if they are overwhelmed.

Despite the SWSAHS advice that the organisational policy states that a MET call is mandatory when clinical criteria are met, there is some lack of clarity around this in its application. When a patient is clearly identified and there is documentation of a decision 'not for resuscitation' or 'not for MET', a MET call is not essential. A medical officer may also document when a MET call is not required for their patient. However in the incidents we examined, staff and management responses to MET criteria varied when clinical indicators fell marginally, or in some cases markedly, outside acceptable limits. It is possible that there is some reluctance to rely too heavily on the MET because all the team members have full time roles in the ICU or in the ED. Calling a MET means that team members are temporarily removed from the care of their own patients.

SWSAHS has acknowledged there is a conflict between the written policy and current practice and has indicated it intends to change the written policy to reflect current practice.

During the first five years, more than 800 MET calls were made at Campbelltown Hospital. This is equivalent to 1.1% of hospital admissions. The majority of calls were made from the medical and surgical wards.

Since MET was introduced, two major reviews of its use have been carried out at Campbelltown Hospital. In 1998 nurses were surveyed to check the profile of the users of MET. In 1999 a review of the first three years of MET mapped key indicators including the reason for and frequency of calls made. Ongoing monitoring of MET usage and effectiveness at both Camden and Campbelltown Hospitals continues through the monthly recording of the key performance indicators (KPI). The data is collated at the Simpson Centre at Liverpool Hospital. The KPI include frequency of MET call, unanticipated ICU transfers, cardiac arrest rates and unexpected death rates. An effective MET system aims to reduce these events. That is, deaths where there has been no decision to place a 'not for resuscitation order' on the patient's health care record, usually after extensive discussion with the patient, family and clinical team.

The nurse informants advised us of nine incidents where staff breached MET protocol by failing to call the MET when the call criteria were present - incidents 11, 12, 13, 17, 19, 26, 41, 42, 62. We found that these allegations were not substantiated in three instances – incidents 11, 12 and 42. In incident 11 the abnormal electronic blood pressure reading was immediately checked manually and found to be within normal limits. Under the circumstances a MET call was not considered appropriate. In incident 12 MET had been called and had attended. In incident 42 there was insufficient evidence to determine whether a MET should have been called. In another two of the cases – incidents 19 and 26 - it was found that the criteria for calling a MET were present and a MET was not called. However after reviewing all the clinical information, we decided that a MET call was not needed in either instance. The clinical review panels were divided in their view as to whether a MET was required in a number of instances. This division in opinion arose because of the absence of a MHS written protocol stipulating whether the MET system was mandatory or discretionary. There was however a firm view, due to concerns with clinician capacity to accurately detect a critical change in health status, that the criteria should be mandatory.

Of the remaining four cases identified by informants, we concluded that the vital signs indicated that a MET call was warranted but had not been made.

In addition to the cases identified by the nurse informants, we identified another five cases – incidents 16, 44, 65, 68 and 69 - where MET guidelines were not followed. We also identified one incident

(incident 34) where the MET call was made too late and one incident (incident 21) where the quality of care provided by the MET was inadequate.

In most cases the failure to follow the guidelines occurred when the patient's systolic blood pressure dropped below 90 and no MET call was made. On some occasions the drop was significantly below 90. In two patients, their systolic blood pressure was recorded as low as 60 yet no MET call was made. We also noted in the medical records of three patients that MET criteria were encountered on more than one occasion but no call was made. The most significant failures occurred in the case of a patient who presented to DEM suffering cardiac failure – incident 16. She was critically ill and stayed in DEM for 10 hours. During that time MET criteria were triggered on six occasions. On five of those occasions the patient's systolic blood pressure dropped below 90 and was twice recorded to be 60. This was the most serious example of failure to follow the protocol to call MET when MET criteria were identified.

The MET concerns we examined mainly related to staff failure to make a timely call to the MET, rather than to the quality of care provided by MET or the time they took to arrive. However, we did identify one case where the quality of resuscitation by the MET was considered to fall below an acceptable standard of care – incident 21. This was the case of an elderly patient who presented to DEM following myocardial infarction. She was admitted to the ward and the following evening the MET was summoned on two occasions. The first call was made when her blood pressure dropped to 80. Two hours later a second call was made when the patient's systolic blood pressure was recorded to be 83 and oxygen saturation levels were 81%. The patient died soon after and there was no documentation of any resuscitation attempts.

In two cases – incidents 17 and 68 – the failure to call a MET occurred in patients who were elderly and suffering multiple or serious medical conditions. These cases are discussed further under the section on decision making about end of life planning.

The incidents involving MET have shown both the system and staff understanding of it require immediate attention. There is a lack of consistency in the understanding and implementation of MET criteria among staff and management.

Of the nine patient cases identified by nurse informants, five were reported to management in July 2002. The nurse submitted details of the cases and her concerns on unsigned problem forms. An internal MHS review was initiated and a clinical manager reviewed each case. The internal reviewer recommended that a MET was not necessary in any of the five cases and no further action was required.

The basis for the MHS reviewer's recommendations included reasons such as:

- the patient's blood pressure was normally low therefore a systolic blood pressure reading of <90 did not require a MET call
- the patient's medication was responsible for the low reading
- the patient's family knew she was dying therefore a MET call was not necessary for a patient demonstrating airway restriction
- manual measures of blood pressure are more accurate than electronic, therefore a MET call was not required for a patient whose blood pressure was 100 on manual testing following an electronic reading of 80.

These findings suggest that MET criteria are discretionary rather than mandatory. However the nurse's actions in reporting the incidents to management indicate that she has a different understanding of the role of the criteria.

Case Study – Incident 41

Failure to call a MET

Mr NE, a war veteran, was taken by ambulance to the ED at Campbelltown Hospital in mid 2002 with a history of retrosternal chest pain and shortness of breath. He was pale and diaphoretic when leaving his home and suffered a respiratory arrest when being placed into the ambulance. He had a history of cardiac ischaemia.

On arrival at the ED, Mr NE was triaged as level 1. He was seen promptly, resuscitation was commenced and he was transferred to the ICU. The provisional diagnosis was ischaemic chest pain, pulmonary oedema, AF, (R) lung aspiration pneumonia, respiratory acidosis. On arrival at ICU he was intubated and bagged.

Mr NE's progress and care in ICU is well documented. He was assessed and attended by a number of VMO and ancillary staff specialists. He was ventilated with a CPAP positive pressure machine for $2^1/_2$ days before this was ceased. However he experienced respiratory distress and was re-intubated for a further two days. He was transferred to the medical ward on his 8th day after admission. Two days after transfer onto the ward, he experienced respiratory distress and wanted to use the CPAP machine. The EN responsible for his care, wanted to call a MET and claims this request was refused by the registered nurse on duty. The EN did however contact an ICU registered nurse, who came to the ward and assessed Mr NE. The ICU nurse advised the EN that a MET was not required and that the CPAP machine could not be brought out of ICU to the ward. It is claimed the ICU nurse then advised Mr NE to calm down and left. The ICU nurse was in fact part of the MET that is made up of staff from ICU. At the time, the CMO on duty in ICU was attending a clinical emergency.

According to the medical record, Mr NE remained acutely distressed and continued to request to be reconnected to the CPAP machine. The EN claimed that she consulted a registered nurse about the management of Mr NE. In view of Mr NE's respiratory distress, the EN allowed him to have assisted breathing through a hand held resuscitation bag. She reported that after about 15 breaths Mr NE became more settled. Mr NE was stable when the ICU doctor attended around one hour later.

The EN was called for a fact-finding interview at which she stated she was issued a first and final warning about acting outside her role. We were not provided with a record of this interview. However, MHS has advised that the 'first and final warning' was not given to the EN for 'this episode of care', and that 'the EN responsible for the patient at this time should have called a MET …'

The issue raised by the nurse informant essentially related to the response of management to a problem report that the EN had bagged a patient, thus exceeding her role.

Our findings

The Commission found:

1. The care provided to Mr NE was unsafe and inadequate for the following reasons:
   - the MET was not called when Mr NE's clinical signs indicated the need to call the MET in accordance with hospital policy and procedure
   - there was a failure to take appropriate clinical action to relieve the acute respiratory distress of Mr NE
   - in view of Mr NE's medical history and recent transfer from the ICU, there was no coordinated care plan for managing a recurrence of his acute respiratory distress.

Our conclusions and comments

We identified a failure by MHS management to respond to staff concerns about the MET protocol not being followed. This reflects a lack of transparency and accountability in the incident management system at MHS. Based on the available information, it does not appear that management provided appropriate feedback to the staff member who submitted problem reports about the five patient cases. In fact, documentation exists which indicates that the MHS clinical manager who assessed the problem forms criticised the nurse for submitting them on the basis that she was not on duty at the time of each incident.

The internal reviewer reported:

> *'I also spoke with her [the nurse] in regards to her not being on duty for any of these issues and as such had no right to make assumptions about what did or did not occur at the time. That patient files are also confidential.'*

The criticism made by the internal reviewer was unfair and inaccurate. While it is correct to say that the nurse who notified the incident to management was not on shift at the time the incident occurred, the nurse was involved in caring for this patient. Nursing and medical staff are expected to regularly review the medical records of their patients to ensure the effectiveness and continuity of care. Nurses should appropriately report concerns even if unreported by others directly involved. This kind of management response may discourage problem reporting. This example suggests a management culture of blaming and targeting individuals rather than identifying causes and preventative steps.

In March 2003, eight months after the initial internal review, the acute services review committee tabled the five cases submitted by the one nurse. They did not specify whether a MET should have been called in any of the cases but recommended that the matters be referred to the nurse educator for mandatory in-service education on the criteria for calling a MET and the documentation of patient observations. To date we have not been given any information about the implementation of the in-service education or the methods of evaluating its effectiveness.

The frequency with which we identified MET issues indicates the need for a full review of the existing MET system. In a number of incidents the patient was in ICU or in ED, locations where MET are not routinely called. However staff do not appear to be familiar with this protocol. We also have some reservations about a policy whereby ICU and ED are not participants in the MET system. The level of skills and experience of ED medical officers is variable and their knowledge of intubation is also likely to vary. This is particularly the case at night and over weekends when there is a significant reliance on locum medical cover. For this reason alone it is expected that a MET would be required in Campbelltown Hospital ED.

The review of the MET system should include clarifying adherence to the criteria and which departments participate in the MET system. It should also introduce a protocol for documentation in cases where criteria are met but not acted upon, and include a comparison of outcomes between cases where MET did and did not intervene.

The clinical review panels strongly recommended establishing a three month trial period when the MET criteria would be mandatory. However, SWSAHS advises it already has a mandatory policy. Action is required to remove confusion and ensure consistent application of the policy. A trial would be one way of raising staff consciousness but is not the recommendation of the Commission. Key data needs to be gathered and compared to the MET systems at other hospitals, particularly those in the same area health service.

MHS gave the Commission a monthly breakdown of statistics on MET calls and KPIs for 2000, 2001 and 2002. The data was quantitative and lacked qualitative analysis to help interpret trends. The raw data shows a consistent annual increase in the number of MET calls. The data for 2000 and 2001 shows a reduction in the KPIs of unexpected deaths and cardiac arrests. However the data did not lend itself to comparisons between 2001 and 2002 and did not identify either baseline levels to allow comparisons of KPIs before and after the introduction of a MET system or benchmarks against other organisations. This information would allow better analysis of the effectiveness of the MET system in place at MHS.

The Simpson Centre recommends collecting data that identifies whether MET call criteria were present before the call was made and whether action was taken. Data provided by MHS shows that in a significant number of cases, MET criteria were present 24 hours before a MET was actually called. For example, figures for Campbelltown Hospital showed rates of 28.43% for 2000 and 29.15% for 2001 where calling criteria were present 24 hours before a MET was called. Figures for Camden Hospital showed rates of 84.62% for 2000 and 80.95% for 2001.

Given that MET is centrally evaluated at Liverpool Health Service consistent application of MET may be supported by central coordination of the education of staff, credentialing and requalification of MET members. It would also allow more direct organisational links to be developed between MHS and Liverpool Hospital, which is generally recognised as a centre with a high level of expertise in the design and use of medical emergency teams. These links could include joint workshops and the sharing of staff involved in the review and coordination of the MET system. The MET system is presently coordinated through a bi-monthly meeting of key clinicians responsible for its use and for the quality of data collection. The impact of this group is unclear.

Of the 47 incidents we examined, nine cases showed a failure to call MET in the presence of MET call criteria - incidents 13, 16, 17, 41, 44, 62, 65, 68 and 69. One incident (21) indicated a poor standard of resuscitation provided by the MET and another incident (34) indicated the MET was called too late. The Commission considers that there is no evidence to suggest that the overall quality of interventions, once activated is less than adequate.

The failure to call the MET may be linked to:

- lack of clarity about whether following the MET criteria is mandatory or discretionary
- the management response to individual staff about their concerns about the MET system
- lack of clarity as to how, when and whether a patient is classified 'not for resuscitation' and what happens if the MET criteria are met
- the dual roles performed by MET staff influencing other staff when deciding whether to call.

We recognise that MHS has kept monthly data and statistical analysis of key performance indicators relating to the MET system and the utilisation of MET has consistently increased over the past six years. We also acknowledge that in March 2003 the acute services review committee made recommendations about the need for further education on MET criteria.

If the MET statistics for Camden Hospital are accurate, they suggest a high rate of delayed opportunities for MET assessment and interventions. A focused management and clinical response was warranted to ensure patient safety was not being compromised. There is no evidence, apart from the provision of education, that this occurred over a three year period.

Our recommendations

We recommend that:

5.15 SWSAHS commission a full review of the MET system in place across SWSAHS including its application at MHS. This review should include:

- the introduction of benchmarks to establish acceptable rates for each of the key performance indicators and further analysis of the statistics currently being recorded
- clarification on the role and nature of MET call criteria (mandatory versus discretionary)
- the identification of competencies for clinical staff to join MET
- confirmation of which units and departments participate in the MET system and those that are exempt, with the reasons
- the development of protocols to ensure that in cases where MET criteria are present but MET is not called, the reason is documented, even if this occurs in a unit or department that is exempt
- increased centralisation of the administration and evaluation of the MET system to enable consistency of application and improved patient outcomes. This would involve closer links between MHS, Liverpool Hospital and other hospitals in SWSAHS, and the active involvement of staff responsible for coordinating and reviewing MET processes across the area.

5.8 PATIENT DECISION MAKING AND PLANNING FOR TREATMENT AND END OF LIFE CARE

Introduction

Of the 47 clinical incidents examined, the Commission identified patient decision making and planning for end of life care as a possible issue in 10 cases. We subsequently found concerns in nine (90%) of those cases.

Out of the 47 incidents, this issue was substantiated or partially substantiated in 19% of cases. These were incidents 10, 14, 17, 21, 26, 37, 42, 68, 69. These incidents occurred between 2000 and 2002 with three in 2001, five in 2002 and one in 2003. Incidents occurred at both Camden and Campbelltown Hospitals.

The advances in health technology and pharmaceutical agents mean that clinicians can prolong life for people who may not otherwise have survived a disease, injury or health crisis. In some cases this capacity to actively resuscitate and treat a previously fatal condition may compromise a person's autonomy to make decisions about the level of treatment they want and their right to die with some dignity.

If a patient is in the end stages of a terminal illness or is suffering from multiple life-threatening conditions, it is necessary to identify their wishes as early as possible. It is important to discuss the options, decide on the level of active intervention that the clinical care team will take and make sure care plans are appropriate. These discussions should also include family and significant others if the patient wishes or guardian if the patient is unable to participate in the discussions and decision making themselves. If there is no clear understanding of the person's wishes and the clinical team's advice is not outlined in a documented care plan, staff are ethically obliged to ensure all life preserving intervention is made available to the patient.

The decision not to provide active care cannot be made by the clinical team alone, an individual member of the clinical team or even the senior medical staff member responsible for coordinating the patient's care.

CASE STUDY • CASE STUDY

Case Study – Incident 68

Inadequate end of life care and decision making of an elderly patient

Mrs Q an 81 year old woman was admitted to Campbelltown Hospital ED in late 2001 having collapsed at home. She was cyanotic both peripherally and centrally in respiratory distress and had a GCS of 13. ECG showed in inferolateral ischaemia. Clinically there was evidence of right sided heart failure. Her past history included IHD, CAL, NIDDM and AF with pace maker. While in ED Mrs Q was anuric. She had RR of 36 – 40, BP of 108/72, PR of 98/min and her O2 saturation was 84% on a non rebreather mask at 1300 hours.

The ICU registrar was contacted at approximately 1330 hours and asked to review the patient. The registrar advised he would 'see the patient when he could' and advised that there were no beds in ICU. Mrs Q was transferred for a CT scan at approximately 1400 hours but the CT was not attended apparently because there was no creatinine level available. On return to ED, Mrs Q was moved from the resuscitation room to an observation bed. No active treatment was initiated.

At 1730 hours 5 hours after triage, it is documented by an ED medical officer that he discussed with Mrs Q's daughter the 'unsatisfactory condition' of Mrs Q. At 1800 hours ICU staff were contacted again about the availability of an ICU bed for Mrs Q and were told that ICU was too busy to accept her. Also at 1800, it is documented in the medical records that end of life issues were discussed with Mrs Q's daughter. However she did not wish to make this decision without consulting the family. There was therefore no documented 'not for resuscitation' order at this time.

At 1900 hours Mrs Q was reviewed by an ICU registrar who noted her history and examined her. He noted in the records that Mrs Q was acidotic, anuric, had deteriorating liver function and a deteriorating mental state. The registrar queried ischaemic disease and ordered pathology but there is no documented treatment or management plan. There is no information of VMO involvement, although the VMO was apparently notified of Mrs Q's admission while still in ED. There was no documented evidence of a 'not for resuscitation' order.

At 1945 hours Mrs Q was still in ED and was again seen by the ICU registrar following a significant deterioration. Mrs Q was noted at this time to be mentally obtunded and cyanosed with an unrecordable blood pressure but a palpable carotid artery. Her heart rate was 50-100 and her blood ph was 6.95. The impression of the registrar was that the deterioration was due to a massive pulmonary embolus. Again there was no documented management or treatment plan and there is no information of VMO consultation or involvement. There was still no documented information of a 'not for resuscitation' order. There was no evidence of active resuscitation of Mrs Q at this point.

Mrs Q was transferred to ICU at 1930 hours. A nursing progress report at 2100 hours describes the deterioration of Mrs Q and states that, on arrival to ICU, Mrs Q responded to adrenaline, bicarbonate, glucose and insulin but there is no documentation of these medications in the medication charts. There is also no documentation for the 2.5mgs of morphine Mrs Q was stated to have been given when agitated.

At 2400 hours the ICU registrar documented that Mrs Q was asystolic with fixed pupils and no pulse or respirations. She was pronounced dead. The registrar notes that the family was aware and stated he would notify the VMO in the morning.

The case was reviewed by the MHS critical care review committee. Their recommendations outlined in a memo dated four months after the incident were:

- follow policy for bed management. If no bed available after four hours, bed to be sought elsewhere in area
- ED staff education re importance of raising NFR issues.

Our findings

The Commission found that the care provided to Mrs Q was unsafe and inadequate for the following reasons:

- there was a failure to provide active resuscitation, assessment, investigation and treatment and to implement a plan of active management for the patient while she was in ED awaiting transfer
- in view of the lack of any active investigations or resuscitation in the first six hours, the giving of adrenaline, bicarbonate, glucose and insulin in ICU, seven hours after triage when she was already profoundly acidotic and obtunded highlights the confused approach to the management of this patient

CASE STUDY • CASE STUDY • CASE STUDY

- required timely senior clinical supervision and support given the seriousness of Mrs Q's presenting condition but this did not occur
- there was a failure to facilitate transfer of Mrs Q out of the ED and into an appropriate care unit in a timely manner. Although we recognise that bed access is a statewide issue, the delay in the transfer of Mrs Q to an appropriate inpatient area and the use of the ED as a holding ward for a patient in a critical condition was inappropriate
- the ED staff failed to consult with Mrs Q or her family about Mrs Q's wishes about treatment decisions.

The Commission is also of the view that the CCRC only partially identified the contributing causes for the poor care provided. There is no evidence that the actions identified were implemented. The management response was inadequate and would not prevent a reoccurrence.

CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY

Case Study – Incident 10

Resuscitation of patient at Camden Hospital

In late 2001 Mr P, a 63 year old man weighing 200kg, was a patient in Camden Hospital for treatment of cellulitis in both lower legs. Three days after admission Mr P was being bed washed when he suffered a cardiac arrest at 1350 hours. A MET was called and CPR was commenced. The MET team resuscitated Mr P but did not intubate him. He was transferred to the ED at 1435 hours.

Mr P was difficult to intubate and Camden Hospital did not have an anaesthetist on call. A senior nurse contacted Campbelltown Hospital but the anaesthetist refused to provide cover for Camden Hospital. MHS advised the Commission that the anaesthetist at Campbelltown Hospital was not rostered or expected to cover Camden Hospital. Medical retrieval was contacted between 1510 and 1540 hours.

No bicarbonate was given and there was inadequate inotrope support evidenced by his ongoing hypotension and lack of urinary output. For no apparent reason, Mr P's adrenalin infusion was turned off at 1527 hours when his BP was 84/52.

At 1837 hours Mr P still had not been intubated and his third blood gases showed him to be severely acidotic with a PH of 6.9 and a base excess of -18. In the notes it states that a doctor was 'aware of poor prognosis and understands v. poor quality of life.'

The medical notes go on to record, 'In view of poor quality of life...no further treatment...Transfer patient to Liverpool'.

Careflight arrived at 1850 hours and intubated Mr P. He was transferred to Liverpool Hospital at 1900 hours.

Our findings

The Commission found that the care provided to Mr P was unsafe and inadequate for the following reasons:

- a patient who has had a cardiac arrest and remains unconscious needs to be intubated as soon as possible. Mr P was in an unstable medical situation and it was inappropriate to transfer him to the ED unintubated

CASE STUDY • CASE STUDY • CASE STUDY

- Mr P was poorly managed in terms of acute resuscitation in the ED. The resuscitation was delayed and was far from pro-active. Mr P was not intubated until the retrieval team's attendance in spite of his reduced level of consciousness, his unstable observations and his worsening blood gases. For some inexplicable reason his adrenaline infusion was turned off at 1527 hours and not started again until 1624 hours. This was in spite of pronounced hypotension. No sodium bicarbonate was given for his metabolic acidosis and there was inadequate inotrope support until the arrival of Careflight. There is no documentation about Mr P's urinary output
- the staff involved did not appear to be skilled in critical care
- there was a lack of documentation about the monitoring and the transfer procedure from the medical ward to the ED was unacceptable because Mr P was grossly unstable at this time, unconscious without a secure airway
- the medication charts did not record the amount of adrenaline or fluid received with resuscitation in either the ward or the ED
- the incident demonstrates a need for clearer end of life planning and decision making processes. Of concern is documentation in the notes that Mr P should receive no further treatment because of his poor prognosis yet the next line records that Mr P is to be transferred to a tertiary hospital.

Our conclusions and comments

Often health professionals are concerned about their legal responsibilities if a patient requests the right to reject medical intervention or emergency life saving measures. Health professionals in New South Wales need to be familiar with local, area or state policy and guidelines (such as the Department of Health document 'Dying with Dignity: Interim Guidelines on Management'[1]) and with the accepted ethical guidelines and conduct standards of their profession. These will help practitioners to ensure the patient receives the best level of care in keeping with patient and/or family wishes and minimise the potential for conflict later. We note that the interim guidelines still need to be finalised.

Patients have the right to make decisions about all aspects of their treatment, including the rejection of treatment. Health practitioners must respect the rights of all patients and should know their personal values and wishes[2]. Cardiopulmonary resuscitation should not be instituted if it is contrary to the patient's wishes or expectations. If possible, this issue should be discussed with the patient and/or family as part of a broader care and treatment planning discussion well before the event.

Medical practitioners must make sure that information about prognosis and treatment options is clearly conveyed to the patient and the patient is given sufficient time and support to participate in decision making. It is essential that discussions are initiated at an early stage of a life-threatening illness or when it is likely that a patient is at the end stage of life. This gives the patient and family more time to consider their options and discuss the issues with, for example, other family members or clinicians.

The senior medical officer coordinating the patient's care should document their discussions including details of the patient's or family's wishes and any directives identified by the patient or family. A management plan should then be developed in conjunction with the clinical team. This plan should be fully outlined in the patient's health care record – it should identify goals and type of treatment and circumstances under which treatment should be foregone. Even if a decision about future intervention is not made by the patient or family, any discussions should be written up in the patient's health care record.

There appears to be a wide variation throughout the NSW health system in the development and implementation of policies and procedures for managing end of life care. This is further compounded by differences in individual staff member's interpretation of and familiarity with any policy or guidelines.

MHS first drafted a policy on 'not for resuscitation' in May 1997. The policy recommended medical staff discuss the issue of resuscitation with patients and document the outcome. In November 2001, a 'Special Care Plan – Not for CPR Order' was introduced and continues to be used by palliative care services. However adoption at a wider level has not occurred. In late 2002, early 2003 SWSAHS established a working party to identify a protocol on 'not for resuscitation' (NFR).

During our investigation, we identified ten instances where there was no information on end of life planning despite evidence that the patient was critically ill or dying. We are critical that in these cases discussions about the patient's wishes relating to their end of life care were not initiated, were not documented or occurred too late in the admission to give the patient or others adequate time for consideration and consultation.

Our overall impression of the management of these patients was that the care fell somewhere between passive and active management because of the absence of any end of life planning. Resuscitation was not attempted, despite the absence of not for resuscitation documentation, or if it did occur it was not active. The patients' health care records often showed a lack of consistency in the approach of different practitioners and an absence or lack of involvement by staff specialists. The lack of formality about patient care planning and management led to staff making decisions about resuscitation on the spot without reference to a reasonable clinical opinion or the patient's own wishes being known.

Two of the cases we reviewed illustrate a failure by clinical staff to adequately plan and document end of life discussions – incidents 17 and 68. It seems that staff understood the patients to be not for resuscitation and consequently did not call a MET or initiate active resuscitation when critical signs were noted before the patient's death. This was despite the absence of any documentation to support such a decision.

In the absence of a clearly articulated approach to decision making and planning for treatment and end of life planning, the patient and/or family are excluded from end of life decision making. The clinical team's intervention can also be inconsistent and can appear insensitive and ad hoc.

We acknowledge the earlier efforts of MHS to introduce a policy on end of life decision-making and the recent actions of SWSAHS in establishing a working party.

Of the 47 cases we examined, nine patients' health care records indicate an inconsistent approach by the clinical team in regard to end of life planning and decision making. As a result, staff sometimes make decisions not to provide active resuscitation for some patients despite there being no documentation to support such a decision and relatives not having been involved. Wherever possible the clinical team should follow Department of Health interim guidelines by discussing and documenting the preferences of patients, guardians or next of kin. The attending or admitting medical officer, in consultation with team members, should then outline the care plan in the patient's health care records.

The focus on 'not for resuscitation' is misleading and tends to suggest a unilateral decision making process by clinicians without involving the patient or a patient's significant others. The emphasis should be on patient decision making and planning for treatment and end of life care.

Our recommendations

We recommend that:

5.16 DOH finalise the policy replacing the 'Interim Guidelines for Dying with Dignity' within six months to clarify the rights and responsibilities of the the community, clinicians and health organisations for decision making and planning for treatment and end of life care. The policy should include an implementation strategy for area health services.

5.17 SWSAHS formally re-issue instructions that all clinicians, including senior or admitting medical officers, are to follow the 'Interim Guidelines for Dying with Dignity.' The attending or admitting medical officer must:

- initiate discussions with the patient and/or family about patient decision making and planning for treatment and end of life care
- ensure discussions occur expeditiously to allow the patient and family time to make informed decisions
- consult with members of the clinical team about the patient's decisions and the plan for treatment and end of life care
- document the content of discussions in the patient's health care records
- ensure that staff responsible for a patient's care are aware of decisions that have been made about treatment and end of life care
- document clear medical orders in relation to resuscitation including what treatment should be started, continued, withdrawn or withheld and the reasons for it.

5.9 COMMUNICATION WITH PATIENTS AND FAMILIES

Introduction

Of the 47 clinical incidents examined, the Commission identified communication with patients and families as a particular issue in eight cases. We subsequently substantiated that in seven (88%) of those there was a failure to adequately communicate with patients and family members, particularly where the patients were more vulnerable because of age or severe illness.

Out of the 47 incidents, this issue was substantiated or partially substantiated in 15% of cases. These were incidents 1, 3, 15, 21, 39, 42 and 61. These incidents occurred between 2001 and 2003 with 2 in 2001, 4 in 2002 and 1 in 2003.

The changing role of health care consumers has been well documented.[3] It has changed from a passive recipient of services to action partner with the health care professional. This change has been challenging for health care professionals because their long years of training have equipped them with a knowledge base they are expected to 'apply' to 'cases' and because their training is socially and culturally isolating.

It has also been challenging because of rising consumer expectations of what medicine can do for them, partly due to the well publicised advertised advances in medicine. Consumer expectations need to be managed by the publication of data on adverse patient outcomes and by health professionals discussing all of the material risks associated with treatment.

The change in the role of consumers is also challenging in the hospital system where demand on clinical teams is high and the proportion of patients with chronic and complex health needs has grown. Communication reaches crisis point when outcomes are not good or there are adverse events.

CASE STUDY • CASE STUDY • CASE STUDY

Case Study – Incident 42

Uncoordinated care of an elderly person with post operation infection

In mid 2002 Mrs KC a 72 year old woman, was transferred from a private hospital to Campbelltown Hospital, 16 days postoperatively for insertion of dynamic compression screws for fractured lower neck of femur at Liverpool hospital. She had a past history of non-insulin dependent diabetes, hypertension congestive cardiac failure and depression. Mrs KC had been bleeding from the surgical site for a number of days and was readmitted under the orthopaedic VMO. She had been on Flucloxacillin and was noted to be jaundiced.

On day 3, Mrs KC went to theatre for cleaning out and resuturing of her wound.

One day 4, a psychiatry review was organised for depression, anxiety and medication refusal. The psychiatrist diagnosed an adjustment disorder and depressed mood. He felt her analgesics were contributing to her night time confusion.

The orthopaedic team appropriately contacted the Area Professor of microbiology on a number of occasions in relation to wound infection, abnormal LFT's and antibiotic choice.

On day 9, Mrs KC's serum potassium dropped to 2.1, she passed a large melaena stool. She was given IV Potassium and oral Chlorvescent. Despite ongoing bloody ooze from her left hip wound

and abnormal LFT's, there was no investigation of this bleeding. There was also no discussion with her family, who were in frequent attendance about diagnosis, prognosis or management of their relative. The family were unable to ascertain who was the medical officer directly responsible for their relative's care.

At 1830 on day 9, a MET was called when Mrs KC was found unresponsive by nursing staff. Although Mrs KC appeared to recover quickly, electrolyte imbalance, low haemoglobin and fresh wound blood were noted. Despite this critical incident, there was no VMO involvement or family consultation.

Over the subsequent week, Mrs KC's condition continued to deteriorate, as recorded in the medical records. Her first INR was ordered on day 12 and was found to be 12.1. Mrs KC's LFT's were again noted to be elevated and she was treated with Vitamin K, FFP and her Clexane was ceased. Mrs KC was transferred from Ward A to ICU without any involvement of her VMO physician.

Once again, there was no discussion with any family members in relation to Mrs KC's decline. The following day a VMO physician discharged Mrs KC from ICU to Ward C, not Ward A where she had previously been, thereby making continuity of care for nursing and medical staff more difficult.

The family were increasingly frustrated by their inability to access information about their relative's medical condition. They were seen by a Social Worker, however no relevant team member was available to address their concerns.

There are nursing entries recording Mrs KC's increasing withdrawal, anger and refusal of medications. She was eating poorly and was becoming nutritionally depleted.

By day 17 Mrs KC's potassium was 1.4, She was given oral Chlorvescent. The orthopaedic RMO finally formalised the consultation process with the VMO physician by arranging "shared care". There is no record that the attending VMO orthopaedic surgeon was informed of this arrangement. Again there was no clarity about who bore ultimate responsibility regarding clinical decisions and management of this patient.

On day 18, both the VMO orthopaedic surgeon and physician reviewed Mrs KC however no proactive treatment or investigation was recommended other than proposing an abdominal CT. Both teams failed to discuss the situation with the family.

Between day 19 and day 22 Mrs KC became increasingly drowsy and oliguric. The CT was performed but was not reviewed for 48 hours. The family were anxious about their mother's clinical decline and were unable to identify any relevant medical officer with whom to discuss their relative's management.

Again there was no senior clinical involvement in decision making, despite a marked deterioration and increasing pulmonary oedema. The medical registrar commenced Lasix and GTN patches. There was no VMO consultation.

On day 23 at 0510, nursing notes document that Mrs KC's respiration had ceased and that an RMO had been contacted. Although the family specifically stipulated that their father, who had a

severe heart valve problem, was not to be contacted in the event of their mother's death, the nurse on duty rang Mr KC at this time. This caused great anguish to the family.

There was no MET call made. Given that there was no 'not for resuscitation' order in the notes and there had been no end of life decision making or discussions held with Mrs KC or her family, a MET call would have been appropriate.

Mrs KC's family described the experience as completely alienating. They felt that no one was taking their concerns on board and that in the last week of their mother's life her management seemed even more disorganised. The family stated that their mother waited days to see a doctor responsible for her care. The description of their experience was that it was *'like trying to find your way to somewhere, when your life depends on it, without a map in a foreign country where you don't speak the language.'* They felt the system lacked compassion and didn't seem to appreciate the vulnerability of the elderly. Families of such patients are an invaluable resource in both information sharing and caring, and should be an active participant in care and treatment decisions.

Our findings

The Commission found:

1. The care provided to Mrs KC was unsafe and inadequate for the following reasons:

- there was a lack of VMO supervision and no comprehensive management plan
- there were days when Mrs KC was not reviewed by the orthopaedic team, even though her condition was clearly deteriorating
- reviews conducted were done by the intern and medical registrar, not the VMO
- there was no review by the orthopaedic team for six days, despite copious wound discharge from the left hip at the suture line site
- it does not appear that any VMO was asked to review Mrs KC about her drowsiness, low urine output and abnormal electrolytes.

2. There was a persistent lack of communication and consultation with Mrs KC's family who were not informed of her diagnosis, prognosis or management plan.

   In a further case, a man wrote to Campbelltown Hospital asking for an explanation for the death of his relatively healthy young wife after what was regarded as a straightforward surgical procedure – incident 39. The General Manager wrote a letter in reply to which the husband took offence.

   SWSAHS advised the Commission that its analysis of complaints data has shown that staff communication was frequently the source of consumer complaints, particularly in high pressure areas where patients may be in pain. The SWSAHS initiative to ensure that consumers who complained are commonly given the opportunity to meet face to face with senior clinicians to discuss issues is a welcome change. While SWSAHS has identified communication as an issue, its action plan to address it is not specific.

Our conclusions and comments

Effective communication between the clinical team and patients and their families is critical to safe, quality care because it:

- can alert the clinical team to risks and needs particular to an individual patient
- addresses the expectation of patients and their families that they will be informed about possible diagnoses, prognosis and any significant change in patient condition
- helps patients and their families make informed care and treatment decisions in consultation with the clinical team
- informs patients and their families about their clinical management plan
- allows any misunderstandings or concerns about inadequate care by patients or their families to be addressed
- minimises aggression in health services
- promotes a partnership framework in the delivery of care.

Consumer views are a critical source of performance feedback. The incidents suggest the staff and management at MHS tended to respond to the concerns, dissatisfactions or unanswered questions raised by relatives in a guarded manner rather than openly and with sensitivity. Also, staff appeared to lack a partnership framework with family and relatives in the delivery of care.

The efforts of MHS to improve consumer participation at a planning and management level are good. The philosophy behind consumer participation and partnership is not yet fully reflected in management frameworks, nor in the delivery of services to individual consumers. Its progress would be equivalent to a number of other health services.

The recognition of a partnership based model by the health system and SWSAHS may provide staff with a framework which assists them in knowing when to share clinical information, when to involve families in decision making and how to communicate appropriately with patients and their families.

Our recommendations

We recommend that:

5.18 MHS provide ongoing education and training to all clinical staff to improve their skills in interpersonal communication, conflict resolution, negotiation and open disclosure to enable communication and complaints to be conducted in a sensitive and open manner with patients and families.

5.10 COORDINATION AND CONTINUITY OF CARE

Introduction

Of the 47 clinical incidents examined by the Commission, we identified coordination and continuity of care as an issue in 13 cases. Of those 13, we were concerned that the adequacy of care in 10 (77%) cases was affected by a lack of coordination and continuity of care in the management plan or patients' health care records.

Out of the 47 incidents, issues involving coordination and continuity of care were substantiated in 21% of cases. These were incidents 1, 2, 16, 21, 23, 26, 38, 41, 42, 70. These incidents occurred between 2000-2003 with one in 2000, four in 2001, five in 2002 and one in 2003.

Coordinated care involves developing a patient management plan and making sure that this plan is communicated both verbally through handover and in writing in the patient's health care record. The plan acts as a link between individual team members, different teams of carers, and different health practitioners. Continuity of care ensures that where care is provided by different specialities and different functional groups, quality care can be delivered as safely as possible. It ensures the treatment plan started in one location is continued in another eg between the hospital and the GP or from the medical ward to the psychiatric ward or between the ward and the x-ray department.

Coordinated care ensures that the right services required by the patient are provided at the right time by the right people. It ensures that the appropriate care or monitoring is provided and the quality of that care is not compromised by misunderstandings or miscommunications. It also guards against shortfalls in staff competency by ensuring that staff caring for the patient have clear instructions and guidelines. Coordinated care supports inexperienced, locum and busy staff to deliver safe care.

Senior medical staff are required to supervise and coordinate care as they have primary clinical and medico-legal responsibility for the patient's clinical management. They must have an active involvement in formulating a diagnosis and an investigation plan and ongoing clinical management.

More junior medical staff, nursing staff and allied health staff also have a responsibility to have input into patient care and management decisions. CMOs and RMOs are required to comprehensively clinically assess a patient and liaise with nursing staff in regards to a patient's needs, current observations and monitoring requirements. They should review the patient at least once a day and be alert to any significant change in the patient's clinical status. If there is a change, they should advise the senior medical officer accordingly. All staff are expected to liaise with patients and their families about issues that might arise in the course of their illness, including any treatment decisions that need to be addressed.

In the 11 incidents we reviewed that fell into this category, there was a lack of a documented or communicated plan of management for each of the patients that contributed to or resulted in an adverse outcome for those patients.

CASE STUDY

Case Study – Incident 23

Patient died 16 hours after discharge from emergency department

In late 2001, a 52 year old woman was taken by ambulance to Campbelltown Hospital ED with a recent history of three days of continuous sharp pain in the left flank. She had a history of hypertension. The previous day she had seen her general practitioner who prescribed amoxyl and voltaren. However during the night her pain increased.

CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY

On arrival at the ED, Mrs T was sweating and moaning. She was assessed by an ED locum medical officer who diagnosed renal colic and advised that, if pain continued, a chest x-ray should be taken. The locum medical officer outlined a management plan stating that if blood samples and urine tested normal, Mrs T could be discharged home. However if the white cell count was elevated she would be admitted and treated for pyelonephritis. Haematology results showed mildly raised levels of white cells (15.8), neutrophils (12.3) and monocytes (1.3) and reduced haemoglobin (95).

Soon after arriving at the ED, Mrs T was administered morphine (5mg) and maxolon (10mg) and indocid (50mg). Over the next couple of hours ceftriaxone (1g) and gentamicin (240mg) were administered. Vital signs indicated hypotension and tachycardia with a pulse rate between 90 and 130. Nursing observations were taken only once in a six hour period and two apparent anomalies in blood pressure readings were not manually checked. The accompanying nursing notes were brief.

Ten hours after first presenting to the ED, Mrs T ate a meal. The medical officer on duty consulted the VMO by telephone and relayed that the patient was pain free, tolerating food and feeling well. On the basis of this information, the VMO agreed to discharge with follow up by the GP. The actual time of discharge was not recorded. The discharge summary recorded a diagnosis of urinary tract infection and suggested follow up by the GP.

Less than 16 hours later, Mrs T was brought back to the ED. She was confirmed dead on arrival. The matter was referred to the Coroner but the hospital did not obtain an autopsy report. We requested a copy of the Coroner's report which confirmed cause of death as *'Dissection of the thoracic aorta caused by aneurysm of left internal mammery artery, possibility of connective tissue disorder'.*

In response to the critical incident, a nurse manager submitted a problem report and sent details of the incident directly to one of the senior hospital managers recommending the need for 24 hour medical registrar cover and suggesting a review of the incident by the critical care committee. The response from the senior manager was critical of the wording of the nurse's report and queried the need for medical registrar coverage.

The incident form was reviewed by an internal MHS reviewer. Strategies identified by the reviewer included:

- the need for better documentation for nursing staff on the effects of treatment
- better monitoring of hypotensive patients
- closer observation of patients in cubicles
- ensure pathology results are reviewed before discharge.

The incident was reviewed by the critical care committee without the benefit of the Coroner's findings. As a result of the committee's review, the emergency nursing assessment form was revised and re-issued one year later. The revised form provided space for an assessment plan.

Our findings

The Commission found:

1. The care provided to Mrs T was unsafe and inadequate for the following reasons:
   - there was a failure to recognise the severity of her condition when the patient attended the ED
   - there was a failure to recognise the significance of Mrs T's hypotension, despite the patient having a history of hypertension
   - there was a failure to recognise the significance of the patient's ongoing hypotension and tachycardia at discharge
   - there should have been a review by a senior medical officer
   - the diagnosis of thoracic aortic dissection is difficult and it would not be expected that such a diagnosis could have been made in the 12 hour period following presentation. However, the patient's worrying vital signs meant that she should have been kept in hospital for further observation with a view to transfer to a tertiary facility if critical signs warranted
   - there should have been close monitoring of vital signs in the presence of hypotension and tachycardia.
2. The Commission considers the action taken by MHS was inadequate for the following reasons:
   - a full medical review of this incident was required but did not occur
   - the revision of the emergency nursing assessment form did not address the critical issues apparent in this case
   - the senior manager's informal response to the nurse who reported the incident was dismissive
   - appropriate remedial strategies should have included those identified by the internal reviewer, but not acted upon by the CCC. Remedial strategies were required to ensure improved nursing monitoring and thorough documentation, improve communication between more junior medical officers and VMOs, including full documentation of that communication, and increase the presence of medical registrars in ED
   - the failure of MHS to adequately respond to this incident has resulted in the loss of an opportunity to improve the quality and safety of care at MHS.

It is understood that the Director of Medicine appointed in January 2003 is working closely with VMO physicians to ensure the timely review of patients.

In its response SWSAHS advised that MHS had systems in place for the documentation of clinical management plans for patients and that care paths which created standard care plans had been in use since 1995. Many of the incidents reviewed showed that plans did not exist, were not carried out or not carried out soon enough.

Our conclusions and comments

The incidents reviewed showed there was inadequate coordination of care within clinical teams and it impeded appropriate delivery of care and ancillary services. While clinical management plans and clinical system pathways may be documented, they were not effectively executed in these incidents. The application of what might otherwise be appropriate protocols were absent. Gaps in care plans have been identified elsewhere in the report.

SWSAHS advised that multi disciplinary review meetings at various intervals, sometimes weekly, occur. These meetings review all patient careplans. These reviews if occurring weekly will not address the poor coordination and the capacity to affect plans identified in the incidents.

The triage sheet and request for admission form will assist in the early identification of necessary elements of an individualised care plan.

Our recommendations

We recommend that:

5.19 SWSAHS and MHS require, as a matter of policy, that at the completion of each patient admission the admitting medical officer documents:

- a comprehensive clinical management plan for the patient, in consultation with the responsible senior medical officer, that is reviewed routinely as part of the clinical review process by the team
- a checklist for nursing staff that explains the monitoring requirements needed for that patient and any other critical elements of the care and treatment that need to be immediately noted and followed by nursing staff.

This should be audited as part of the routine audit of health care records.

5.11 RELATIONSHIPS AND COMMUNICATION WITHIN AND ACROSS CLINICAL TEAMS

Introduction

Of the 47 clinical incidents examined by the Commission, team communication was identified as a possible issue in 14 cases. A feature of a number of these cases was the lack of collegiality or effective communication within the group of clinicians responsible for the care of patients within a clinical unit. This is symptomatic of poor team work. We subsequently found that team communication was an issue in 12 of these cases (86%).

Out of a total of 47 incidents, this issue was substantiated in 26% of cases. These incidents were 1, 2, 7, 16, 21, 22, 23, 38, 39, 43, 65, and 69. These incidents occurred between 2001-2003 with seven occurring in 2001, two in 2002 and two in 2003.

Teamwork is defined as a cooperative effort by members of a team to achieve a common goal[4]. It is increasingly evident that improved teamwork can have a profound impact on patient care in the acute care setting.[5] It is especially important in an acute care setting as there is often no opportunity for lengthy discussion of differences – a multidisciplinary approach to patient care must be driven by a common understanding of collective objectives to be effective.

CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY

Case Study – Incident 1

Nurses disciplined after an open dispute about patient safety in the operating theatre at Campbelltown Hospital

In January 2001, Ms Z aged 10 was admitted to the paediatric ward in Campbelltown Hospital at 1200 hours for a closed reduction of a fracture in her forearm. This was not an emergency procedure. The fracture had been set in the ED five weeks before. No medical admission was done.

Ms Z was transferred to the OT at 1420 hours. No pre-operative assessment had been done.

Ms Z has a family history of malignant hyperthermia that is a significant risk factor for general anaesthesia. The NUM of the operating theatres, contacted the Director of Medical Services who instructed that the head of anaesthetics should be consulted before proceeding.

The anaesthetist for the afternoon emergency cases was an anaesthetic CMO. The CMO started taking a history from Mrs Z, Ms Z's mother, standing at the front door of the operating theatres at about 1500 hours. The corridor was very busy at the time.

While the CMO was taking the history from Mrs Z, the NUM asked to speak to the CMO privately. The NUM expressed her concerns to the CMO and suggested that the procedure should be postponed because:

- Ms Z had a possible family history of malignant hyperthermia
- the anaesthetic equipment had not been appropriately flushed out
- a supply of the antidote drug Dantrium was not available
- there was not a VMO anaesthetist on site

- a full pre-operative assessment had not been done
- the surgical procedure was not urgent
- it was more appropriate for Ms Z and her mother to go back to the ward for a proper work up
- the Director of Anaesthetics was being contacted about the case.

The CMO continued to take the history from Mrs Z and asked Mrs Z to contact a family member by phone to obtain more details of the family history of malignant hyperthermia. After contacting the relative, Mrs Z passed the phone to the CMO. Mrs Z felt that the CMO was rude. She could hear the telephone conversation with her relative and she felt that the CMO was getting the information muddled up.

Another nurse started her shift as the NUM of the operating theatres and the previous NUM asked her to take over the matter. The second NUM asked the CMO to discuss the matter in the NUM's office. They disagreed about whether it was appropriate for the CMO to continue taking the history and about the reasons Mrs Z was becoming upset.

The Director of Anaesthetics instructed the CMO to contact the VMO anaesthetist on call. The NUM indicated that the operating theatre could not remain on standby waiting for the VMO anaesthetist to arrive. The NUM asked the CMO to make the decision to postpone the operation.

The NUM sat with Mrs Z until the anaesthetist arrived. Mrs Z then discussed the options with the CMO and the anaesthetist. Mrs Z felt that the CMO was prepared to put her daughter's life at risk and decided that she wanted her daughter transferred to Liverpool Hospital.

Two days later, the CMO put in a written complaint to MHS management alleging that the NUMs had intimidated, degraded and humiliated her in front of the patient and Mrs Z.

MHS management investigated the CMO's complaint and made recommendations in their investigation report two months after the incident. The recommendations covered policies and procedures for pre-operative assessment but also included a formal warning to both the NUMs.

The second NUM submitted an incident report three months after the incident. One week later another registered nurse also lodged an incident report about the CMO. As a result the General Manager of MHS conducted some fact finding interviews. In response to concerns raised by three nursing staff, the General Manager decided to suspend the two NUMs on full pay.

The response by MHS to this incident is analysed in greater detail in Part 6 of this report.

Our findings

The Commission found:

1. The care provided to Ms Z was unsafe and inadequate for the following reasons:
   - there was a failure to recognise and document the anaesthetic risk and ensure that appropriate safeguards were implemented in response. The malignant hyperthermia risk should have been clearly identified, the risk to Ms Z should have been explained to her and her mother and the anaesthetic department should have been notified

- the risk was exacerbated by communication difficulties with the family and within the clinical team
- there was an inappropriate pre-operative assessment and communication between the clinical staff
- the clinical situation warranted a specialist anaesthetist to be directly involved with the patient's care.

2. There were a number of systemic and other issues raised by this incident as follows:
   - the mother of the young patient expressed her distress at the anaesthetic CMO's communication in a letter of complaint to MHS. The communication was described as inappropriate
   - apparently there was no established mechanism for members of the clinical team to express concerns to management about the competence of other members of the team
   - apparently there was no mechanism for members of the team to express urgent concerns about patient safety in relation to a proposed treatment
   - the incident demonstrates a lack of adequate anaesthetic supervision at the time of the incident. We note that management took appropriate actions in 2002 to improve clinical competence through a program of training, education and supervision.
   - there should have been an existing protocol/guideline for patients with a family history of malignant hyperthermia, including how to prepare the anaesthetic machines
   - there should be a system of six monthly performance management reviews that would have picked up on-going performance concerns in relation to the clinical staff
   - there was a dispute between medical and nursing staff in front of the patient and her mother. Disagreements are an inevitable part of a multidisciplinary team, but there needs to be appropriate ways to resolve these
   - there was a breakdown in teamwork without the necessary systems in place to address the breakdown.
3. It is not clear that the CMO was only taking a history and had no intention of performing the anaesthetic on Ms Z without the VMO in attendance. The CMO had apparently stated '…I wanted to do the case myself, without consulting VMO'.
4. The disciplinary action taken against the two NUMs over this incident was inappropriate for the reasons set out in Part 6.
5. The nurses as members of a clinical team must be able to raise concerns about safe practice and to be listened to respectfully if clinical teams are to provide safe care. In this case the nurses had legitimate safety concerns and professional obligations to raise them.

Our conclusions and comments

Equally problematic for continuity and coordination of care is a lack of cooperation and shared ethos between clinical teams that can impact negatively on patients' care and outcomes. This 'problem' was also identified in the incidents we reviewed.

In two incidents, nursing staff were apparently not made aware by medical staff of the serious nature of a patient's clinical condition and the need for them to closely monitor that condition. In addition there were no documented orders for the nursing staff to follow in providing care.

In another incident, poor communication between emergency department clinical staff and the clinical staff in the medical ward to which a patient was transferred resulted in a misunderstanding about the nature of the patient's clinical condition. This led to an adverse outcome that may have been prevented.

In three incidents there was poor communication between the emergency department and the mental health service about patients who presented to the ED needing specialised care and treatment – incidents 22, 59 and 60. In incident 22 there is evidence of multiple problem forms being submitted over a period of 15 months, together with a number of emails. The issue was not effectively responded to by management.

Communication issues in the operating theatre suite at Campbelltown Hospital included a dispute between a doctor and a nurse over the anaesthetic management of a paediatric patient that occurred in the presence of the patient and his mother – incident 1. There was also an incident of poor communication between theatre staff members about their respective roles and responsibilities. This resulted in the fall of an anaesthetised patient from the operating table – incident 7. In another incident, there was failure to adequately communicate with clinical staff responsible for the post-operative management of a patient that the lengthy and difficult nature of the surgery performed could result in post-operative problems.

Poor communication with other hospitals about patient transfers occurred in three instances - one where a patient was being transferred from Camden to Campbelltown and the others where the transfer was from Campbelltown to Liverpool - incidents 34, 44 and 63.

Quality activities may be initiated at a team or department level after the identification of a risk or an opportunity to improve the safety and quality of health services.

Clinical teams at MHS may identify risks and improvement opportunities by:

- reporting an incident, problem or risk
- analysing service data, audit results, cases reviews or patient outcomes
- having input to local climate surveys, team planning days and other feedback to managers
- reviewing new research, evidence and policy
- a request from a MHS committee
- referring an issue for consideration by senior management or MHS executive.

In each case the quality activity initiated varies depending on the impact and likelihood of risk and the complexity of the issue. For example, a problem incident report may identify a simple risk that can be immediately addressed and eliminated. On the other hand, analysis of variance data or a review of a

number of cases may identify a systemic risk that can only be addressed by forming a multidisciplinary team to implement quality activities under the PDSA cycle.

Once begun, quality activities within departments are monitored within the normal management processes of the organisation. This is particularly true of simple activities and activities that can be implemented by individuals or one department. These include performance management, regular department meetings, supervision arrangements and ongoing risk assessments.

Specific strategies are used to monitor the implementation and outcomes of more complex quality activities.

These include:

- developing project action plans, including clear statements of responsibility, milestones and key performance indicators
- appointing an executive sponsor, especially for cross continuum projects
- having timelines for progress reporting such as to the relevant MHS committee or executive
- conducting surveys, reviews or informal evaluation of the impact of quality activities.

Quality activities are also supported through organisational policy, training and education and the assistance of members of the quality support unit and clinical governance team.

Although we have seen documented examples of these various quality activities at MHS and support a diversified action base to support quality improvement, we still have concerns about the:

- organisational capacity to target long standing or emerging high risk care provision
- immediacy of response to remove barriers to good care or to strengthen care processes
- lack of team based analysis of care.

We have observed an accelerated roll out of MHS's quality and safety framework since the complaint was lodged. We also acknowledge key systems issues which impede communication across the organisation. They include high demand, staff shortages, limited clinical leadership, low bed numbers, high reliance on locum staff, access block and recruitment issues. Improvement in the factors will enhance team communication.

There is a critical need for effective teamwork and communication in the acute care setting given the identifiable risks to the safety and quality of care for patients. Our investigation showed that in at least 11 of the reported incidents this did not occur. It resulted in or contributed to substandard care being provided to patients and poor outcomes for those patients.

The notion of the multidisciplinary clinical team is important but there are problems about making it work in reality in the health system. In its response SWSAHS acknowledge that effective communication is critical to effective patient care. It states that MHS has been working to create structures that promote multi disciplinary work. For example all care planning, case reviews and quality assurance meeting are expected to be multi disciplinary in approach. Examples of multi disciplinary work include the Acute Services Review Team, the service agreement between Mental Health and ED and the Chronic and Complex Program. While this may be the policy of a strategic direction of SWSAHS and MHS, there was little evidence of multi disciplinary review by MHS. The Commission agrees with the strategic direction.

The impression of MHS developed by the Commission is that, as in many health services, the professional groups have not shown that they can share completely the collective objectives of providing safe, quality care to patients and develop a culture of cooperation, collegiality and effective communication strategies to achieve that goal. Until they do, patients will remain at risk, relying on the earnest best endeavours of individual clinicians brokering one-off relationships with other individual clinicians.

It is imperative that the health system develops strategies to improve the relationships and communication between the individuals and professional groups that make up clinical teams. They need to focus on safe quality care for the patient rather than on defending the boundaries of each profession's roles.

Our recommendations

We recommend that:

5.20 DOH support ICE to develop a statewide program of education and training for clinicians that may be integrated into other programs or be a discrete program. The program should emphasise team based care and focus on:

- developing and improving the relationships and communication between the individuals and professional groups that constitute clinical teams
- a safety and quality values base for behaviour in a team environment for achieving safe, quality care for patients.

5.21 SWSAHS and MHS invest in strategies that will improve the relationships and communication between the individuals and professional groups that constitute clinical teams.

5.12 RECOGNITION OF AND RESPONSE TO DETERIORATING OR CRITICALLY ILL PATIENTS

Introduction

Out of the 47 clinical incidents examined, the Commission identified the recognition of and response to deteriorating or critically ill patients as a possible issue in 12 incidents. Of these we substantiated 10 incidents (83%) that raised concerns about whether the particular patients had received adequate care in response to critical clinical deterioration.

Out of a total of 47 incidents, this issue was of concern to the Commission in 21% of cases. These incidents were 10, 16, 18, 33, 34, 38, 39, 46, 66 and 69. The incidents occurred between 2000 - 2003 with one occurring in 2000, eight in 2001 and two in 2003.

Nine of the incidents occurred at Campbelltown Hospital - five in ED, two in ICU and two in a medical ward. Two incidents occurred in ED at Camden Hospital.

This issue relates to the need for health providers to recognise a patient is deteriorating clinically and the timely implementation of treatment based on correct diagnosis. These capacities rely on good nursing and medical competence, a good medical and nursing infrastructure and good nursing and medical leadership in a clinical team setting.

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Case Study – Incident 16

Critically ill woman deteriorates in emergency department

Mrs G was a 55 year old woman who presented to Campbelltown Hospital emergency department at 1713 hours in mid 2001. Her previous history included mitral valve replacement two weeks earlier, NIDDM and hypertension.

Mrs G was triaged at 1713 hours as category 3. At 1720 her blood pressure was recorded as being 69/49, her respiratory rate 30/min and her temperature 35.3 degrees C. At 1745 hours the locum medical officer assessed Mrs G and diagnosed cardiac failure, predominantly right sided. An indwelling urinary catheter was inserted, ECG attended and bloods sent to pathology. At 1835 hours 80 mg of lasix was given intravenously. At no stage was the on call physician contacted by ED staff.

On the night of Mrs G's presentation, there was no ICU medical coverage and so no new admissions to ICU were to be made. However at 1955 hours the ICU registrar happened to call into the hospital and agreed to assess Mrs G. The registrar ordered the administration of 1 litre haemacel as a fluid challenge and commencement of tridal infusion. The haemacel was not given until $2^{1}/_{2}$ hours later.

After discussing the case with the registrar, the ED locum medical officer recorded a problem list of (1) ?sepsis, (2) metabolic acidosis, (3) pleural effusion and (4) diarrhoea. He telephoned the VMO cardiologist and informed him of the presenting symptoms. The CMO, when asked by the VMO, did not know the patient's vital observations. The CMO checked these and called the VMO a second time to inform him that blood pressure was 60/30 and the patient was

asymptomatic apart from dyspnoea. The VMO instructed that Mrs G should immediately receive intravenous fluid resuscitation, inotropic support, broad-spectrum antibiotic cover and transfer to Liverpool Hospital or an equivalent facility. The ICU registrar from Liverpool Hospital stated that there were no beds available but transfer would be possible in the morning

At 2230 hours the nursing vital observation chart documented the first blood pressure recorded by the nursing staff since the patient's arrival at the hospital, five hours previously. At this time it was realised that Mrs G was critically unwell and she was transferred to the resuscitation room.

The VMO cardiologist arrived at the hospital sometime before 2400 hours and found Mrs G to be anuric, hypotensive with a metabolic acidosis and a WCC of 24,000. He performed an Echo which excluded tamponade and found a competent mitral valve, a small pericardial effusion and a LVEF of 50%. He commenced an inotrope infusion and colloid resuscitation.

A fluid balance chart was only commenced at this time. The patient had been anuric since admission.

At 0230 hours the patient's blood pressure was noted to be 103/51, respiratory rate of 23 and GCS of 15/15. Liverpool Hospital finally agreed to accept Mrs G's transfer which occurred at 0400 hours via ambulance and flight nurse. She died soon after arrival at Liverpool.

The MHS critical care review committee reviewed Mrs G's notes. Seven months after the critical incident the committee requested the Director of Emergency Medicine oversee and report back on their recommendations.

These recommendations were:

- education on the use of spacelabs when recording blood pressure
- inservice on GTN infusions and inotropes
- ensure medical staff know about interhospital transfer procedures.

In July 2003 MHS informed the Commission of the following:

- the in-service had not taken place
- information on the transfers of critically ill patients had been included in the survival kit for all new/relief medical staff
- information on transfers directs staff to contact medical retrievals who will advise where an ICU bed is available
- a MET call was not made for Mrs G because the emergency department does not contact MET staff unless they are overwhelmed and need additional support
- a staff specialist roster started in March 2003 to ensure after hours coverage by VMOs.

In their response to our criticisms of the medical management of Mrs G, MHS stated that the night in question was particularly busy with 102 presentations in the 24 hours up to midnight. Staff coverage of the evening shift was one team leader, one triage nurse and three RNs, one of whom was away ill. From 2330 hours there was one senior and one junior medical officer. There was no medical coverage for ICU during that night.

Comments by the MHS nurses who responded to the Commission's criticisms included:

- nursing staff were with the patient but documentation of vital signs was not attended

- hourly observations are attended on all patients as a minimum requirement with more frequent observations of unstable patients
- MET was not called because a senior medical officer was in attendance.

Our findings

The Commission found:

1. The care provided to Mrs G was unsafe and inadequate for the following reasons:
   - there was a complete failure of care to adequately monitor and appropriately respond to this patient's vital observations in particular at 1720 when BP was 69/49 and temperature was 35.3
   - there was a failure to recognise just how critically ill this patient was and failure to adequately resuscitate her
   - the patient should have been transferred to an ICU bed soon after her presentation but she remained in the emergency department for 11 hours
   - when staff failed to locate an ICU bed at Liverpool Hospital, no further attempts to locate an ICU bed were made despite critical signs. Liverpool Hospital had a role in advising use of the medical retrieval system
   - the patient did not receive inotrope support, plasma expanding fluids, adequate diureses, fluid monitoring, antibiotics or septic work up until almost five hours after presentation
   - an adequate, coordinated care plan, responsive to the patient's condition was not evident
   - the patient was not seen by a VMO until 6½ hours after presenting to the emergency department
   - documentation failed to reflect progress of the patient's condition during the first half of the ED stay.
2. MHS has informed us that ED staff do not call a MET unless they are overwhelmed. This patient's systolic blood pressure was recorded as being between 60 and 88 on five occasions, with three occasions recorded as below 69. On two occasions respiratory rate exceeded the MET criteria, reaching 165 and 150/minute. These critical levels required urgent intervention. In their response, MHS advised that on the night in question staff were extremely busy and hence delays in the monitoring and management of the patient occurred. This response serves to reinforce that MET was required to adequately resuscitate the patient.
3. The MHS response to the critical incident was inadequate. It failed to explore the reasons for and strategies to avoid the following issues:
   - nursing staff did not closely monitor a critically ill patient
   - nursing staff failed to appropriately respond to critical vital observations
   - medical staff failed to ensure timely review by a VMO
   - lack of clinical expertise in ED and in ICU
   - lack of resuscitation skills of ED and ICU staff

- lack of after hours medical coverage in ICU
- a critically ill patient remained in the ED for 11 hours
- inotrope support was not administered until the VMO attended, 6 1/2 hours after the patient presented
- the acute services critical care review committee (ASCCRC) did not review the case until seven months after the incident
- MHS advised that of the three recommendations made by ASCCRC, two of these had not been implemented two years after the incident.

4. The action taken by MHS that all new and relief staff now receive instruction on how to locate an ICU bed and that in March 2003 a staff specialist roster started to ensure after hours specialist coverage is important and appropriate. However the effectiveness of these measures needs to be evaluated further. In addition to the rostering of VMOs, it is essential that contractual arrangements ensure the VMO attends to critically ill patients in person.

5. Current policy of the ED states that hourly observations are attended on all patients as a minimum requirement, with more frequent observations of unstable patients. There is no information to indicate that the implementation of this policy is being monitored nor that staff have been educated in the determination of an unstable patient. In the case of Mrs G, dramatically low vital signs did not result in more frequent observations.

6. Review of medical records showed the separation of nursing records from medical records. To facilitate chronological interpretation and ensure information is readily available to all staff, integration of records is strongly recommended.

Case Study – Incident 34

Delayed surgical review complicates care of an elderly patient with a perforated duodenal ulcer

Mrs O, an 88 year old woman, was brought in by ambulance to the ED at Camden Hospital just after midnight in mid 2001. She had a referral letter from her general practitioner with a diagnosis of '? perforated peptic ulcer'. On admission she was pale, dry retching with severe abdominal pain, tenderness and guarding.

Mrs O was admitted under a VMO surgeon. At 0200 hours she was noted to have deteriorated with a BP of 80 systolic. She was given haemaccel 500 ml over 2 hours. By 0545 hours Mrs O had not passed urine since admission. Surgical review was to take place later in the morning.

Mrs O continued to deteriorate and was managed with IV fluids and antibiotics. Between 0615 hours and 0740 hours, an RMO reviewed Mrs O and discussed her management with Dr D3 who recommended transfer to Campbelltown Hospital. At 1000 hours Mrs O's BP was 90/47 having dropped from 117/51. Her respiratory rate was 44 per minute. No MET was called.

At midday she was transferred to Campbelltown Hospital. Mrs O was diagnosed as having diverticulitis and was admitted to a ward from the ED. On arrival at the ward the intern noted

'looks unwell', cold extremities, reduced air entry and bilateral crepitations. Mrs O had been given pethidine for abdominal pain just prior to her transfer to the ward.

The next entry in her medical record was not until 2020 hours when a MET call was initiated in response to an RN discovering Mrs O 'to be quite unwell' with a respiration rate of 40, BP of 98/52 and oxygen saturation of 82% - 94% in spite of oxygen 6 - 8 l/m via a Hudson mask.

Mrs O was not reviewed by a surgical registrar until this MET call was initiated and she was transferred to ICU. That night she was taken to the operating theatre where she had surgery for a perforated large duodenal ulcer. She deteriorated slowly and died six days later.

The Director of the ED wrote a case review of Mrs O's case in a memo to the Medical Director of Health Services. He drew attention in particular to two concerns - failure to diagnose and delays in treatment. He concluded that her death may have been preventable if she had received more urgent surgical intervention.

There were five recommendations at the end of the case review:

- continued and ongoing education for medical officers on the management of abdominal pain in the elderly
- ongoing education in, and reinforcement of the need for careful monitoring of patients, documentation of vital signs and clinical findings and shock recognition
- initiation of a more suitable transport arrangement for patients to be transferred from Camden to Campbelltown and contingency plans available when excessive delays are encountered with ambulance transport
- re-establishment of 24-hour registrar coverage for surgical registrars at Campbelltown with a system of adequate support to Camden ED
- review of a back up surgical coverage system for instances where the surgical registrar is in theatre and not available.

The MHS CCRC reviewed this incident three months after it occurred and identified the following concerns:

- X-rays should have been done immediately
- there was a delay in transfer by ambulance to Campbelltown ED
- there was a lack of nursing documentation in the Campbelltown ED
- there was a lack of recognition that Mrs O was critically ill.

The committee recommended that the case be reviewed with the staff at Camden. A memo dated six months after the CCRC meeting requests the Manager of the ED to implement the recommendation and report back in three weeks.

In July 2003, MHS advised us that the following actions had been implemented:

- development by the Director of Emergency Medicine of an education program on the management of abdominal pain in the elderly
- planning for a Level 2 patient transport service between Camden Hospital ED and Campbelltown Hospital to start in July 2003
- implementation of a dedicated pager for the surgical registrar on-call for the ED.

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Our findings

The Commission found:

1. The care provided to Mrs O was unsafe and inadequate for the following reasons:
   - Mrs O was not reviewed by a surgeon at Camden Hospital in spite of her presentation with an acute abdomen and her being sent to the hospital by her general practitioner with a diagnosis of '? perforated peptic ulcer'
   - the abdominal x-ray was misread, there was a failure to recognise free air under the diaphragm diagnostic of hollow viscus perforation, and indicating the need for an urgent laparotomy
   - the delay and lack of response to Mrs O's acute abdomen and subsequent deterioration represents severe mismanagement. Mrs O should have been surgically assessed in ED and immediately scheduled for surgery
   - Mrs O should have been directly transferred to Campbelltown Hospital. The delay was unacceptable
   - there were no nursing entries for five hours after Mrs O presented to the ED in spite of her deterioration
   - the observations recorded at 1000 hours on the day of admission should have triggered a call for the MET
   - there was an inappropriate delay before Mrs O's acute abdomen was correctly diagnosed at Campbelltown Hospital
   - a diagnosis and management plan should have been noted on admission at Campbelltown Hospital
   - Mrs O should not have been sent straight to a ward at Campbelltown Hospital because of her critical status
   - a surgical review should have been organised as a matter of urgency.
2. In response to this incident, MHS was slow to address the recommendations of the Director of the ED and the recommendations of the CCRC.

Our conclusions and comments

SWSAHS advised the Commission in its s.43 submission that it was managing the risks associated with this issue and increasing the medical infrastructure and coverage, improving nursing skills through initiatives such as the new position of advanced clinical nurses in ED and more nurses attending short courses. In 2003 the Acute Medical Unit was established to relieve pressure on ED.

There is evidence from the incidents we reviewed of the existence of an endemic problem in the two MHS emergency departments in recognising and treating seriously ill patients.

The failure to recognise and respond to deteriorating or critically ill patients appears to be strongly linked to the lack of skills and experience of the RMOs and CMOs, and the lack of senior medical staff /VMO involvement in the active diagnosis, management and treatment of the affected patients and supervision of more junior medical officers. The CCRC also failed to identify and rectify major problems in critical care.

Another contributing factor to the poor management of the critically ill patients was inadequate documentation of vital signs and the necessary observations that identify deterioration in the patient's condition by both medical and nursing staff.

There was also a failure to call MET when the MET criteria were evident. An effective MET system should be the safety net that ensures that sudden, rapid clinical deterioration is addressed.

While we have made some specific recommendations in this section, other recommendations made elsewhere which relate to clinical leadership, support and supervision will improve the clinical teams' performance in this area and make the system of care safer.

The Commission accepts the SWSAHS submission that it is still well below the number of junior medical officers, registrars and consultants required to meet the demand on its services. This situation is a major factor affecting its capacity to identify and treat seriously ill patients. The Health Care Complaints Act 1993 precludes the Commissioners from making recommendations in relation to resources. The following recommendations may otherwise assist.

Our recommendations

We recommend that:

5.22 SWSAHS and MHS review and enhance the system for routine clinical case and incident investigation and review. As part of this review they should consider:

- having an expert multidisciplinary committee with an independent, experienced clinician from outside the MHS as chairperson
- establishing a commitment to and culture of open disclosure
- developing guidelines to ensure that any member having a conflict of interest in relation to a particular case will disqualify themselves from reviewing that case
- the committee becoming integrated into the broad quality and safety systems at MHS
- the committee using data from an integrated and comprehensive information system that tracks critical care incidents, adverse events and near misses through the review process, to corrective actions and evaluation.

5.23 SWSAHS and MHS develop clear protocols to ensure appropriate and timely attendance of senior medical clinicians when a patient is identified as deteriorating or has become critically ill. These protocols should include:

- protocols for medical staff and nursing staff notifying and requesting the attendance of senior medical clinicians with clear instructions on alternative arrangements if that senior medical clinician is unavailable
- support for senior medical clinicians to ensure that they are available to respond promptly to sudden, rapid, clinical deterioration in patients and reflect this obligation in their contracts.

5.24 SWSAHS and MHS develop clear protocols to enable staff to seek a second opinion from a senior medical clinician if they are concerned about the clinical assessment, treatment or care of any patient.

5.13 DOCUMENTATION OF TREATMENT AND CARE IN HEALTH CARE RECORDS

Introduction

Of the 47 clinical incidents examined, the Commission identified 22 possible cases where the documentation of treatment and care in health care records was inadequate and may have had a negative impact on patient care. We subsequently found that poor documentation of care was of concern in 21 (95%) of these cases.

Out of a total of 47 incidents the issue was of concern in 45% of cases. They were incidents 3, 10, 12, 14, 15, 16, 17, 18, 21, 34, 36, 37, 38, 42, 46, 63, 65, 66, 67, 68 and 69. The incidents occurred between 1999-2003 with one occurring in 1999, eleven in 2003, six in 2003 and two in 2003.

Adequate documentation of patient care in the health care records is vital to ensuring the continuity and integrity of patient care. Poor record keeping by health care practitioners can place consumers and providers of health services at high risk.

Schedule 2, clauses 1 to 5, of the Medical Practice Act Regulation 1998 (NSW) highlights the importance of records and requires that specific information is to be recorded in a patient's medical record by medical practitioners.

In at least twelve of the incidents we reviewed, we identified inadequate documentation in the health care records when compared to the requirements of the Regulation.

Clause 1 of the Regulation states that:

(2) A record must include:

(a) any information known to the medical practitioner who provides the medical treatment or other medical services to the patient that are relevant to his or her diagnosis or treatment (eg information concerning the patient's medical history, the results of any physical examination of the patient, information obtained concerning the patient's mental state, the results of any tests performed on the patient and information concerning allergies or other factors that may require special consideration when treating the patient), and

(b) particulars of any clinical opinion reached by the medical practitioner, and

(c) any plan of treatment for the patient, and

(d) particulars of any medication prescribed for the patient.

(3) The record must include notes as to information or advice given to the patient in relation to any medical treatment proposed by the registered medical practitioner who is treating the patient.

(4) A record must include the following particulars of any medical treatment (including any medical or surgical procedure) that is given to or performed on the patient by the registered medical practitioner who is treating the patient:

(a) the date of the treatment,

(b) the nature of the treatment,

(c) the name or names of the person or persons who gave or performed the treatment,

(d) the type of anaesthetic given to the patient (if any),

(e) the tissue (if any) sent to pathology,

(f) the results or findings made in relation to the patient.

Clause 2 of the Regulation describes the general requirements as to the content of a medical record:

(1) In general, the level of detail contained in a record must be appropriate to the patient's case and to the medical practice concerned.

(2) A record must include sufficient information concerning the patient's case to allow another registered medical practitioner to continue management of the patient's case.

(3) All entries in the record must be accurate statements of fact or statements of clinical judgment.

Clause 3 of the Regulation describes the form of medical records:

(1) Abbreviations and short hand expressions may be used in a record only if they are generally understood in the medical profession in the context of the patient's case or generally understood in the broader medical community.

(2) Each entry in a record must be dated and must identify clearly the person who made the entry.

(3) A record may be made and kept in the form of a computer database or other electronic form, but only if it is capable of being printed on paper.

Clause 4 of the Regulation requires that in altering and correcting of records:

A registered medical practitioner or medical corporation must not alter a record, or cause or permit another person to alter a record, in such a manner as to obliterate, obscure or render illegible information that is already contained in the record.

Clause 5 of the Regulation provides for delegation:

If a person is provided with medical treatment or other medical services by a registered medical practitioner in a hospital, the function of making and keeping a record in respect of the patient may be delegated to a person other than the registered medical practitioner, but only if:

(a) the record is made and kept in accordance with the rules and protocols of the hospital, and

(b) the registered medical practitioner ensures that the record is made and kept in accordance with this Schedule.

The Department of Health also has a number of policies relating to the expectations for documentation in patients' health care records. These include Circular No: 98/59 – Principles for the Creation, Management, Storage and Disposal of Health Care Records.[6]

This circular states the purpose of health care records.

The health care record shall be sufficiently detailed and comprehensive to provide effective communication to the health care team; provide for a person's effective, continuing care; enable the evaluation of a person's progress and health outcome; and retain its integrity over time.[7]

The circular goes on to outline a series of principles including the individuality of a record, continuity of care, confidentiality, authenticity, relevance, completeness and comprehensiveness, who is responsible for documentation, timeliness of documentation, ownership of the health care record, access to records, quality improvement, review, evaluation and research, durability, storage and security, retention obligations and disposal. Each health service is required to develop and implement appropriate policies based on these principles.

A number of health professional organisations, such as the Australian Council on Health Care Standards, have developed comprehensive standards on health care records and the obligations of health care professionals.

Our conclusions and comments

The incidents we reviewed showed that there are significant issues and an inconsistency in approach to the documentation by clinical staff in patients' health care records that leads to failures in providing well planned, coordinated, ongoing management and care for patients at MHS. Health records are integral to safe health care. We acknowledge the difficulties in keeping good records in busy environments such as ED, particularly at times of overload, but health practitioners must be resourced to enable them to keep adequate records.

In its s.43 submission to the Commission, SWSAHS states it has a policy on documentation in its Clinical Manual, internal audits have found compliance to be high, a recent ACHS accreditation survey found documentation standards were high and other team and department audits are positive but showed there needs to be a focus on legibility and ensuring that every step of patient care is documented.

SWSAHS accepted the Commission's findings in 14 of the 20 cases where a preliminary substantiation had been made. The Commission reviewed the SWSAHSs responses where they disagreed and have found the issue substantiated in those matters. SWSAHS also notes *'this suggests that there is a need for MHS to improve documentation in clinical records to ensure patient care is being made on full information and that actions may be traced during latest review.'* While not definite it would appear that SWSAHS accepts the Commission's conclusions. The following recommendations are made:

Our recommendations

We recommend that:

5.25 SWSAHS and MHS improve the quality and consistency of documentation and compliance with contemporary standards on documentation including DOH policy, the Medical Practice Regulations, accreditation standards and area health service and hospital policy. They should review all policy, guidelines, record systems, employment contracts, review and educational and audit strategies in relation to the documentation by all clinicians in patients' health care records.

5.26 MHS conduct quarterly random audits of health care records to assess compliance with contemporary standards on documentation. The outcomes of these audits should be reviewed by the information management committee, in collaboration with the clinical advisory council, to assess the appropriateness of documentation by all clinical staff and take action when improvements are needed.

5.27 SWSAHS continue to develop an area wide means of tracking patient's health care records and a policy that ensures:

- current health care records always accompany a patient to any site in SWSAHS
- there is clear and consistent guidance about clinical team member's responsibilities regarding documentation, including the prescription and administration of drug therapy in any SWSAHS service.

5.14 NOTIFICATIONS OF DEATHS TO THE CORONER AND DECISION MAKING CONCERNING POST MORTEMS

Introduction

Out of the 47 clinical incidents examined, the Commission identified the notification of deaths to the Coroner as a possible issue in nine cases. We subsequently found it to be an issue in six instances. (66%)

Out of a total of 47 incidents, the Commission was concerned about this issue in 11% of cases. These incidents were 12, 15, 23, 30, 42 and 69. The incidents occurred between 2000 - 2002 with one occurring in 2000, three in 2001, two in 2002.

The Coroner's role is to determine the cause of death through autopsy and to ensure certain deaths are properly investigated. *The Coroner's Act 1980* imposes an obligation for any person to report certain deaths. The Act also imposes an obligation for medical practitioners not to certify deaths in certain instances. Because medical practitioners certify death it usually falls to them to them to exercise judgement about whether a death is reportable. This process should not prevent other members of the team from reporting deaths they think are reportable. Departmental circulars need to be clear on this point.

The relevant provisions of the *Coroners Act 1980 (NSW)* are:

12A Obligation to report death

(1) A person who:

(a) has reasonable grounds to believe that a death or suspected death would be examinable by a coroner under section 13, 13A or 13AB, and

(b) has reasonable grounds to believe that the death or suspected death has not been reported in accordance with this subsection, must report the death or suspected death to a member of the police force, or to a coroner or assistant coroner, as soon as possible after becoming aware of those grounds.

12B Medical practitioner must not certify cause of death if death is reportable to a coroner

(1) A medical practitioner must not give a certificate as to the cause of death of a person for the purposes of notification of the cause of death under the Births, Deaths and Marriages Registration Act 1995 if the medical practitioner is of the opinion that the person died in any of the following circumstances:

(a) the person died a violent or unnatural death,

(b) the person died a sudden death the cause of which is unknown,

(c) the person died under suspicious or unusual circumstances,

(d) the person died having not been attended by a medical practitioner within the period of 3 months immediately preceding his or her death,

(e) the person died while under, or as a result of, or within 24 hours after the administration of, an anaesthetic administered in the course of a medical, surgical or dental operation or procedure or an operation or procedure of a like nature, other than a local anaesthetic administered solely for the purpose of facilitating a procedure of resuscitation from apparent or impending death,

(f) the person died within a year and a day after the date of any accident to which the cause of his or her death is or may be attributable,

(g) the person died while in or temporarily absent from a hospital within the meaning of the Mental Health Act 1990 and while the person was a resident at the hospital for the purpose of receiving care, treatment or assistance,

(h) the person died in circumstances that are examinable as referred to in section 13A (Deaths in custody etc examinable only by State Coroner or Deputy State Coroner),

(i) the person died in circumstances that are examinable as referred to in section 13AB (Child or disability deaths examinable only by State Coroner or Deputy State Coroner).

(2) Despite subsection (1), a medical practitioner may give a certificate as to the cause of death of a person if the medical practitioner is of the opinion that the person:

(a) was 65 years of age or older, and

(b) died in circumstances other than those referred to in subsection (1) (b), (c), (d), (e), (g), (h) or (i), and

(c) died after sustaining an injury from an accident, being an accident that was attributable to the age of that person, contributed substantially to the death of the person and was not caused by an act or omission by any other person.

(3) Subsection (2) does not apply if the accident concerned occurred in a hospital or nursing home.

(4) If a medical practitioner certifies the cause of death of a person in pursuance of subsection (2), the certificate must state that it is given in pursuance of that subsection.

(5) A medical practitioner who is prevented from certifying the cause of death of a person because of this section must, as soon as practicable after the death, report that death to a member of the police force.

It is important to note that the obligation in 12A is on any person. This means that any person on the treating team has an obligation to make a referral.

The NSW Department of Health is very definite in its instructions in relation to coroner's cases and the jurisdiction of the Coroner. The Department of Health Circular No: 99/57 has specific instructions in relation to:

- the jurisdiction of the Coroner
- anaesthetic deaths
- obligation to report death
- guidelines for nursing staff and medical officers on deaths in hospitals and the Coroner
- transfer of medical records for post mortems
- discharge type summaries for coronial cases in hospitals
- objections to a post mortem examination.

The MHS Clinical Manual provided to the Commission contains very specific instructions in relation to the death of a patient. Section 2E of the manual informs medical and nursing staff of their responsibilities for a referral to the Coroner.

It has instructions about:

- the jurisdiction of the Coroner
- care of the body
- anaesthetic deaths
- deaths in operating theatres or surgical unit

- maternal deaths
- mortuary
- release of clinical records
- counsellors
- documentation on coroner's forms.

In the Commission's view MHS's documented information is satisfactory.

The Commission was advised by SWSAHS that the manual is available to all staff via the intranet and in hard copy in all 24 hour clinical areas. Clinicians are made aware of the requirements for reporting to the Coroner through orientation programmes. Referrals to the Coroner are entered in a database administered by the Medical Support Unit. No inquests resulted from recorded referrals. All files are seen by the Medical Director of Health Outcomes prior to transfer to the Coroner.

In addition to identifying the notification of the coroner as an issue for closer examination in nine cases, the Commission reviewed all of the 47 incidents where deaths had occurred to determine whether the deaths were notifiable by the staff of MHS and whether the Coroner had been notified.

The Commission is aware of 21 deaths related to the incidents examined. Table 5.2 records those incidents where a death occurred, the location of the death by hospital campus, whether or not MHS staff had an obligation to notify and the Commission's reason for that opinion. The table also details whether or not the Coroner was actually notified and for sake of completeness, which matter the HCCC identified for particular examination and whether it substantiated the issue in that incident. The Commission has relied on the Coroner's advice as to whether he was notified of the deaths.

Table 5.2 – Consideration of notification to the Coroner required

Location of Death and Year of Incidence	Incident No.	Description	Notifiable by MHS Hospital staff to the Coroner under the Coroners Act 1980?	Reason MHS had an obligation to notify or not	Was the matter notified by any person to the Coroner?	Identified as HCCC issue for investigation	Issues substantiated by HCCC
Liverpool Hospital 2001	10	Patient transferred from Camden to Liverpool Hospital after arrest followingadmission for cellulitis in lower limbs	No	Death did not occur at MHS	No	No	–
Campbelltown Hospital 2002	12	16 day admission of 87 year old with knee pain and unable to mobilise	Yes	Sudden death, causeunknown (death certified as pulmonary embolus)	No Referred by DOH after HCCC preliminary report	Yes	Yes
Campbelltown Hospital 2002	14	11 day admission of 88 year old for cellulitis – chronic and complex medical conditions	No	Cause of death known	No	No	–
Campbelltown Hospital 2001	15	Patient died less than an hour after being discharged from ED after attending with severe central chest pains. Past history included bilateral skin drafts to legs as an inpatient eight days earlier.	Yes	Sudden death, cause unknown (Cause of death certified as acute pulmonary embolus)	Yes – after HCCC preliminary report	Yes	Yes

Location of Death and Year of Incidence	Incident No.	Description	Notifiable by MHS Hospital staff to the Coroner under the Coroners Act 1980?	Reason MHS had an obligation to notify or not	Was the matter notified by any person to the Coroner?	Identified as HCCC issue for investigation	Issues substantiated by HCCC
Liverpool Hospital 2001	16	Patient presented at Campbelltown Hospital ED and assessed as having cardiac failure, predominately right side. Patient described as being asymptomatic apart from dyspnoea. Later found to be anuric, hypotensive with a metabolic acidosis. Patient was then transferred to Liverpool Hospital where she died shortly afterwards.	No	Death did not occur at MHS	Yes	No	–
Campbelltown Hospital 2002	17	82 year old patient awaiting a nursing home placement	No	End of life care required	No	Yes	No
Liverpool Hospital 2001	18	Patient presented at Campbelltown Hospital four days after giving birth, sent home with diagnosis of flu. Attended GP Unit at Campbelltown the following day with total body pain and swollen arm, sent to ED where history of rigors, watery diarrhoea, swollen limbs, diagnosis possible myositis or viral infection, and immediately commenced a broad range of tests including blood culture – no antibiotics ordered. Restless overnight, walked unsteadily to shower, drowsy and in sceptic shock, given haemacel. Sceptic work up performed and given antibiotics started. Transferred to Liverpool by Careflight where she died of puerperal sepsis.	No	Death did not occur at MHS	Yes Autopsy and investigation conducted then dispensed. (Cause of death post childbirth infection)	No	–
Campbelltown Hospital 2002	21	85 year old patient admission for heart attack.	No	Cause of death known (certified as acute myocardial infarction and cardiogenic shock of some days duration)	No	No	–
Campbelltown Hospital 2001	23	Post discharge death after difficult diagnosis missed. Dead on arrival	Yes	Sudden death cause unknown	Yes Autopsy conducted then dispensed. Cause of death thoracic aorta aneurysm	Yes	Yes
Camden Hospital 2002	24	84 year old admitted at end of life with congestive cardiac failure	No	Cause of death known	No	–	–
Campbelltown Hospital 2002	26	Slow – gastro intestinal bleed fixed after 6 weeks and over 30 units of blood in patient with metastases in liver and abdominal cavity	No	Cause of death known –	No	Yes	Yes
Campbelltown Hospital 2000	30	38 year old patient with complex health problems admitted with chest pain.	Yes	Patient could have had cerebral lupis. Family refused autopsy. (Death certified as pulmonary embolus).	Yes after HCCC preliminary investigation	Yes	Yes

Location of Death and Year of Incidence	Incident No.	Description	Notifiable by MHS Hospital staff to the Coroner under the Coroners Act 1980?	Reason MHS had an obligation to notify or not	Was the matter notified by any person to the Coroner?	Identified as HCCC issue for investigation	Issues substantiated by HCCC
Campbelltown Hospital 2001	34	Patient underwent surgery for perforated duodenal ulcer after transfer from Camden and died six days later.	No	Cause of death known	No	No	–
Liverpool Hospital 2003	38	Transfer of patient from Camden ED via Campbelltown for abdominal pain. Chronic and complex conditions.	No	Death did not occur at MHS	No	No	–
Liverpool Hospital 2003	39	Patient admitted for an emergency laparoscopic cholecystectomy after waiting 11 months. Operation took 3 hours under laparoscopic procedure and should have been changed to an open procedure. Patient deteriorated with post operative intra abdominal sepsis and died later after transfer to Liverpool Hospital.	No	Death did not occur at MHS	Not at the time Referred later by Liverpool. Family requested autopsy which was initially refused.	Yes	No
Campbelltown Hospital 2002	42	72 year old patient had surgery where left femur pinned and plated after a fall. Admitted to med ward at Campbelltown pre and post surgery, six days later a wound dehiscence developed and likely infection of the surgical site. 16 days post surgery bloody ooze from wound, taken to surgery and wound cleaned. Patient continued to gradually deteriorate.	Yes	Cause of death not clear.	No	Yes	Yes
Liverpool Hospital 2002	45	56 year old patient from Campbelltown to Liverpool hospital after heart attack	No	Death did not occur at MHS.	No	No	–
Campbelltown Hospital 2001	46	26 year old patient admitted to ICU with respiratory distress due to asthma, died several hours later.	No	Cause of death clear	Yes after HCCC preliminary investigation	Yes	No
Campbelltown Hospital 2003	61	69 year old obese woman admitted with marked hyponatraemia, hyperkalaemia with intravascular dehydration after 7 months of treatment	No	Cause of death clear	No	No	–
Campbelltown Hospital 2001	68	81 year old patient with a chronic heart condition collapsed at home.	No	Cause of death clear	No	No	–
Campbelltown Hospital 2001	69	Patient admitted with a history of congestive cardiac failure and advanced CODP. Died 6 hours after triage. No resuscitation or intubation were performed despite the patient having a BP systolic of 60 and GCS of 3. There was no explanation given as to why the patient had a GCS of 3.	Yes	Death certificate stated cause of death as being due to septic shock despite being treated on admission for ischaemic heart disease and CCF.	Yes after HCCC preliminary report	Yes	Yes

Fourteen deaths occurred at Campbelltown, one at Camden and six at Liverpool. Fifteen of the 21 deaths occurred at MHS. The table indicates that of the six cases staff where at an obligation to report a death to the Coroner, only one case had been. On receipt of the Commission's preliminary report, SWSAHS ensured notification in those cases the HCCC identified notification as a possible issue. Since then the HCCC identified incident 42 as a reportable death and SWSAHS will be requested to provide the relevant details to the Coroner.

No conclusion can be drawn from the fact that all of these cases occurred at Campbelltown other than, at that hospital, notifiable cases are not being reported. The predominance of cases at Campbelltown Hospital reflects the source of the Commission's information. It cannot be used to draw a conclusion that there is a particular problem at Campbelltown compared with Camden or other facilities within SWSAHS.

The complaint made to the Commission mainly concerned Camden and Campbelltown hospitals. The Commission did not review the deaths at Liverpool hospital because of this, even though the substantive care of the patients who died was given at either Camden or Campbelltown hospitals.

The obligations under the Coroner's Act arise when a person dies. No obligation to report arises for either Camden or Campbelltown for patients who died at Liverpool hospital.

Two observations can be made from the cases examined by the Commission. Firstly it is clear that members of the clinical team who disagree with a cause of death given by a medical practitioner are not notifying the Coroner when they could do so. Policy guidelines should address how different opinions within the clinical team can be resolved and the lawful obligations of each team members.

Secondly, an underlying concern of the nurse informants was that the adequacy of care was sometimes a contributing factor to a patient's deterioration. An autopsy by the Coroner may not lead to an inquest where concerns about the adequacy of care might come to light. Where the coroner has such concerns he is required by the Coroner's Act to notify the HCCC. The fact that the HCCC is better placed to examine such an issue is highlighted by incident 23 where the Coroner conducted an autopsy and dispensed with an inquiry. The Commission examined the case and found the care provided inadequate for a range of reasons.

In its s.43 submission the SWSAHS advised that clinicians and departments had reviewed the cases. Results of those were provided to the Commission and taken into account in forming our final conclusions. The SWSAHS provided no overall concluded view.

Our conclusions and comments

MHS are not appropriately referring deaths to the Coroner and are not seeking advice from the Coroner's office if they are unsure.

The obligation under the *Coroner's Act 1980* is clear. The most probable cause for this is that clinical staff at MHS are not familiar with the requirements of the *Coroners Act 1980* and how to appropriately exercise their judgement on shift. This is not surprising when other policies and procedures are not being followed as they should and junior medical staff were not being adequately supervised.

We found no evidence that the failure to notify was deliberate and designed to cover up deaths arising out of inadequate care.

Our recommendations

We recommend that:

5.28 SWSAHS develops as a matter of urgency an area-wide system for monitoring and reviewing all deaths that occur when a person is under the care of a health service. This system should include:

- the requirement that a senior clinician review the circumstances of the death and the possible need for referral to the Coroner before the release of a deceased person
- an evaluation of the quality of end of life clinical decision making and care
- identifying where improvements are required in the safety and quality of care
- ensuring that appropriate referrals to the Coroner are occurring.

This information must be reported routinely to the Area Health Service Board for their review.

5.29 SWSAHS and MHS review their policies, protocols and orientation for clinical staff to ensure that:

- there are clearly outlined referral criteria to the Coroner with illustrative case studies available
- if there is doubt as to whether a patient's death should be reported to the Coroner, an appropriate clinician makes direct contact with the Coroner's Office to seek clarification
- there is adequate opportunity for consultation and explanations for families/next of kin when a death is reported to the Coroner
- all clinical staff have their attention drawn to the requirements of the Coroners Act 1980 through an orientation and ongoing training program covering referrals to the Coroner and the DOH guidelines in Circular No: 99/57, with input from the Office of the State Coroner where appropriate.

5.15 PATIENT TRANSFER TO HIGHER LEVEL UNITS OR HOSPITALS

Introduction

Out of the 47 clinical incidents examined by the Commission, we identified patient transfer to higher level units or hospitals as a possible issue in 16 incidents. Of the 16 incidents identified the Commission subsequently found the issue to be of concern in 13 (81%) of cases.

Out of a total of 47 incidents, this issue was substantiated in 28% of cases. These were incidents 2, 3, 15, 16, 26, 33, 34, 35, 37, 38, 39, 45 and 63. These incidents occurred between 1999-2003 with one in 1999, 6 in 2001, 3 in 2002 and 3 in 2003. The incidents occurred at both Camden and Campbelltown Hospitals.

The service delivery structure for MHS is based on a continuum of service model across both Campbelltown and Camden Hospitals. MHS has seen rapid changes in an environment where there is increasing demand for services. This has also had an impact on the organisational structure and the arrangements by which people work within the organisation.

The two hospitals are only 20 minutes apart by road, so the services provided at Camden Hospital have been gradually modified to take account of services that can be provided at Campbelltown Hospital. The children's ward was transferred to Campbelltown Hospital in the early 1990's and the opening of a maternity unit at Campbelltown has seen a steady decline in births at Camden Hospital. Both hospitals share the same visiting medical officers but the development of other infrastructure, particularly the availability of staff specialists and registrars, has largely taken place at Campbelltown. This has led to significant changes in the scale of services at Camden Hospital. Since 2001, the surgical service at Camden Hospital has been limited to patients requiring day surgery. In 2002 a decision was made to only admit acute medical patients to Campbelltown Hospital.

The NSW metropolitan critical care plan identifies:

> *…critical care services as those services which are provided to patients suffering potentially life threatening illness or injury and whose injury is time critical. The clinical settings in which these services are routinely delivered include Pre-Hospital Care, Emergency Departments, Intensive Care Units, Retrieval and Trauma Services. Similar care may sometimes be required in the hospital ward setting.*
>
> *The optimal practice of critical care medicine demands the early recognition of, and response to, potentially life threatening illness and injury in a systematic way. The quality of care delivered should be consistent across all settings where acute patients are received and managed.*[8]

The functional components of this plan include the planning and review of services to develop a networked approach to critical care service delivery within each area health service. This network should be coordinated by the area critical care committee who will advise area administration. One of the terms of reference of the area critical care committee is to facilitate and monitor the inter-hospital transfer of critically ill or injured patients between acute hospitals in the area network.

In the course of our investigation, problems with the transfer of patients for surgical review, higher level acute care or investigations became obvious. This was particularly evident with patients at Camden having to be transferred to Campbelltown. These transfers often caused frustration and took considerable time to be arranged – there were often delays of several hours.

The MHS Nurses Procedure Manual states that if a patient arrives in ED and there is no bed available at Campbelltown or Camden, and the team leader has contacted four other SWSAHS hospitals to try to locate a bed and none is available, then the patient is to be admitted to ED under the care of the appropriate VMO. This was the situation in some of the incidents that were identified.

The MHS Clinical Manual[9] states that all admissions to Campbelltown Hospital are required to be seen in the ED before proceeding to the ward. Additionally, if a patient requires medical and nursing care of a higher level than can be given at Camden and no bed is available at Campbelltown, every reasonable attempt is to be made to find a bed within SWSAHS. This occurred in a number of the cases identified. If no bed is available in SWSAHS, every reasonable attempt is to be made to find a bed within the metropolitan area. This was not always done in the incidents identified. If no bed is available in any other hospital, then the patient is to be admitted to Campbelltown Hospital ED until a bed becomes available. This was usually the case in the incidents we reviewed.

The issue of hospital transfer needs to be addressed. Some incidents were handled appropriately but in others the hospitals failed to follow through all the necessary steps.

CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY

Case Study – Incident 35

Delay in transfer of an urgent surgical patient from the Camden Hospital emergency department

Mrs R was a 91-year-old woman who was transferred from an aged care hostel to Camden Hospital by ambulance in October 2002 for treatment of a strangulated hernia. She was triaged in the ED at 1430 hours as level 3. Mrs R was left on the ambulance trolley for an hour and ten minutes in spite of having faeculent vomiting, oxygen saturations of 90% and tachycardia.

Mrs R had chest and abdominal X-rays. She was diagnosed as having an incarcerated inguinal hernia with a bowel obstruction and dehydration.

Camden Hospital does not have a surgical service on site. The surgical registrar at Campbelltown Hospital was in theatre and could not be contacted. Mrs R was left in the Camden Hospital ED for more than seven and a half hours until she was transferred by ambulance to Campbelltown Hospital some time after 2200 hours

At Campbelltown Hospital, Mrs R was reviewed by a surgical registrar at 0030hours and taken to the operating theatre at 0100 hours where a bowel resection was carried out. Nine days later Mrs R was discharged back to her hostel accommodation.

The incident was not reported to MHS management at the time. In their response to the Commission, MHS identified the problem in this case as being the availability of transport. The use of a NSW Ambulance Service transfer quite often led to prolonged delays. MHS has now established its own transport service to provide patient transfers between Camden and Campbelltown Hospitals.

We noted in Mrs R's medical records that the ambulance transfer from Camden Hospital ED to Campbelltown Hospital was only booked at 2200 hours.

CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY • CASE STUDY

Our findings

The Commission found:

1. The care provided to Mrs R was unsafe and inadequate for the following reasons:
   - Mrs R had an urgent surgical problem that needed prompt surgical intervention. Prompt surgery may have avoided the need for resection of the length of bowel trapped in the hernia
   - Mrs R was inappropriately delayed in the Camden Hospital ED
   - the urgency of Mrs R's clinical situation was not recognised.
2. In relation to the response to this incident, MHS partially identified causal factors. While the suggested action may improve the timeliness of transfers, it did not identify the medical assessment as an issue.

On 16 July 2002, the executive committee of MHS produced a document that proposed changes to patient flow. The proposal was that all acute medical patients should be admitted or transferred to Campbelltown Hospital from both Campbelltown and Camden EDs, and that all patients in Campbelltown Hospital awaiting transfer to a nursing home, rehabilitation or palliative care should be transferred to Camden Hospital. The purpose of these recommendations was to reduce the adverse events occurring in Camden medical ward and ensure better resources for acute care patients.

Since the incidents occurred, MHS has introduced level 1 hospital transport between Camden and Campbelltown campuses. Although this will reduce delays associated with the means of transport, it does not address the clinical issues identified in the incidents.

In its s.43 submission SWSAHS advised the Commission that in 2003 it had developed and implemented transfer guidelines to identify ICU patients that need to be transferred to a higher tertiary ICU and that the implementation of a level 2 transport service has decreased reliance on the Ambulance Service in transferring patients between the two campuses.

Our conclusions and comments

The clinical review panels generally found that the incidents they reviewed relating to transfers to and from the hospitals within MHS and SWSAHS were alarming. In at least one incident, attempts should have been made to transfer a critically ill patient to any available hospital for critical care. A failsafe system was in place for the transfer of critically ill ICU patients but in this case it was ignored.

We also found that the division of services between the two hospitals was problematic. In one incident, the family of a patient placed pressure on staff not to transfer the patient because of the patient's physical condition. This patient needed to be transferred to receive essential clinical assessment and treatment and the VMO was unwilling to travel from Campbelltown to assess the patient. This type of conflict is not conducive to effective patient care.

The actions taken by SWSAHS and MHS do not adequately deal with acute patients requiring transfer when a facility is in code red or no beds are available.

We are therefore of the view that acute patients should not be admitted to Camden Hospital. Appropriate guidelines still need to be developed to ensure Camden Hospital inpatients who become acute can be provided appropriate care. We also consider that having an emergency department in a hospital that is not equipped to manage acutely ill patients is problematic because it means that patients have to be transferred to another hospital.

Our recommendations

We recommend that:

5.30 SWSAHS and MHS review and improve, as a matter of urgency, all protocols for patient transfers to higher level units and hospitals to ensure appropriate and timely transfer occurs to minimise risks to patients. This review should include:

- the development of protocols allowing timely and unrestricted transfer of patients to appropriate critical care units within MHS
- the development of protocols allowing timely transfer of patients to Liverpool Hospital
- the development of a protocol that ensures that patients presenting at the ED with an illness potentially requiring urgent surgical intervention (such as a person presenting with the symptoms of an acute abdomen) have to obtain timely surgical review or be urgently transported to a facility that can offer this service
- undertaking routine audits of transfers to determine the number and quality of the referrals and documentation accompanying patients who are transferred to monitor and evaluate the timeliness as well as the appropriateness of the transfer of care.

5.16 MANAGEMENT RESPONSE TO ADVERSE EVENTS

The term 'Management' has been used throughout the report to encompass SWSAHS and MHS senior executive, including continuum heads and management structures, committees and quality forums.

This section of the report considers the effectiveness of SWSAHS, MHS and other management responses to the individual clinical incidents. It analyses how the quality and safety systems were performing during the period of time over which the incidents occurred - 1999-2003. During that time, management took a number of key actions to improve the functioning of its clinical governance systems. An overview of the functioning of these management systems is described in Part 7.

This section highlights the priority that senior management teams must give to quality and safety. It is the Commission's experience that there are gaps in the clinical governance systems of many health services. Statewide system and management performance indicators need to be developed and implemented so that the performance of management teams can be monitored and evaluated. The informants were most critical of a lack of timely and effective response when things went wrong and reports are made to management.

Macarthur Health Service

Background

In 1999 MHS established the 1999-2004 Acute Services Business Plan. A review of cases was commenced by the Medical Management Committee, the Surgical Management Committee and Critical Care Committee. Cases were identified using indicators such as MET utilisation, deaths, unanticipated ICU admissions, and cardio-respiratory arrests.

In recognition of the difficulties of staff with other full time duties undertaking this activity in May 2001, the Critical Care Committee became the Critical Care Review Committee (CCRC), whose sole business became the review of cases. SWSAHS advised the Commission that by November 2001 the CCRC became overwhelmed by the volume of cases before it. The CCRC identified emerging themes and developed an action plan to address them. There were no dedicated resources for the CCRC or to support its reform work.

By mid 2002 the CCRC made a business case to MHS executive for resources to assist it. This was approved by the MHS executive. In December 2002 a clinical nurse specialist with full time clerical support commenced employment and implemented the Acute Services Review Team (ASRT). After his appointment the first Director of Medicine joined the ASRT in January 2003. Directors of Obstetrics and Gynaecology, Anaesthetics and Medical Education have also been employed in the last two years and approval has been given for the employment of a number of registrars. These amongst other management actions will support the strategies to improve the quality and safety of health services at MHS.

MHS adopted the use of Root Cause Analysis (RCA) and the Severity Assessment Code (SAC) risk assessment tool in 2003. Other specific management strategies were implemented including increase in staffing and the appointment of a clinical nurse educator.

This background does not reflect the voluminous plans and strategies developed by MHS since 1999, the time of the earliest incident.

Clinical incidents and management response

Out of the 47 clinical incidents reviewed the Commission identified the issue of management response to adverse events for examination in 33 cases (or 70% of cases). The Commission found the management response in 29 of the 33 cases (or 88%) to be inadequate. The relevant incidents are 1, 2, 4, 5, 7, 11, 12, 13, 15, 16, 17, 19, 22, 23, 24, 26, 33, 34, 39, 41, 43, 44, 59, 60, 65, 66, 67, 69, 70. Details are included in the incident reports in Appendix A. Part 7 of the report deals with a related issue – the timeliness of reviews and implementation of recommendations.

Of the 47 incidents, the Commission is of the view that management was either not advised of the incident or a review was not necessarily warranted in 14 cases.

In three cases major issues were either not identified or management had been informed but did nothing – incidents 10, 26 and 43. In incident 26 a senior nurse wrote to MHS management about the appropriateness of a patient remaining at Camden Hospital given there was no anaesthetic or surgical cover. The nurse suggested that Camden required an admission policy, to exclude patients who could not be safely cared for. No action was taken until the commencement of a dedicated hospital transfer service more than one year later. The Commission agrees with the assessment of the nurse and her recommended action. In this case it would appear from emails that a number of managers were directly written to about the incident but no action was taken. This signals a lack of clarity at a number of different levels in management about responsibilities and the available pathways for incident management.

In incident 43 a nurse alleged that she was slapped on the wrist by another health practitioner in surgery. There was a witness to the incident. Management failed to investigate the allegation. At the least the incident report indicated such a poor level of team functioning that some action was required.

In incident 10 a senior nurse wrote to MHS management about the management of medical emergencies at Camden Hospital because the most senior experienced people at Camden were providing unacceptable care. It would appear the MHS did nothing in response. After reviewing the incident, the Commission formed the view that there were issues about care, including the resuscitation.

It is clear that nurses raised significant concerns about the safety of care at Camden Hospital in November 2001, February 2002 and April 2002 and no action was taken. Their concerns have been substantiated by the Commission's review of these clinical incidents. It appears that management did not appreciate the seriousness of the concerns raised.

Critical Care Review Committee

It is known to the Commission that the CCRC reviewed 12 of the 47 incidents. These were incidents 3, 7,13, 16, 23, 33, 34, 65, 66, 67, 68, 70. Ten of these incidents occurred in 2001. Two occurred in 2002 (July and December).

The Commission was satisfied with the outcome of the review in two cases – incidents 23 and 34. In seven of the cases the review missed significant clinical issues. Apart from these cases, the CCRC failed to identify that no clinician apparently took overall responsibility for patient care in incident 7. The standards in place in the hospital were below the ACORN standards and it took the hospital one year to implement the acceptable standard. Delay in implementation and lack of implementation of the Committee's recommendations was a significant feature in the majority of cases. In incident 68 the Committee only partially identified the root causes and there is no evidence of implementation. In the case of incident 33, the Director of ED carried out an incisive, timely and thorough review. The CCRC

reviewed the incident and ignored the advice of the Director and refuted the standards identified. The Commission supports the findings of the Director of ED.

There are various concerns about the functioning of this Committee. Many cases were reviewed without medical input. The ineffectiveness of the Committee may be partly explained by the volume of cases, the lack of resources and the lack of adequate medical input. It was clearly appropriate for MHS to replace this forum with another – the Acute Services Review Committee in which the new Director of Medicine now participates.

Acute Services Review Committee

It has been suggested that the ASRC reviewed seven of the 47 clinical incidents. These were incidents 2, 11, 16, 19, 24, 33, and 69. Four of these incidents occurred in 2001, and three in 2002. The timing of the reviews suggests that these incidents were in fact reviewed by the CCRC, not the ASRC. The Commission was satisfied with the outcome of two of these reviews however the implementation of recommendations was significantly delayed. In two cases wider systems issues were not identified and in three cases serious clinical issues were not identified.

Of the incidents which occurred in 2003, the Commission is aware of two reviewed by the ASRC incidents 17 and 39. The Committee requested a Root Cause Analysis to be completed. The ASRC reviewed incident 17, seven months after the incident occurred. The Committee referred the matter to the nurse educator to consider mandatory in-services on the code blue MET calls. In the Commission's view this action was appropriate however, notes the recommendation has been made a number of times. The Committee does not appear to have picked up on the lack of involvement by the patient and relatives in end of life decision making and the lack of documentation of that involvement.

There is insufficient information for the Commission to form a definitive view about the performance of this Committee.

Perinatal Mortality and Morbidity Committee

This Committee was referred two cases- incidents 18 and 44. In relation to 44, which occurred in 1999, it was identified that the registrar failed to recognise the severity of the patient's condition. It was recommended that communication between registrars and VMOs should be improved. However there is no evidence to indicate any changes were implemented.

Incident 18 occurred in 2001. On review the Commission found that the Director ED's analysis was incisive. It came to a slightly different view in relation to the MHS Perinatal Mortality and Morbidity Committee recommendations. Patients presenting within six weeks of delivery should have an Obstetrician & Gynaecologist review on presentation not discharge. There was no VMO involvement in the woman's management plan and the causal factor for this should have been identified.

The Commission has no concerns about the functioning of this committee.

Reportable Incidents

Incidents 3 and 39 were notified through the Critical Reporting System. The Critical Incident Reporting protocol[11] was established some years before the earliest incident examined. The protocol requires critical incidents to be reported to DOH. Under the protocol, critical incidents include patient deaths or significant bad outcomes due to possible poor hospital/service administration. It is probable that a number of incidents examined were not reported in accordance with the protocol.

The definition of a reportable incident has recently been made more objective by the use of the Severity Assessment Code. It is a risk matrix used to identify the severity of an incident using a consequence table and the likelihood of its recurrence using a frequency table. The numerical score now determines how an incident should be managed.

Root Cause Analysis

Root Cause Analysis was adopted by MHS in 2003. The framework is new and most health services are still learning how to apply it. It was applied in incidents 3 and 39. In incident 39 the RCA analysis identified the late scheduling for theatre, the lack of recognition of a significant deterioration in the patient's condition and a number of other key factors. The clinical review panel identified a further root cause – the length of time the patient waited for surgery. On the information available to the Commission it appeared that there was no post-surgery death review process, although clearly this case was picked up through another system.

In incident 3, the Commission noted that the Root Cause Analysis team focused too heavily on the fact that a nurse did not escort the patient to the operating theatre. While it represented a breach of procedure, it was not a causal factor. The Commission found that the hospital system should not have accepted an incomplete 'Request for Admission' and that the system for pre-operative assessment was inadequate. It is expected that SWSAHS will ensure that these issues are addressed.

The Commission has insufficient information to make a definitive finding in relation to the effectiveness of the utilisation of RCA at MHS.

Other management action

A range of other management action was taken in relation to incidents 1, 4, 7, 11, 13, 15, 19, 22, 41, 59 and 60.

In relation to incidents 1 and 11, management took disciplinary action against nurses. The Commission considered these actions inappropriate for the reasons set out in Part 6. In relation to incident 41, while MHS denies giving the enrolled nurse her first and final warning, the Commission considers that MHS inappropriately handled the issues raised by the incident.

In incident 4 an incident report was submitted suggesting a policy and procedure to prevent admission without notification and authorisation of an appropriate VMO or registrar. An email was later sent to MHS senior managers. Two months after SWSAHS had a proposal for Emergency Orthopaedic Networking covering the hospital concerned. The proposal was developed by the SWSAHS Orthopaedic Network which had been meeting since mid 2001, prior to the incident occurring, to develop a plan for a single on-call emergency roster for orthopaedic surgeons. Clearly both MHS and SWSAHS knew about the issue prior to the incident and appropriate action was being taken, although not soon enough for the patient concerned. The fact that the nurse involved is still raising this as an issue of management inaction two years later may indicate feedback was not given in relation to the problem report and email submitted. In relation to the solutions arrived at, the clinical review panel commented that the on call arrangement may not be satisfactory as the demands of the large tertiary facility may prevent adequate access at the hospital involved. A 24 hour on site registrar would be preferable.

Incident 7 was reviewed appropriately by an MHS internal expert after referral by SWSAHS.

In incidents 13 and 19, inappropriate action was taken against the nurses by a senior clinician.

In incident 15 a consumer complaint was reviewed internally by three clinicians. The Commission was satisfied with the quality of this review.

In incident 22 a problem report was completed about difficulties in obtaining psychiatric assessment in ED. An internal review occurred but no recommendations were made. The case was discussed at the ED Working Party which made no recommendations, probably appropriately so because the issue was across service areas. The problem was well recognized before incident 22 occurred. Two weeks later a problem report was submitted about a similar issue in ICU. (A third incident (incident 60) occurred in the same month.) The Director of ED called a forum to discuss the ongoing problems and it was decided that a psychiatric review could be done by phone. Clearly this was not acceptable however the mental health team maintained it has inadequate resources to perform after hours assessments. Sixteen months later a psychiatric registrar was employed. In June 2002 a working party was established to respond to the issues. Nine months later a service agreement is reported to have been signed by the General Manager. This was not sighted by the Commission. It appears that clinicians affected by the agreement have concerns about it and this may affect its effectiveness.

The Director also reviewed incident 59 appropriately and discussed the cases with the After Hours Hospital Managers Committee and convened a forum. Prior to incident 60 being referred to the CCRC, it was satisfactorily reviewed by the Director of ED.

MHS management moved to implement systems for quality and safety appropriately by creating structures to review clinical cases. Early structures are ineffective, partly due to resourcing issues.

The structure has been modified and better resourced. The Commission is unable to comment on the current performance of quality forums within MHS.

South West Sydney Area Health Service

SWSAHS advised the Commission it knew about five of the clinical incidents. This section deals with the adequacy of the actions taken by SWSAHS in relation to the clinical incidents it knew about.

Incident 3

Incident 3 involved the removal of the wrong breast of a patient in late 2002. SWSAHS became aware of it because MHS reported it to DOH through the Reportable Incident Reporting System four days after it occurred. SWSAHS noted MHS had:

- reviewed the clinical record
- convened a sentinel event review team
- reported the case to the CCRC
- undertaken a root cause analysis.

SWSAHS reports it has been monitoring progressive implementation of recommendations because the Area Director of Operations makes reports to DOH. The case is included in a report to the Area Clinical Council and from there to the Board of Directors.

Incident 7

Incident 7 involved an anaesthetised and intubated patient who fell off the operating table onto the floor. The matter was reported as a reportable incident. The Area Director Operations referred the matter

to the Area Director Medical and Clinical Services for a review to be undertaken in consultation with the Director of Anaesthetics, Liverpool Hospital. SWSAHS reported to the Commission that recommendations from the review were considered and implemented.

As a result the hospital had now introduced bandage type support and a strap attached to each side of the table.

The review commissioned was narrow in scope. Other issues appear not to have been considered ie the Clinical Review Panel's view that endoscopy procedures should be undertaken in Xray not in the operating theatre, and the fact that it appeared that neither the anaesthetist nor the endoscopic saw it as their responsibility and no one appeared to have overall responsibility for the patient.

Incident 18

Incident 18 involved an emergency department failure to diagnose puerperal sepsis in a post-natal patient in 2001. SWSAHS first heard about this matter when a request for a briefing note was received from the DOH in March 2003. SWSAHS advised the Commission that MHS had met with the patient's husband and referred the case to the Coroner.

In 2003 SWSAHS arranged for the Area Director, Medical and Clinical Services to explain again to the patient's husband what had happened. SWSAHS also referred the matter to the HCCC for review. In referring the case SWSAHS outlined a number of initiatives and improvements that have taken place since 2001. The MHS Perinatal Morality and Morbidity Committee also considered the matter and made recommendations, which were implemented.

Incident 39

Incident 39 involved a delay in the diagnosis of a post-operative intra-abdominal infection in January 2002. SWSAHS first knew of the incident in February 2003 when a letter addressed to the Minister of Health was forwarded to it. The matter was subsequently reported through the Reportable Incident Reporting System, though it was not clear at whose instigation. On review of the matter SWSAHS noted the case had not been reported to the Coroner and did so. The case was also forwarded to the Commission for review. SWSAHS advised its intention to report the case to the Area Clinical Council and then to the Board of Directors.

After examining the case the Commission noted that MHS had referred the incident to the ASRC for review but a root cause analysis was subsequently undertaken with the Director of Liverpool Intensive Care Unit.

Incident 61

Incident 61 involved treatment of a patient with chronic health problems over 7 months as both inpatient and outpatient. The patient's partner was distressed at being required to administer the clexane injection and re-dress his wife's cellulitis legs without adequate training and supervision.

SWSAHS first became aware of the issue when the Commission notified it about the complaint and suggested resolution through conciliation. However, a number of further issues arose and the Commission decided to review the matter as a part of this investigation. The only issue substantiated by the Commission concerned the health service's communications with the family.

Our conclusions and comments

In relation to SWSAHS no obvious concerns were raised about its performance in relation to the individual incidents it knew about. It would not have had sufficient information through these incidents alone to be expected to have concerns about the organisational performance of MHS. This is a critical issue, given the ultimate governance responsibility that the SWSAHS Board and Executive carry for the safety and quality of care across the entire area health service. Note the recommendation relating to the review of all patient deaths in part 5.14 of this report. The overall operation of the critical incident reporting system forums within SWSAHS needs review as further discussed in Part 7. A more objective and systemised approach to incident reporting is being developed by the Department of Health and this will assist area health services implement a more reliable system.

In relation to MHS the analysis of management's response to the incidents was variable. The evolution of a robust clinical incident reporting system was in its infancy during the period over which the clinical incidents occurred. While policies and procedures were promulgated and were relatively clear, the other critical steps of clinical review, action and evaluation were not well established. Simultaneously, staff were developing expectations about what the new frameworks and systems would do to address some of the long standing difficulties they were experiencing in the provision of safe, high quality care.

This review has highlighted the priority for management to implement effective systems. It is apparent that effective implementation of the quality and safety systems required additional resources at MHS. Realistic appraisal of differential resources required across area health services to achieve the implementation of major changes must occur at a statewide level. At an area health service level strategic aims and objectives must likewise be appropriately resourced.

5.17 OUR CONCLUSIONS

No conclusion can be drawn from this investigation about the hospitals' comparative performance against other hospitals or the prevalence of the incidence of adverse events or poor quality care. Reasons for this are discussed in Part 4 and the introduction to Part 5.

Generally speaking, MHS is a case study of the impact of statewide issues including low nursing morale, varying skills and knowledge of CMOs, a reduction in the number of medical officers choosing to specialise, a shortage of suitably qualified nurses and doctors and the increase in demand in emergency departments for medical conditions treatable by general practitioners.

Contextually, it is important to recognize that MHS was managing an exponential increase in demand on its services because of the growth in population. A paucity of a skilled and sufficient workplace and limited clinical leadership are also a particular problem for MHS. This review of MHS has highlighted the need for an effective statewide service planning and evaluation framework which will enable AHSs to plan new health services and the growth of established ones. The framework should enable AHSs to identify risks, strategies to manage them, and a budget necessary to safely open and deliver health services.

Structurally, although the structure of the health service is innovative, the nursing management structure required immediate attention. The reporting structure had 18 nursing units reporting directly to the Director of Nursing and Acute Services. It is the Commission's view that this structure makes it impossible for the Director of Nursing to provide the desired level of leadership and is a barrier to appropriate management responses to clinical issues when they arise.

More particularly the incidents show that the variability in the quality of care continued over four years despite the measures introduced by MHS in that time. Most of the changes introduced by MHS are endorsed by the Commission and they provide a necessary foundation for better quality of care. The trouble for MHS was that the impact of the changes did not occur early enough in the delivery of care. Health Services across the state introducing the quality and safety framework need to escalate efforts and ensure that systems changes are actually improving the quality of care in real terms.

The Commission concludes that significant improvement in the workplace culture at both hospitals needs to be effected. A lack of performance management, poor documentation, poor compliance with procedures and the lack of effective remedial action by management in response to significant concerns are evidence of a problematic culture struggling in the context outlined above.

Apart from these general observations, a high percentage of the issues identified in relation to the 47 incidents investigated were substantiated. Of the 47 incidents examined, the Commission was satisfied that in two cases an adequate level of care was provided. The clinical incidents show a variable standard of patient care and safety at both Camden and Campbelltown Hospitals, ranging from good care to very poor care where patients were placed at risk. In some incidents the care was so poor that the patients suffered serious deterioration in their health. This makes remedial action at both hospitals a very high priority.

The Commission's conclusions and comments in relation to the 14 issues identified are recorded in the body of Part 5 under each of the issue headings. The details are not repeated here. A summary of those conclusions is:

- There were significant issues relating to the availability of and supervision by senior medical staff, particularly VMOs and this has significantly affected the variability in the quality of care received by patients.

- Significant shortcomings were found in the quality of care provided to a selection of patients by some VMOs and in the support and supervision provided by these VMOs to CMOs and RMOs. There appears to be a lack of accountability evidenced in part by poor or absent documentation.
- There were incidents of inadequate standards of nursing care provided in the emergency departments at both Camden and Campbelltown Hospital, the intensive care units and, to a lesser degree in the medical wards and operating theatres.
- The MET system is not consistently working. It needs refinement and staff need further training.
- There is a sufficient pattern of inadequate care in relation to end of life decision making to suggest that there are cultural and systems issues which need improvement together with team communication and communication with families.
- Communication with patients and families was an issue in 7 out of 8 cases.
- Poor patient outcomes occurred in some cases because of poor coordination of care. Information technology overall requires improvement to better facilitate coordinated care.
- Professional barriers and the hierarchy of professions is the prevalent culture and is reinforced by management's approaches to problem solving. It needs to be replaced by effective team work where the collective objective is providing safe, quality care to patients.
- The hospitals are not reliably able to consistently identify and respond appropriately to critically ill patients. This failure can be attributed to a number of factors including a lack of supervision of CMOs and RMOs and inadequate coverage by senior medical officers in all units and departments.
- Documentation of care was poor in almost half of the cases examined. Poor documentation places all patients at risk and this issue requires immediate attention.
- Not all deaths are being appropriately reported to the Coroner.
- There are significant difficulties with transfers to and from hospitals.
- The functioning of the quality review forums in those incidents in which review occurred, including the clinical care review committee, is poor. The quality reviews seen by the Commission appeared to be mainly carried out by nursing staff. They should regularly involve medical staff.

The analysis of these events shows that adverse events are the result of:

- organisational factors
- circumstantial factors
- contextual factors
- team factors
- individual factors.

The Commission was additionally concerned by the SWSAHS and MHS submissions in relation to some of the 47 incidents reviewed by clinicians and clinical departments. The review results were in Attachment A to its submission. The Commission has noted that the open and incisive input from key clinicians was overlooked in the submission. It suggested a lack of openness on the part of some of the clinicians assisting the area. An open culture remains a key challenge for SWSAHS and MHS as the quality and safety framework depends upon open and robust critical analysis. It tends to suggest that the necessary medical leadership may still be missing from some of the existing quality forms.

ENDNOTES

1 Department of Health (2003) Dying with Dignity:Interim Guidelines on Management, 1 March 1993

2 Department of Health (2003) op cit.

3 eg. Compensation and Professional Idemnity in Health Care, A Final Report, 1995, AGPS: Canberra

4 Risser et al "A structured teamwork system to reduce clinical errors" in Error reduction in Health Care Patrice L Spath (ed) 2000 AHA Chicago Press.

5 ibid

6 NSW Department of Health (1998) Circular No: 98/59 Principles for the Creation, Management, Storage and Disposal of Health Care Records, 10 July 1998.

7 NSW Department of Health (1998) Circular No: 98/59, op cit, p 1.

8 Department of Health New South Wales Metropolitan Critical Care Plan – September 1996.

9 Macarthur Health Service Nurses Procedure Manual, Section 1A p.5

10 Macarthur Health Services Clinical Manual, Section 3 Non Clinical Procedures, 3.2 Admissions/Transfers through Emergency Department.

11 NSW Health Circular, 97/58 "Incidents Reportable To The Department"; to be read in conjunction with circular 02/19 of February 2002. The Department is presently drafting a revised circular.

Contents

6.1 INTRODUCTION 144

6.2 ACTION TAKEN AGAINST NURSES N2, N4 and N6 144

6.3 ACTION TAKEN AGAINST NURSE N3 152

6.4 SUMMARY OF INFORMATION 160

6.5 INITIAL RESPONSE FROM MACARTHUR HEALTH SERVICE 162

6.6 SECTION 43 SUBMISSION 163

6.7 OUR FINDINGS AND CONCLUSIONS 164

6.8 COMMENTS AND RECOMMENDATIONS 178

PART 6

Action taken by Macarthur Health Service against nursing staff

Action taken by Macarthur Health Service against nursing staff

6.1 INTRODUCTION

This part of the report concerns two of the issues raised in the complaint.

These issues are that:

- the culture at MHS does not support the open disclosure of errors and adverse events
- MHS management minimises incident reporting by bullying, intimidating and disciplining nurses who report adverse incidents.

We investigated the action taken by MHS against four of the nursing staff at the two hospitals. The nurses had raised concerns about management's use of disciplinary processes in response to reporting clinical and workplace incidents. The nurses were N2, N3, N4, and N6. Nurse N3 was employed as an enrolled nurse in the medical ward at Camden Hospital during the relevant period. Nurses N2, N4 and N6 were employed in the operating theatres at Campbelltown Hospital.

The focus of this part of our investigation was to find out if there had been a failure to follow correct personnel procedures. We also wanted to know whether those failures had adversely impacted on patient care and the fostering of a quality and safety culture at MHS.

We interviewed each of the four nurses and a number of MHS staff including the Acting Director of Nursing and Acute Services at the relevant time and the General Manager of MHS. These interviews were important to check factual material that was not in the MHS files and to obtain the perspective of staff and MHS management on what occurred, how it affected them and what led to the nurses raising their concerns with the Minister for Health.

We obtained documents from the disciplinary files of Nurses N2, N3, N4 and N6 and documents concerning the nurses from 'Other Papers Folder Documents Vol 6'. We also retained the services of a barrister, with industrial and employment law experience in the public sector, to assist us with our investigation.

In our preliminary report, we attached a range of detailed documents as appendices. The documents included extracts from our interviews with the nurses, indexes of disciplinary files, and copies of reports and statements from MHS. These documents were all made available to MHS, SWSAHS and the Director-General but have not been included in the final investigation report.

Department of Health review

The four nurses indicated to the Commission that they would like the DOH to review the outcome of the investigations that led to the disciplinary action being taken against them and the appropriateness of the action taken.

We therefore forwarded the matter to the Department in May 2003 to instigate the review process and to ensure that each of the nurses affected by disciplinary decisions were provided with the most appropriate and timely means of having their matter reviewed.

6.2 ACTION TAKEN AGAINST NURSES N2, N4 and N6

Our investigation covers the period from January 2002 to July 2002. At that time, Nurse N4 had been employed with MHS for 19 years and held the position of clinical nurse specialist. Nurse N2 had been

employed for 5 years and was also a clinical nurse specialist. Nurse N6 had been employed in the Campbelltown operating theatres for 14 years and was the nurse unit manager.

At the time of their initial interviews with the Commission in November and December 2002, Nurses N2 and N4 were no longer working in the Campbelltown operating theatres but N6 still held the position of nurse unit manager. Nurse N2 and Nurse N4 have since resigned from their positions but Nurse N6 is still employed at MHS.

We obtained copies of the disciplinary and personnel files for the three nurses and were also given a folder of documents about the circumstances of the three nurses and their current situation. This folder of documents was called 'Other Papers Folder Documents Vol 6' and was separate from the copies of the disciplinary and personnel files.

We also had access to the interviews conducted by the Director of Audit of the DOH with Nurse N2 and Nurse N4 and a response provided by MHS.

The incidents involving Nurses N2, N4 and N6 overlapped and disciplinary action occurred during the same period. It was convenient therefore to examine these three matters together.

Clinical incident on 15 January 2002

The starting point of the events that led to the disciplinary action taken against the three nurses was an incident (incident 1) involving a patient, Ms Z, in the operating theatres on 15 January 2002. Ms Z was a 10 year old child who presented with her mother at Campbelltown Hospital on 15 January. Ms Z had a fractured arm which was in a cast and required closed reduction under general anaesthetic. Ms Z's mother told hospital staff that there was a strong family history of malignant hyperthermia. However, when Ms Z came up to theatre later that day, theatre staff had not been made aware of the family history and there had been no pre-anaesthetic consultation before Ms Z left the ward. If the child's history had been known, certain necessary safety precautions would have been put in place. These precautions include having an anaesthetic machine that had been cleared out (this includes running through pure oxygen for 24 hours), having supplies of a certain drug, and having a senior visiting medical officer anaesthetist available to assist in the theatre.

When Ms Z presented in the operating theatre Nurse N6, the theatre manager, found out that none of these preconditions were met and in her view it would not be possible to proceed with the reduction of the fracture at that time. The anaesthetist Dr D1 arrived in the theatre and proceeded to take a history from the child and the mother. The child and the mother became distressed during this time. Nursing staff drew Dr D1 aside and told her that the operation could not proceed and that she was apparently upsetting the mother and child. Dr D1 lodged a grievance against two of the nurses, Nurse N2 and Nurse N6, the following day.

The incident was investigated by the Quality Manager and the Director of Medical Services for MHS. They interviewed the relevant parties and prepared an investigation report which provided a useful summary of the facts and issues. The report is dated 15 March 2002 and makes a number of recommendations, including a recommendation that Nurse N2 and Nurse N6 be given a formal warning.

Tensions developed in the operating theatre apparently related to Dr D1's grievance about the two nurses. This led to Nurse N2 filling out an incident report on 12 April 2002 in relation to the matter. On 18 April 2002 Nurse N4, who was not involved in the Ms Z incident, lodged an incident report or

grievance about Dr D1. Nurse N4 reported verbal disagreements between Dr D1 and herself in theatre on 18 April 2002 which culminated in Dr D1 slapping her on the hands at the patient's bedside and Nurse N4 withdrawing from the case. Apparently, as a result of the incident report by Nurse N2 about Dr D1 on 12 April 2002, arrangements had been made for other operating theatre nursing staff to attend interviews with MHS management. Four nurses refused to attend interviews on 19 April 2002.

On 19 April 2002 the General Manager of MHS and the Human Resource Manager met with two registered nurses and an enrolled nurse from the operating theatres – Nurses N17, N18 and N19. The nurses were accompanied by a person from the NSW Nurses Association. The relevant note of that meeting (Other Papers Folder Documents Vol 6) stated that the meeting was called at the request of the Association's representative. However, some of the other documents suggest that some or all of the operating theatre nursing staff who attended the meeting had been requested to meet with management that day in relation to Nurse N2's incident report.

Allegations against Nurses N2 and N4

At the meeting on 19 April 2002 the three nursing staff, Nurses N17, N18 and N19, made a series of allegations of bullying and harassment by Nurses N2 and N4. The allegations are recorded in general form on a one page statement by the General Manager. The statement does not show which staff member made what complaint and there is a general lack of detail.

In response to the concerns raised by the three nursing staff, the General Manager made a decision to suspend Nurses N2 and N4 on full pay as of 19 April 2002. This decision was made in consultation with the Manager of Human Resources for SWSAHS. However there is no document on the disciplinary files or in the 'Other Papers Folder Documents Vol 6' recording the involvement of the Manager of Human Resources.

Nurse N2 was on duty and was told of the decision to suspend her that afternoon. Nurse N4 was at home and was asked to come into the hospital. She did so somewhat reluctantly and was then informed that she was suspended. A letter dated 19 April 2002 was given to both Nurse N2 and Nurse N4 on that day stating:

> *'Dear ……*
>
> *A number of bullying, harassment and victimisation allegations have been raised in regards to your behaviour. Macarthur Health Service considers these allegations serious and need to be investigated. I have decided that these allegations will be investigated by an independent person to the organisation.*
>
> *Given the nature of the allegation, I consider that it is in your best interest and that of the Health Service that you not be on duty at this time. Therefore I now direct you not to report for duty until further notice by the Health Service. You will continue to be paid during the period of absence.*
>
> *In making the direction that you will not be reporting for duty does not nor should not imply that the allegations are true but rather that they need to be investigated.*
>
> *You are also directed to have no contact with staff either on duty or socially until this investigation is completed.'*

Report by Ms Stow

On 30 April 2002 the General Manager asked Ms Jan Stow to survey and report on the operating theatres at Campbelltown Hospital. Ms Stow is a retired senior nursing administrator and independent of the health service. The letter commissioning the services of Ms Stow was not included in the papers made available to the Commission but the covering letter accompanying Ms Stow's report notes that she was commissioned on 30 April by the General Manager.

Ms Stow's report is dated May 2002. It starts with the background to the report and then refers to three significant incidents. Firstly, there is bullying involving a visiting medical officer and secondly there is the complaint made by Dr D1 about Nurses N2 and N6. The third incident is the allegation made to the General Manager by the three nursing staff (who are not named) against Nurses N2 and N4 - this is noted to be under investigation by senior management.

The survey of the operating theatres at Campbelltown Hospital involved interviewing sixty staff using a standard questionnaire. The staff interviewed were assured that their comments were confidential. An analysis of the answers and a transcript of the comments is attached to the report. Nurses N2 and N4 were not among the staff interviewed.

The staff do not seem to have been told that Ms Stow was investigating specific allegations of bullying against named staff members. In the background section of her report she states that she was engaged to review the operating room work environment.

Ms Stow's report includes statistical information about the responses to the standard questions and summaries of comments made. The comments include general statements about unnamed staff by unnamed interviewees as well as specific comments recording allegations about named staff members. In the conclusion to the report there are specific and serious allegations about named staff members and then thirty-three recommendations. The first four recommendations specify proposed management action to be taken against both named and unnamed staff members in relation to allegations of bullying, harassment, discrimination, corrupt conduct and professional misconduct. The other recommendations concern staff training and development and the review of operating theatre policies, procedures, processes and related actions by management.

MHS investigation process

The documents suggest that between April and June 2002, in addition to the Stow review, there was a fact finding investigation conducted by the Human Resources Manager and the Director of Aged Care and Rehabilitation at MHS into allegations of bullying, harassment and corrupt conduct against Nurses N2, N4 and N6 and another identified nurse.

On 24 May 2002 Internal Audit Services, SWSAHS was asked by the General Manager to examine matters in the Stow report relating to alleged corruption. On 4 June 2002, the Director of Internal Audit Services at SWSAHS reported to the General Manager noting that there was no evidence of corrupt conduct. The report also noted the emotional content of the Stow report and that its use of the terms fraud and corruption were inappropriate.

In 'Other Papers Folder Documents Vol 6', but not in the disciplinary files, there is a statement by Nurse N18 dated 28 May 2002 noted to have been requested by the General Manager on 27 May 2002, a statement signed by nurse N17 dated 28 May 2002 which refers to a meeting between the General Manager and her on 27 May 2002, and a further document addressed to the General Manager dated

30 April 2002 recording alleged harassment and improper conduct by Nurses N2 and N4. The signature on the final page is unintelligible but could be that of Nurse N19. There are no notes of the meeting with the General Manager and the nurses on 27 May 2002. There are no documents in the file that suggest the three nurses alleging the bullying and harassment in the operating theatre were interviewed by the Human Resource Manager or the Director of Aged Care and Rehabilitation as part of their investigation.

Disciplinary action against Nurses N2 and N4

After Nurses N2 and N4 were suspended, their legal and union representatives requested details of the allegations against them that had led to their suspension. These requests, which included the identity of the complainants, were refused by return correspondence signed by the General Manager.

In an undated letter, Nurse N4 was invited to a fact finding interview about the allegations against her on 12 June 2002. Attached to that letter was a two page document called 'Allegations against N4, 7 June 2002'. The allegations concerned bullying, harassment and victimisation of staff, inequitable access to educational opportunities, discriminatory rostering practices and discriminatory flexible work practices.

Similarly, in another undated letter, Nurse N2 was invited to attend a fact finding interview on 4 June 2002. Attached to that letter was a four-page document called 'Allegations against N2'. These allegations are set out under headings including discriminatory rostering practices, discriminatory flexible work practices, bullying, harassment and victimisation of theatre staff. They include some similar allegations to those made against Nurse N4.

Separate fact finding investigation reports were completed about Nurse N2 and Nurse N4 by the Human Resource Manager and the Director of Aged Care and Rehabilitation on 4 July 2002. Both reports refer to the Stow report, the statements from staff 'who originally made allegations' against Nurses N2 and N4, an analysis of theatre staffing conducted by the Quality Manager, a file note of a meeting between the Acting Director of Nursing and Acute Services, the General Manager, and Nurse N6 on 23 April 2002 (no copy of this document appears in the files) and fact finding interviews conducted with Nurses N2, N4 and N6. The reports specifically refer to the reports of bullying and harassment identified in the Stow report as a basis for substantiated findings against the nurses and their recommendations that the nurses face disciplinary action.

Nurse N4 was invited to attend a disciplinary interview on 5 July 2002 as was Nurse N2. After the disciplinary interview, very similar letters were sent to both Nurse N2 and Nurse N4 on 5 July 2002 advising that the allegations against them had been found proved. They were issued with a first and final warning, directed not to return to work in the operating theatre and advised that their clinical nurse specialist status would be removed.

The letter to Nurse N4 included findings in relation to two specific reported incidents of harassment including obstructive and argumentative behaviour towards an anaesthetist CMO and being verbally aggressive and intimidating towards staff about attendance at an in-service session. This was further *'supported by five general reports of harassment and five general reports of abuse of power identified with the operating suite report conducted by an external consultant. Those findings constituted a breach of the South Western Sydney Area Health Service Code of Conduct Section 4.'*

The findings in relation to Nurse N2 were of two specific incidents of harassment – staff being pressured and intimidated into adopting new work practices (sponge bags) and her behaviour towards Dr D1 on

15 January 2002. It was also noted that her treatment of a theatre orderly constituted inappropriate behaviour rather than harassment and this *'was supported by six general reports of harassment and six general reports of abuse of power identified within the operating suite review report conducted by an external consultant. Those findings constituted a breach of the South Western Sydney Area Health Service Code of Conduct Section 4.'*

Action taken against Nurse N6

Nurse N6 attended a fact finding interview in June or July 2002 about the allegations of victimisation and intimidation in the operating theatre. The letter requesting Nurse N6 to attend a disciplinary interview was dated 25 July 2002 and notes that the matters raised at interview will be the outcome of the recent fact finding processes and the management of the operating theatre. During the disciplinary interview on 31 July 2002, Nurse N6 was asked further questions about the Dr D1 incident. The Acting Director of Nursing and Acute Services (ADNAS) and the Quality Manager (QM) asked a number of questions of Nurse N6. It was put to her that her conduct on that day constituted harassment, a fact that Nurse N6 and her representative from the Nurses Association, Ms JG, strongly disputed. There was a concession that there was perhaps no intentional harassment, however, the interview continued as follows:

ADNAS: *' That doctor was made to feel harassed and intimidated by Nurse N6 and that's her feeling. We can't change that. That's how the doctor felt.'*

JG: *' The doctor may very well have felt that way and it's all we've discussed before, it's how individuals perceive it but that doesn't necessarily mean to say it was the intent, the intent was to look after the safety of the patients.'*

ADNAS: *'I honestly believe that was the intent. But it was the way it was done.'*

N6: *' How does that constitute harassment? How does that relate. I don't understand it at all. Harassment is constant.'*

ADNAS: *' No it's not constant.'*

N6: *'It's a one off you're telling me.'*

ADNAS: *' Well it could be.'*

JG: *' Well if we're going by the DOH definitions and it does say they continue. I'm not sure of the wording but it certainly says a lot more than one off.'*

ADNAS: *'Dr D1 felt, the way you made her feel.'*

N6: *'But because Dr D1 felt that doesn't mean that it's true. That's how she felt but we can't change that…'*

QM: *' But there is a different reason behind it. The situation was Dr D1 did not have the opportunity to make the clinical call, where as if she'd been able to make the clinical call and she was going to go ahead and you stopped it Nurse N6, then you're complying with duty of care to her patient that's the difference.'*

JG: *'But she would have perceived that she was being harassed.'*

N6: *' I was the patient's advocate on that particular day regardless, I mean who are we putting first here, we're putting Dr D1 before the safety of the patient?'*

ADNAS: *'No we're not.'*

N6: *'Yes you are.'*

ADNAS: *'Well she found that bullying and intimidating.'*

N6: *'How can it be bullying when you tell somebody that you can't go ahead with the case because it is unsafe. How can that be bullying?'*

ADNAS: *'It must be in the way that you approached it Nurse N6.'*

N6: *'I could hardly speak that day, I couldn't speak above a whisper.'*

Nurse N6 was also questioned about her management of an allocation of time in lieu, flexible work practices, the signing off of time sheets, pay for staff and delegation of managerial duties to staff.

Further on in the interview the Acting Director of Nursing and Acute Services stated:

ADNAS: *'The management of inappropriate behaviour of a number of staff is substantiated.'*

Nurse N6 sought more specific information about that allegation. The Acting Director of Nursing stated:

ADNAS: *'Well they're the issues that come to mind, the fact that you didn't address the issue Nurse N6, and may be if you were to address these issues earlier as they happen rather than saying nobody gave it to me in writing, then maybe we wouldn't be where we are today with two staff who… the whole situation has gotten out of hand. Maybe you have to take some account for having a part to play in that. What part did you play in that has led these two girls to having disciplinary action taken against them. As the manager, had you done something earlier and nipped it in the bud.'*

On the same day that Nurse N6 attended her disciplinary interview, a fact finding investigation report on Nurse N6 was completed by the Acting Director of Nursing. This report found that certain allegations were substantiated and recommends that Nurse N6 be given a first and final warning. A letter was sent to Nurse N6 on 5 August 2002 advising her of the outcome of the fact finding and disciplinary process and issuing her with a first and final warning.

Letter to the SWSAHS Board

On 1 October 2002, a letter was sent to the Chairman of the Board of Directors of SWSAHS by 94% of the staff of Campbelltown Hospital operating theatre. The letter did not include individual signatures but simply concludes with the words *'94% of the staff of Campbelltown Hospital operating theatre.'*

The letter records concerns about recent events in the operating suite and refers to the incident in January 2002 involving an anaesthetist and a further incident in March involving the same anaesthetist and another senior nurse. It goes on to refer to the suspension of two nurses and the independent investigation into the operating theatre conducted at the request of the General Manager. The letter notes that the results of this investigation revealed that 94% of the staff interviewed, which included nursing, medical, clerical and auxiliary staff, were happy working in the theatre in the current environment. Six percent, which equates to 3.6 of the 60 people interviewed, were unhappy or had

concerns about the running of the department. It noted further action taken in relation to staff including the resignation of one of the nurses and the fact that the nursing unit manager, Nurse N6, was being asked to attend a further fact-finding interview.

The letter ended by saying:

> *'Since all of these events have taken place, morale in the work place is rock bottom. Sick leave has increased dramatically with nurses feeling physically ill at the thought of going to work and taking time off citing depression. We've also for the first time in the history of Campbelltown theatres had to employ agency nurses from ASEPS.*
>
> *There are nurses in the complex looking for alternative employment and some of the VMOs have been heard to say that they will withdraw their services. What was once a happy work place with everyone enjoying their job with a flexible and democratic leadership of our Nursing Unit Manager has deteriorated to a unit full of unhappiness, suspicion, fear and intimidation.*
>
> *Even though the original fact finding investigation was found to be flawed by the New South Wales Nurses Association it has, nevertheless, resulted in damage to the professional reputation of the two nurses involved which is irreversible. Our current concern is for the Nursing Unit Manager whose leadership appears to be unjustly in question by management.'*

Efforts to reintegrate Nurses N2 and N4

Included in the papers provided to the Commission was the General Manager's undated response to the Acting Director of Operations SWSAHS. In this letter the General Manager records the efforts made to reintegrate Nurses N2 and N4 back into the workforce after the disciplinary action had occurred. She noted that Nurse N4 was offered a position at Liverpool Hospital in the operating theatres and then, at a further meeting on 14 August 2002, offered a transfer to day surgery at Camden Hospital. On the same day a meeting with Nurse N2 was held where she was offered a position at Bankstown Hospital in the operating theatres. Nurse N4 accepted the offer to return to Camden but the letter noted that day surgery staff complained about alleged previous bullying and harassment by Nurse N4 in the past.

On 9 September 2002 Nurse N4 tendered her resignation. Nurse N2 did not accept the position offered at Bankstown and tendered her resignation.

The General Manager noted that, as a result of the findings in the Stow report, a number of other nursing and medical staff were also named and investigated in relation to claims of bullying and harassment but to a lesser extent. Those staff attended individual meetings and each was given a verbal warning.

6.3 ACTION TAKEN AGAINST NURSE N3

Nurse N3 was employed as a casual enrolled nurse by SWSAHS in July 2001. At that time, she had had 13 years of experience as an enrolled nurse in a number of different places. In February 2002, Nurse N3 applied for a permanent part time position at the medical ward, Camden Hospital. She accepted that position in June 2002.

Nurse N3's personnel and disciplinary file from MHS includes the documentation relating to her recruitment to the casual and the permanent position. There is also a transcript of a fact finding interview conducted with her on 17 June 2002.

Present at this interview were the Acting Nurse Unit Manager, Nurse Manager, Nurse N3 and Nurse N7, and a witness support person for Nurse N3. The interview begins with reference to a letter sent to Nurse N3 on the previous Friday. However, there is no copy of the letter in the file.

The Nurse Manager began the interview by stating that they were doing a fact finding interview to establish the facts in two episodes of care.

Incident one

The first incident was provision of care to Mr NE (incident 41) on 10 June 2002.

Nurse N3 was asked to give her account of the incident. Nurse N3 was on duty with Nurse R3, an RN. Nurse N3 stated that the patient complained of being unable to breathe. She said he was hyperventilating and she and Nurse R3 tried to calm him down. The patient was taken to the toilet and returned to bed but he still complained of not being able to breathe. Nurse N3 said they did his observations - his oxygen saturation was 100%, and his respirations were about 35. He was hyperventilating, using his accessory muscles, not cyanotic, he was not panicking, and he was 'air hungry'.

Nurse N3 asked Nurse R3 whether they should make a medical emergency team (MET) call but Nurse R3 suggested they ring the intensive care unit (ICU) instead. Nurse N3 rang ICU and spoke to a registered nurse. She explained what the problem was stating the patient was complaining of shortness of breath and felt he needed a CPAP machine (continuous positive air pressure). Nurse N3 asked them to send a doctor up to review the patient noting he was clinically stable but needed review. The ICU nurse said the doctor would come when he was able.

Nurse N3 then returned to the patient. The registered nurse was still with the patient who had a Hudson mask on. The patient was still distressed and still asking for the CPAP machine. Then Nurse R4, an RN from the ICU, came up and asked the patient what the matter was. Nurse R4 was apparently familiar with the patient. She examined him and said he was okay, he had no pulmonary oedema, he had no creps, his chest was clear. She told the patient to calm down. She asked if they had given him any Ventolin and anything to calm him down. They said no, they were waiting for the doctor. Nurse N3 asked whether they should call a MET and the ICU nurse said no. She advised the patient that he could not have CPAP on the ward. The patient still said that he needed the CPAP machine to force the air down. The nurse told them the patient was stable and she would send up the doctor when he was available.

Nurse N3 stated she then gave him some Ventolin. They also gave him some mist morphine which had been ordered for the patient as required. The patient was still nervous. He was sitting forward,

hyperventilating and panicking. Nurse N3 asked him if he wanted the bag and he said yes. Nurse N3 got the bag hooked into his mouth, inflated the air reservoir, put on the oxygen and gave him less than a minute of very gentle air pressure to calm him down and to reassure him that the air was going down.

Nurse N3 stated she was careful not to press too hard so as not to give him a tension pneumothorax. She also did not want to over oxygenate him because she knew he had chronic airways limitation. After a minute he said he was okay and she then removed the mask. He calmed down and started to breathe more slowly and carefully. Nurse N3 then wrote down some notes but promised to come back and check him every few minutes. When she came back, the patient told Nurse N3 that he needed the bag again. Nurse N3 stayed there and then gave him another Ventolin ampoule. He still asked for the bag and she gave him the bag one more time. He calmed down.

Dr D49 came up from ICU to see the patient and they told him what had occurred. The doctor said the patient seemed stable and didn't need to go down to ICU. They completed the records and finished their shift.

At the interview, Nurse N3 was shown the nurse initiated medication chart. She was also asked to confirm that Nurse R3 was with her the whole time. The Nurse Manager noted that Nurse N3 had signed for the nurse initiated medication.

Incident two

The second incident dealt with the care of Ms AA and the insertion of an indwelling catheter on 24 May 2002. Nurse N3 stated that she was working with Nurse N20, registered nurse, and Nurse N21, trainee enrolled nurse. They were working at Camden Hospital and they divided the wards into sides. Nurse N20 was administering medications and was in charge.

The patient had been climbing out of bed mainly because she continually needed to go to the toilet. Nurse N3 stated she believed that the patient had a urinary tract infection. She said that she and trainee Nurse N21 took her to the toilet for the umpteenth time. Nurse N3 stated that she performed a bladder scan and then told Nurse N20 the results of it and that she thought the patient had a urinary tract infection.

Nurse N3 asked Nurse N20 what she wanted to do. Nurse N20 said the patient would need an indwelling catheter. Nurse N3 agreed and Nurse N20 asked her whether she was happy to do the catheterisation. Nurse N3 said she had done indwelling catheterisations before and was happy to do it.

Nurse N20 said it would be great if she could do it as she was busy. Nurse N3 took trainee Nurse N21 with her and showed her how to set up the trolley following the hospital protocol. She then inserted an indwelling catheter. It drained around 400ml out of the patient. From then on the patient did not need a special nurse and stopped climbing out of bed.

Nurse N20 thanked Nurse N3 and trainee Nurse N21 and wrote up the report. Nurse N3 felt there was nothing to add to what had been written in the notes.

Nurse N3 stated that the first that she had heard there was a problem was when the Nurse Manager asked her to talk them through the catheterisation. Nurse N3 said it was an easy catheterisation and she located the urethra on the first attempt.

The Nurse Manager asked what she meant by following the hospital protocol. Nurse N3 replied that she

meant using the catheter packs, swabbing the vagina with normal saline, inflating the balloon, checking that it inflates, locating the urethra or visualising where it is, inserting the catheter until the urine flows and inflating the balloon with 5ml of water.

The Nurse Manager asked whether Nurse N3 was aware that MHS policy says that indwelling catheters are to be done by a medical officer or a registered nurse. Nurse N3 stated she did know this.

The Nurse Manager asked for her comments in view of the policy. Nurse N3 stated that it was in her job description to act under the direction of a registered nurse and she believes that if she is competent in carrying out a procedure, if the registered nurse feels confident in her doing that procedure, and neither of them have any concerns then, depending on the circumstances, there are occasions when it is necessary to extend the role of every person working in the hospital when the need arises. She noted this applies to enrolled nurses, registered nurses, nurse unit managers and clinical nurse educators.

The Nurse Manager asked if she was aware of any adverse effects to the patient following the catheterisation. Nurse N3 replied no.

The Nurse Manager asked if she was aware that the patient had a positive midstream urine sample taken four days after the catheterisation. Nurse N3 stated no but she would say that the patient had an infection before the insertion of the catheter.

The Nurse Manager asked why Nurse N3 had undertaken the procedure. Nurse N3 said because the patient was constantly asking to void and then being unable to void, asking to go to the toilet and only passing small amounts of urine and was confused. The patient had been admitted with confusion, was febrile and not able to pass urine.

The Nurse Manager asked Nurse N3 to clarify whether Nurse N20 actually directed her to put the catheter in. Nurse N3 said Nurse N20 was aware that she was putting it in and did not tell her not to put the catheter in.

The Nurse Manager asked whether trainee Nurse N21 enquired whether this was part of the job description of an enrolled nurse. Nurse N3 stated she told Nurse N21 that it was not a usual thing for an enrolled nurse to insert a catheter but, depending on the hospital and your level of experience, you may be required to insert them if you are competent to do so.

The Nurse Manager enquired where Nurse N3 had done catheterisations for fifteen years and Nurse N3 stated she had done them at hospitals she had worked in including South Western Sydney Private and Royal Prince Alfred.

Nurse N3 enquired how the matter had got to this stage of her being interviewed when she had not been asked any questions on the ward, and why other staff who were not related to this incident had been asked to comment on her performance.

The Nurse Manager said she had been asked to do a fact finding interview by the Acting Director of Nursing and Acute Services. The incident involving Mr NE had come to the attention of the Nurse Unit Manager on the ward following hand over.

The Nurse Manager also said that there was concern about the medication chart which showed Nurse N3 signing off for a nurse initiated medication. This was against hospital policy. They had investigated the file of Ms AA and it appeared from the notes that trainee Nurse N21 had passed a catheter. The

Nurse Manager said that the hospital was responsible for the supervision and training of enrolled nurses and they saw this as a fairly grievous offence.

Nurse N3 asked why this had gone to a fact finding process as she had observed other incidents on the ward concerning other people that had only resulted in an interview with the nurse unit manager.

Disciplinary interview

On 4 July 2002 Nurse N3 attended a disciplinary interview. It would appear that a letter was sent to her requesting her to attend the disciplinary interview but this letter does not appear on the file. The disciplinary interview was conducted by the Acting Director of Nursing and Acute Services and the Nurse Manager. Nurse N3 did not have a support person with her at the interview.

The Acting Director of Nursing and Acute Services stated that the interview would deal with a number of matters. These included Nurse N3 signing for nurse initiated medications, the care of a patient using a Laerdal resuscitator and the catheterisation of a patient. In addition, since the initial fact finding interview, there had been a further incident where it was alleged Nurse N3 had cannulated another patient. Nurse N3 agreed to deal with this further cannularisation incident during the second interview.

Incident one

In relation to the nurse initiated medication, Nurse N3 stated that Nurse R3 had since left SWSAHS. She said that they were both unsupported in the ward at the time as they could not get a doctor to come and help when the patient was in respiratory distress. She confirmed that she had signed as administering the patient Ventolin although she was not administering the drug. She said that she mistakenly signed for it because she could not find the registered nurse. She said she did not exceed her training and that the ICU nurse had told her to initiate the Ventolin. Nurse N3 confirmed that Nurse R3 told her to give the second nebuliser and that it was given on two occasions within half an hour.

Nurse N3 confirmed that she wrote up one lot of Ventolin at 4:05pm and another at 4:20pm on the nurse initiated medication sheet. She said it happened very quickly, like in an arrest situation. They had no medical back up and she wanted to make sure that everything was written up. Nurse N3 stressed that it was Nurse R3 who got out the medication and gave it to her. The Acting Director of Nursing and Acute Services stated that Nurse R3 disputed that. The Nurse Manager stated that the only signature in the medication chart is Nurse R3's signature for 6pm and that Nurse R3 recalled giving a 6 pm Ventolin but doesn't recall any other doses at 4:05pm or 4:20pm. Nurse N3 reiterated that Nurse R3 was in the room the whole time.

The Nurse Manager noted that the only evidence is Nurse N3's signature on the nurse initiated medication chart, administering a schedule medication that even registered nurses in the hospital may not initiate as it requires a medical officer's order.

Nurse N3 started to raise other concerns she had about practices on the ward. She defended her conduct and that of Nurse R3 on the night in question and said the nurse unit manager apologised to her and said it should never have come to this. She noted the large amount of work in the ward and how it was unreasonable to expect Nurse N20 to oversee everything that was done, do every catheterisation, phone every doctor, write every report, check everyone's notes, check everyone's observations, give all the medications and oversee the whole ward. She noted that if people are put in a situation where the registered nurse has 90% of the job and the trainee nurse has 10%, it follows that

the enrolled nurse, if they are experienced, will be taking on a bit more of the load. She said she had provided the medication because she is an experienced nurse and had never had any problem at any other hospital she had worked in.

Incident two

In relation to the catheterisation, Nurse N3 agreed that it was not within the bounds of MHS policy but she had done it many times in other hospitals she had worked in. Nurse N3 reiterated the reasons why she performed the catheterisation even though she was aware that it was outside hospital policy. She knew that the lady was uncomfortable and had been uncomfortable for days. Nurse N3 stated her action was not outside of what she knows and what she had been taught.

The Acting Director of Nursing and Acute Services asked her about her aseptic technique and Nurse N3 stated that her aseptic technique is as good as anyone else's. She repeated her view that the patient had already had a urinary tract infection that had not been picked up. The patient was only being given IV fluids and nothing for a urinary tract infection. She noted other patients have come into the ward with confusion and dehydration and lethargy and been diagnosed with a urinary tract infection.

The Acting Director of Nursing and Acute Services stated it was in dispute as to whether the catheter went straight in. Nurse N3 stated that the catheter went straight in. The Acting Director of Nursing and Acute Services stated that trainee Nurse D21 stated that Nurse N3 did not get it in first go - that she had two attempts with the same catheter.

Nurse N3 stated that Nurse D21 was under the spell of people who can make life very difficult for you if you don't go along. She mentioned some names and said if you're not in their team they would make life hard for you which is why she is sitting here and why two others had left. She also mentioned other nurses who had left the medical ward because other staff members had made life unpleasant for them.

Incident three

The next matter dealt with was the insertion of a cannula into a patient, Mrs BB. There was a doctor at the nurses' station at the time of the incident. Nurse N3 said the doctor on the morning shift was also the doctor on the afternoon shift and he said that he had tried previously to cannulate the patient who had a large haematoma on her arm. He told the registered nurse on duty and Nurse N3 that he could not cannulate the lady. He had had a few attempts that morning and felt upset at what he had done to her arm as it was black and swollen.

The registered nurse said, *'We'll go and have a go and see if we can get it'*. They gathered the equipment and went to the patient. Nurse N3 said they held the patient's arm, they could see a vein, they put the tourniquet on and inserted it together. They got the cannula in, flushed it, gave some IV antibiotics and everything was fine. Nurse N3 stated she inserted the cannula into the vein under the direct supervision of the registered nurse who asked her to do it while she held the patient's arm.

The Nurse Manager asked her about her accreditation for cannulation. Nurse N3 said she had cannulated for six years at Royal Prince Alfred Hospital but they did not have cannulation courses in those days.

She was asked about Liverpool Hospital and Nurse N3 said at Liverpool she did not cannulate. The Nurse Manager confirmed that Nurse N3 had not done an official vena puncture cannulation course and she was not accredited or registered. Nurse N3 said that was correct.

Nurse N3 was asked again why she would put it in and Nurse N3 went into more detail as to why she did put it in and how the registered nurse told her to put it in while she held the vein. Nurse N3 confirmed that she exceeded her role under the direction and supervision of a registered nurse. However, she had done this in other ways while at Camden where she had changed chest drains and taken out a femoral line because the registered nurses on the wards didn't know how to do it.

The Nurse Manager noted that the New South Wales College of Nursing course does not include the administration of nebulised medications. This is an additional certificate and it is a schedule 4 drug that had to be ordered by a doctor. The administration of medication course is for schedule 2, schedule 3 and unscheduled drugs.

Nurse N3 stated that she might have gone beyond the policy but not beyond her scope in practice over the last 14 years. She stated that she had worked in hospitals where she was allowed to exceed the boundaries.

The Nurse Manager stated that she checked with the Royal Prince Alfred Hospital and it is certainly not the policy there for enrolled nurses to catheterise. In response to a question from the Nurse Manager, Nurse N3 confirmed that she had probably catheterised three times.

The Acting Director of Nursing and Acute Services pointed out to Nurse N3 that the hospital would have been held liable if there had been an injury to the patient and to protect herself she must work within her scope as an enrolled nurse. Nurse N3 again stated that they needed to see who was doing the complaining and that she was going to start making a list of what they do on the ward. Nurse N3 said that she had some things documented and she would start writing incident forms for some of the practices that go on in the ward.

There was then a break. When the interview resumed, Nurse N3 was advised that she would be given a first and final warning in regards to practising beyond the scope of an enrolled nurse. The Nurse Manager also encouraged her to have some career counselling and to think about a future as a registered nurse by going and doing further training. Nurse N3 stated that would not suit her at the moment as she had a young family.

The Nurse Manager confirmed to Nurse N3 that the New South Wales Nurses Registration Board put boundaries on practice commensurate to the skills and knowledge base taught in courses. Nurse N3 was advised that for the average enrolled nurse these boundaries are there to protect patients. A 14-week theoretical course cannot be compared to a three-year undergraduate degree. Nurse N3 was told that the people of New South Wales, and patients in particular, have to feel confident that people who are nursing them are skilled to nurse to a certain point. It is the same for registered nurses who also have boundaries.

The Nurse Manager noted it was up to nurses to keep their accreditation valid so the fact that Nurse N3 had never been through a cannulation course means she had never been accredited to do that on her own. She was therefore on her own and was being sucked in by people asking her to work beyond her scope of practice. The Nurse Manager noted it must be difficult when you are trying to settle into an area and wanting to be part of a team.

Disciplinary letter

On 15 July 2002, Nurse N3 was sent a letter confirming that the allegations that she exceeded the scope of her clinical practice as an enrolled nurse were substantiated.

This decision was based on four specific incidents which were:

- the administration of a schedule 4 medication on two occasions, which she initiated
- the bagging of a patient with a Laerdal resuscitator to provide a placebo effect
- the urinary catheterisation of a female patient
- the intravenous cannulation of a patient.

In the letter, Nurse N3 was directed to work within her scope of practice as an enrolled nurse and, when in doubt, to refer to the clinical manual and work instructions. She was asked to send the nurse manager her accreditation for the enrolled nurse medication course so she could be accredited at MHS. She would also be given a Salbutamol learning package. Successful completion of the course accredits enrolled nurses to administer nebulised Ventolin that has been ordered by a medical officer. She was also asked to consider career counselling and further education as a registered nurse. She was warned failure to comply with the policies governing clinical practice for enrolled nurses would result in further disciplinary action. This could lead to termination of employment and referral to the Nurses Registration Board.

On 17 July 2002, Nurse N3 requested that her disciplinary record and warning be removed from her permanent record in six months time, after a consideration of her further practice. She requested a follow up interview with the Acting Director of Nursing and Acute Services and a union representative in six months.

Letter from Nurse N3

On 21 July 2002 Nurse N3 sent a separate letter to the Acting Director of Nursing and Acute Services responding to the disciplinary letter. In the letter, Nurse N3 denied that she initiated or administered medication. In relation to the bagging of a patient with a Laerdal resuscitator to provide a placebo effect, she stated that this procedure was within the scope of an enrolled nurse and referred to section 10a of the clinical manual. She recorded her disappointment that SWSAHS had failed to protect her and her patient by not ensuring access to a medical officer.

In relation to the female catheterisation and the cannulation, Nurse N3 noted that this was done under the direction and with the knowledge of a registered nurse. She noted the lack of staffing and the inadequate skill mix on the shift. She said this puts undue stress on staff and requires the next senior nurse to take over duties, roles and responsibilities not normally required if the ward was adequately staffed and the skill mix reasonable.

Nurse N3 stated that since her employment at SWSAHS she had been continually requested and expected to exceed her scope as listed in the clinical manual. She stated that other staff continued to exceed their scope and some are not even capable of reaching their scope. She said she would continue to bring to the attention of administration specific incidences of dangerous practices, long standing problems that the medical ward has with accessing the MET, and other problems that made her feel uncomfortable in her workplace.

She referred to her previous record as an enrolled nurse for 14 years in major teaching hospitals during which she was never asked to undergo a fact finding interview or attend a disciplinary interview. She stated that she believed the action was harsh and evidence of the fact that she was being singled out and unduly punished. She noted her unfair treatment had caused her and her family stress, anxiety and insomnia.

The review by SWSAHS

On 29 July 2002, the Acting Director of Nursing and Acute Services told Nurse N3 that she would send all the documents relating to the fact finding and disciplinary process to the Human Resources Department of SWSAHS for an independent review. They would review the process and make recommendations to the General Manager.

On 2 October 2002, the Human Resources Coordinator of SWSAHS wrote to Nurse N3 and stated that the matter was being investigated. She noted that a side of the tape recording of the disciplinary interview held with Nurse N3 on 12 July was not included in the transcript of the interview. A full copy of the transcript was sent to Nurse N3 on that day.

On 18 October 2002, Nurse N3 was sent a report on the investigation of the disciplinary matters. The report recommended that the warnings given to Nurse N3 in relation to each of the four matters should remain. The General Manager advised Nurse N3 in a letter that she had accepted the recommendations in the report. It would appear from the file that Nurse N3 went on sick leave on 17 October 2002.

In her interview with the Commission, Nurse N3 stated that she believed she had been victimised and discriminated against as she had not been offered the position of Palliative Care Volunteer Coordinator by SWSAHS. She wrote a letter to the General Manager of MHS in September 2002 requesting that the matter of her failure to obtain the position be reviewed.

On 11 December 2002, the General Manager wrote to Nurse N3 stating that the recruitment and selection process for the position had been reviewed and found to be valid. It was noted that Nurse N3 contacted the selection committee convenor and met with her and another person and received feedback about why she was unsuccessful in obtaining the position. It was also noted that transcripts of referee reports were not provided to applicants. One of Nurse N3's referees was a relative and other referees were unable to adequately comment on her performance in the workplace so contacting further referees was unnecessary. The process of selection and recruitment involved assessing information gathered by the selection committee from the application, interview and referee checks. The selection committee deemed the appointed candidate to be the best applicant overall after reviewing the information gained in the process.

Nurse N3 is currently on unpaid leave from MHS.

6.4 SUMMARY OF INFORMATION

The following observations are based on our review of all the transcripts and documents.

Disciplinary action against Nurses N2 and N4

The decision to suspend Nurses N2 and N4 was made by the General Manager of MHS in consultation with the Human Resources Manager, SWSAHS. It was based on a meeting between the General Manager and three members of the operating theatre complex staff, Nurses N17, N18 and N19, and their union representative. The three staff members apparently expressed fears about what may happen to them because they had complained about the two nurses, but the precise nature of their concerns remains unclear. No further inquiries were made before suspending the two nurses, although the Acting Director of Nursing and Acute Services was aware of a fear amongst the three nurses of being sued for defamation.

The Nurse Unit Manager of theatres, Nurse N6, was not consulted about the decision to suspend the two nurses and was not told the reasons for the suspension beyond the information given to all the staff.

Nurses N2 and N4 were simply informed of the suspension. They were not given an opportunity to comment on the reasons for the suspension or advised who had made allegations against them. This situation continued throughout the period of their suspension. Another member of staff escorted both Nurses N2 and N4 off the premises and this was observed by other staff members. Nurse N4 was at home on the day in question and was asked to come to work so she could be informed of her suspension. She was then escorted off the premises.

The Acting Director of Nursing and Acute Services stated that the nurses were not escorted off – they were accompanied off the premises by the Quality Manager who provided support to them because they were upset.

The Stow report

The decision to commission Ms Jan Stow to conduct a review and investigate allegations of bullying and harassment was made by the General Manager on or about 19 April 2002 when the two staff were suspended.

There was no discussion about commissioning this review with Nurse N6 and it was not foreshadowed in any management meetings that Nurse N6 attended on a regular basis.

Staff interviewed by Ms Stow were apparently unaware that Ms Stow would be providing information about individual staff members to management and that it would be used in fact finding and disciplinary investigations concerning individual staff members.

Ms Stow did not interview Nurses N2 and N4 but she did make adverse comments about them and other staff members in the report and recommended that action be taken against them.

The removal of Nurses N2 and N4 from the operating theatres

At the end of the disciplinary processes, Nurses N2 and N4 were told they would not be able to return to work in Campbelltown operating theatres. They were advised that management would look at placing them somewhere else within MHS.

Nurse N2 was told there were vacancies in psychiatry, maternity and intensive care. She believed these were not valid options. She had not worked in any of those areas for some years and her career focus in

terms of training, skills and experience was in operating theatre nursing. She said she felt she had been constructively dismissed. There were further negotiations with management and she was eventually offered a place in the Bankstown Hospital operating theatres. Nurse N2 did not pursue that option and eventually resigned. She said at the time the negotiations were occurring she was seeing a psychiatrist because of the distress she experienced following the disciplinary process and her suspension. She had heard that other staff within MHS had heard that she was being moved from Campbelltown for alleged bullying and harassment and thought if she did start work at Bankstown others would know about the allegations and she would not feel comfortable.

Nurse N4 stated she was devastated by management's decision that she could not return to Campbelltown Hospital operating theatres. She said she had planned her career pathway in the public health system. She had done one master's degree and was working on a second. She was offered redeployment within mental health originally and was then offered a job in the Camden Hospital day surgery unit. She felt none of those options were suitable. She loved the operating theatre and thought she was a valued member of staff. She believed that, even if she was guilty of bullying which she denied, the punishment involved in removing her from the workplace was harsh and unreasonable. She said that at the meeting with the General Manager and the Human Resources Manager of SWSAHS in August, the Nurses Association put to management that she be allowed back to Campbelltown. She said the General Manager replied that people in the theatres feared for their safety and that of their families and there was no chance of her going back to theatres.

Nurse N6 stated she was not consulted by management about the decision not to allow Nurse N2 and N4 to return to theatres.

The Acting Director of Nursing and Acute Services stated that, while the Stow report and the investigation was occurring, there was a lot of payback experienced by the nurses who came forward with complaints. Staff in the complex were traumatised and mediation or conciliation between staff was not an option so Nurses N2 and N4 could not return to theatres.

The General Manager stated that she approved the disciplinary recommendations and agreed to meet with the nurses concerned when they were negotiating their return to employment.

The operating theatre complex - before and after

A number of staff interviewed stated that the complex was a successfully functioning unit with high standards of care, very low staff turnover and, on the whole, committed and satisfied staff who worked as a team. The nurses felt they had standing in the department and were never short of equipment or supplies.

After the Stow report and the departure of Nurses N2 and N4, both nursing and medical staff reported that morale in the theatres was poor. There was higher staff turnover, agency staff had to be used for the first time, and there was a sense of apprehension and distrust directly related to the removal of the two nurses.

Possible links between incident reporting and disciplinary action

In her interview with the Commission, Nurse N3 stated that she believed she was made the subject of disciplinary action because she was raising patient care issues with her colleagues.

The Acting Director of Nursing and Acute Services stated she was aware Nurse N3 had made incident reports – they were undated and unsigned and management were not clear who had put them in. However, the incidents were investigated and acted upon.

Some of the nurses in the operating theatre said that management encouraged staff to use the incident forms and they were easy to use. However, the common experience was that there was no feedback or information about any action taken.

The Acting Director of Nursing and Acute Services noted that, in her substantive position in maternal and community health, it was their practice to acknowledge receipt of reports. She noticed when she arrived in acute services that this was not happening.

6.5 INITIAL RESPONSE FROM MACARTHUR HEALTH SERVICE

On 29 January 2003, SWSAHS was provided with an interim report containing our preliminary observations in relation to the disciplinary action taken against the nurses. These observations were based on interviews with staff, site inspections and a review of hospital policies and practices. We also gave some indication of the direction of the investigation at that time.

In their response to the interim report, MHS raised a number of concerns about our approach and interim preliminary views.

These concerns include the following.

- The Commission had mistakenly formed the view that the area is not entitled to take disciplinary action until the performance management process has been exhausted and had confused aspects of performance management with disciplinary processes.
- The Commission, because of its confusion about the two processes, suggests all disciplinary matters should be resolved through the performance management process.
- Bullying and harassment are unacceptable conduct and it is appropriate for an employer to take disciplinary action against employees who bully and harass others in the workplace. The degree of bullying and harassment will allow the employer to determine the results of the disciplinary action.
- If an employee acts outside the scope of their registration or licence, it is a serious matter and it is appropriate for an employer to take disciplinary action against the employees who do so. The degree of the conduct will allow the employer to determine what disciplinary action should occur ranging from a warning to dismissal.

We address these comments in the conclusion and findings section of this report.

6.6 SECTION 43 SUBMISSION

The Commission considers that the s.43 submission from MHS and SWSAHS fails to deal satisfactorily with several of the issues we raised in our preliminary report. They also fail to appreciate that the opinions of the Senior Counsel they retained to review our report support many of our findings, and the opinions of our counsel, about the disciplinary processes involving the nurses. This was despite their counsel considering additional material to that considered by our counsel.

The submission demonstrates a continuing lack of insight into how and why these nurses were inappropriately dealt with by MHS.

SWSAHS and MHS provided comments in relation to this part of our investigation in their s.43 submission to our preliminary investigation.

A summary of the main points made by SWSAHS and MHS in their submission and our views on these points is as follows:

The main concerns of SWSAHS appear to be firstly that we formed the view that, even though there was no direct or causal relationship between the incident reporting and disciplinary action, the effect of the disciplinary action was to negatively impact upon clinical governance and open disclosure. Secondly, we do not have jurisdiction to deal with purely industrial matters and, because there was no link between the incident reporting and the disciplinary action, we should not comment on these matters.

The Commission view is that the disciplinary action taken in relation to Nurses N2, N3, N4 and N6 was directly raised by the nurse informants and the Director-General in the complaint (see 6.1). These matters also impacted upon clinical governance and the quality and safety of health care delivered by MHS. They are therefore matters that come within the jurisdiction of the Act.

Reviewing and analysing what occurred with the nurses, the relevant clinical incidents and the relevant MHS policies was an important and necessary part of the investigation of the complaint.

We appropriately forwarded the nurses' concerns over what happened to them to the Department of Health for them to conduct a review.

We have drawn conclusions about the effect of disciplinary action on the culture at MHS based on information obtained during the investigation. Although disciplinary processes and quality improvement programs may be separate areas of activity for management, a central feature of the complaint was how management's actions affected the staff concerned and staff perceptions of how nurses were likely to be treated by management.

We remain of the view that, given the deficiencies of the processes identified in the report concerning these nurses, there should be recommendations in relation to the future utilisation of disciplinary processes by MHS management. It is appropriate to keep these recommendations in the final report to assist the Department of Health, SWSAHS and MHS ensure these aspects of MHS's functions are improved and strengthened.

6.7 OUR FINDINGS AND CONCLUSIONS

The following findings and conclusions are made after considering all the information obtained, including the response from MHS and the s.43 submission.

South Western Sydney Area Health Service policies

The SWSAHS 'Policy Document on Disciplinary Action' accords with the Department of Health framework for managing the disciplinary process. The policy is appropriate and satisfies the fundamental requirements of a fair and equitable disciplinary process when dealing with staff.

The way in which incidents or complaints about staff are to be investigated under the disciplinary procedures is explained on pages 4 to 7 of the policy document and in relevant parts of the Human Resources Manual entitled 'Disciplinary Action'.

The procedure for first formal warnings and second and final warnings is on page 8 and 9 of the policy.

The procedure for suspending staff is on pages 11 and 12. It says that:

' When the conduct of the employee and the consequences of their actions may be prejudicial to the Area Health Service, the employee, other staff or the public, the employee may be directed not to report for duty pending completion of the investigation. If this is to occur:

a) approval from the Area Service Director is required

b) the employee is to be advised of the reason(s) for this action

c) the employee is to be told that they are not to return to the Area Health Service without seeking approval

d) the employee is to be paid in accordance with Department of Health guidelines. General Managers and Area Health Service Directors are to monitor employees directed not to attend for work. This should not extend beyond 30 days without consultation with Area Human Resources.'

The SWSAHS 'Policy Document on Performance Management' and the relevant parts of the Human Resources Manual on performance management are also appropriate and accord with the Department of Health framework for managing performance.

The relevant part of the SWSAHS Human Resource Manual on staff grievance management states:

'What is a workplace grievance?

A workplace grievance is a real or perceived wrong, causing concern and grounds of complaint; a feeling of resentment or injustice of having been unfairly treated.

Workplace grievance can stem from a variety of reasons that may relate to a range of issues including employment conditions, implementation (or lack of implementation) of policies, unfair work rostering, harassment, discrimination, unsafe work practices, personal or professional relationships within the workplace.

The aim of the Area Health Service Grievance Management policy is to assist managers and staff to maintain and where necessary, restore a harmonious and effective working environment by providing a structured process for resolving staff grievances.'

The definition of harassment is on page 3 in the section called 'Harassment free workplace'. A similar definition appears in the 'Joint Management Employee Association Policy Statement on Bullying, Harassment and Discrimination' in the Department of Health Circular No 2001/109.

Although the policies were appropriate, MHS failed to properly apply them and breached them when taking disciplinary action against Nurses N2, N4 and N6.

Breaches of policies by Macarthur Health Service

Our investigation identified three main breaches of policies in the disciplinary action taken against Nurses N2, N4 and N6.

These breaches related to not doing a fair, impartial and complete investigation, the decision to suspend the nurses and a lack of procedural fairness.

1. Failure to undertake a fair, impartial and complete investigation

The policies require that management conduct fair, impartial and complete investigations into allegations or complaints about staff. This did not occur in this case because the Stow report was used inappropriately and the investigation was incomplete. For example, relevant witnesses were not interviewed and factual conflicts were not resolved.

Inappropriate use of the Stow report

MHS engaged Ms Stow to investigate allegations of bullying and harassment and relied upon her report as grounds for taking disciplinary action and as a basis for disciplinary findings and sanctions. Ms Stow conducted a review using a standard questionnaire and 'confidential interviews'. Staff were told that they were participating in a review.

The process Ms Stow adopted did not meet the policy requirements of an impartial investigation to identify the truth by examining all relevant information. In our view, it was wrong to use the Stow report as a basis for disciplinary action, findings and sanctions. It was not only unfair to Nurses N2, N4 and N6 but it was also unfair to the staff members who participated in the review. Nurse N4 gave the example of a staff member, who MHS found Nurse N4 had bullied on a particular occasion. Nurse N4 reported that the nurse was horrified when she learnt after the event that the incident in question was relied upon for disciplining Nurse N4.

Incomplete investigation

The two managers assigned to investigate the allegations against Nurses N2 and N4 did not interview any witnesses except for Nurses N2, N4 and N6. They relied on the Stow report and the statements provided by the three complainant nurses - Nurses N17, N18 and N19. Those statements are unsatisfactory in many respects and were an inadequate basis to make adverse findings against the nurses. They contain claims of inappropriate behaviour by Nurses N2 and N4 but little or no details are given.

An adverse finding of bullying was made against Nurse N2 concerning the introduction of the sponge bags. The finding appears to have been based on a statement by Nurse N19 on this issue which apparently refers to a staff meeting in October 2001. It states:

> *' N2 introduced sponge bags to be used and trialled, the majority of people used and did not like it for various reasons(sic). These racks were removed NUM's orders, at this meeting, N2 and N4 demanded the persons or person responsible return them immediately and that they will be used regardless. …'*

Nurse N17 notes that she believed the sponge bags were an infection control risk. She stated:

> *'However, there was general coercion from N2 to use these bags. Staff including myself, N22, N23, N24 and N25 felt pressured to use these bags despite the obvious risks in their use. I felt intimidated when questioned as to why I was not using the bags.'*

Similarly, the basis for the allegation that Nurse N4 bullied staff in relation to an in-service session is contained in a statement dated 30 April 2002.

> *'Feb 2002*
>
> *I witnessed incident in tea room N4 aggressive behaviour telling people that if they didn't go to 'love the law' as arranged by N2 and herself that she would take this as a personal insult – other witness N26.'*

On an objective reading of the statements it is simply not possible to conclude whether the conduct of Nurses N2 and N4 amounted to bullying or harassment, who was bullied and, in some cases, where or when the alleged incidents occurred.

The investigation reports and other records also show that other people allegedly harassed by Nurses N2 and N4 - namely N25, 01 a wardsman, N26 and Dr D1 - were never interviewed by the fact finding investigation team nor were any statements obtained. Given that the definition of harassment centres on conduct or treatment that causes offence, it would be crucial to hear from the people alleged to be victims of harassment or bullying to determine if an offence or grievance had occurred.

Nurses N2, N4 and N6 provided detailed responses to the allegations against them. There is no evidence that the investigation team examined relevant patient records or went back to other witnesses to sort out the factual conflicts raised by these responses. The investigation reports the team prepared are clearly deficient. They include very little or no analysis of the allegations and the evidence and do not set out in any detail the basis for the findings. There is no reference to the SWSAHS definitions of bullying or harassment or how the investigators came to their conclusions that the nurses' conduct fell within the definitions.

There is nothing in the documents that suggests that the investigation team sought or received any specialist or expert assistance from within SWSAHS to help them structure the investigation or make their findings - this is recommended at 5.1 of the 'Policy Document on Disciplinary Action'.

2. The decision to suspend the nurses

There are no documents on the files that directly or adequately record the decision to suspend the nurses and the processes undertaken, apart from the letters to the nurses advising them of their suspension.

The 'Policy Document on Disciplinary Action' requires that management consult with SWSAHS Human Resources if the suspension is to exceed thirty days. In this case the suspensions began on 19 April 2002 and continued until after the disciplinary action was finalised on 5 July 2002. There are no documents on the files recording the decision to continue the suspension or that the required consultation with SWSAHS Human Resources occurred.

We accept that suspension with pay on one view is not a punitive action, but the series of events that occurred in the operating theatres show that when staff are suspended you can expect that:

- other staff will learn of the suspension
- the staff members concerned are likely to feel guilt, shame and suffer serious psychological stress

- the longer the suspension the more difficult it may be to successfully reintroduce the suspended staff member to the workplace
- because the reasons for the suspension will not be made known to other staff, the suspension is likely to create speculation, fear, uncertainty and distrust within the workplace.

Due to the lack of documentation relating to the decision to suspend Nurses N2 and N4, it is unclear whether other options such as counselling, mediation, targeted rostering, extra supervision, special duties or temporary secondment within SWSAHS were considered.

It is a serious matter for a health service to suspend a staff member and extend the suspension when there is a flawed process involved. The personal consequences for the staff member and for the workplace can be destructive. It is a decision that should not be taken if the process is flawed or there is an inadequate basis to make such a decision as occurred in this case.

3. Lack of procedural fairness

From the documentation provided to the Commission, it would appear that the three nurses who made complaints to the General Manager were not required to attend a fact finding interview with the investigation team. They had a meeting with the General Manager on 19 April 2002 – a one page statement by the General Manager is the only record of this meeting. There was at least one other meeting on 27 May 2002 but there is no record of this, although the three nurses were apparently requested to write up a statement of their complaints.

The people accused, Nurses N2 and N4, had no such opportunity to speak to the General Manager directly until after adverse findings had been made and disciplinary action taken. They were also not interviewed by Ms Stow.

We appreciate that the General Manager was not personally conducting the investigation, but she did make the decision to suspend the nurses in consultation with the Human Resources Manager of SWSAHS. Given she was at arms length from the investigation, it would have been preferable for the witnesses she had met with initially to have been interviewed by the investigators - rather than evidence for the investigation being provided through meetings with the General Manager. The investigation team also relied on notes of a meeting between the General Manager, the Acting Director of Nursing and Acute Services and Nurse N6 in April 2002 even though the status of that meeting was unclear.

The involvement of the General Manager in a process that was being conducted by other managers could also create a perception that the investigation was being conducted with prejudice or a lack of procedural fairness contrary to the 'Policy Document on Disciplinary Action' and to general legal and policy requirements. This is because the General Manager, as the ultimate decision maker, had also become involved in the investigation process. This perception is reinforced by the General Manager's reported statements to the union representatives during the return to work negotiations that, based on her interviews with the three nurses, Nurses N2 and N4 would not be allowed to return to the operating theatre complex. There was no mention of the actual disciplinary findings against the nurses as the basis of the decision.

The nurses were not provided with proper, detailed particulars of the allegations made against them during either the fact finding or disciplinary processes.

This is not just a matter of SWSAHS policy but a fundamental requirement of procedural fairness. A person who has allegations made against them is entitled to know the full details of the allegations. There has to be full disclosure of the particulars of the allegations and the evidence to support them, such as witness statements, so that people can fully respond. There was not full disclosure in this case.

In workplace disputes, the background relationships between the parties may be very important. In this case there was personal animosity between one of the accusers, Nurse N17, and one of the accused, Nurse N2, dating back to Nurse N17's arrival at theatres and related to Nurse N2's family relationships. Had Nurse N2 and her advisers been told that Nurse N17 was one of the complainants, they may have been able to provide important information that was relevant to the investigation and decision making.

Additionally, the timing of the complaints against Nurse N2 coincided with a dispute arising from Nurse N2's concerns that Dr D1 was inappropriately marshalling support among nursing staff, including Nurse N17, in relation to her grievance against Nurse N2 and Nurse N6. Nurse N17 was apparently upset and angry about being asked to attend an interview about that matter with management and, on the same day, made complaints to management about Nurse N2 citing matters that had occurred months and, in some cases, more than a year before.

It may be permissible in certain circumstances to delay advising those whose conduct is called into question the identity of those making the allegations. For example, if there are concerns about possible intimidation or to enable initial inquiries to be made. In this case, staff were apparently expressing fear of intimidation. However, as a matter of procedural fairness and policy, it is not right to continue to withhold that information throughout and beyond the disciplinary process as was the case here. It may be that staff were given assurances of confidentiality or anonymity or the decision makers were simply concerned to preserve privacy. However, where employees' employment rights are in jeopardy, procedural fairness requires that the evidence is put to the employee and they are given the opportunity to respond - see page 7 (d) and (e) in the 'Policy Document on Disciplinary Action'.

The failure to provide the nurses with specific details of many of the allegations made about them is a serious breach of the disciplinary procedures and procedural fairness. Indeed, some of the allegations were so general they were incapable of proper particularisation and should never have been acted upon. For example, the allegations that Nurses N2 and N4 were *'power hungry'* and *'.. N4 feels that she has sole ownership of education – very controlling'.*

Just as serious is the refusal of MHS to provide more details about their actions in relation to Nurse N2 when requested by her solicitors on 23 April 2002. MHS proceeded with the disciplinary action over the objections of the solicitors despite failing to provide the specific information that allegedly supported the allegations.

In Wilson -v- Department of Education and Training [2000]100 IR1, the Full Bench of the Industrial Relations Commission of New South Wales adopted and restated the Commission's findings in Antonakopoulos -v- State Bank of NSW (1999) 91 IR 285 at 390:

> *'… a failure by an employer to adopt appropriate procedures when effecting a dismissal or a failure to follow procedures prescribed in an industrial instrument, or in procedures laid down administratively by an employer, may be properly taken into account by the Commission…. a failure by an employer to apply, or to properly apply those procedures may in appropriate cases, or of itself support a finding that the dismissal was harsh unreasonable or unjust.'*

The policy adopted by MHS refers to the decision in Antonakopoulos and, although this decision refers to cases resulting in termination, the underlying philosophy is that policies must be applied correctly.

We found that there was a lack of procedural fairness in relation to:

- lack of specificity or particulars in some of the allegations or complaints
- failure to properly investigate
- suspending nurses for a lengthy period without giving them an opportunity to respond or providing them with details of the reasons for their suspension
- giving preference to some individuals' information over the nurses' information without sufficient basis
- basing decisions on irrelevant or inappropriate information, such as the Stow report.

Use of first and final warning

All four nurses were given a first and final warning. The 'Policy Document on Disciplinary Action' clearly sets out a range of options once allegations are proved. One of the factors to be considered is the seriousness of the conduct. The options range from starting with informal procedures such as counselling by the supervisor through to first formal warnings and ultimately dismissal.

Although the policy allows for first and final warnings where the incidents are very serious, the absence of any document on the file giving reasons for the findings and the sanctions imposed make it difficult to see why the conduct of the nurses was considered to be so serious as to warrant such action. In the case of Nurses N2, N4 and N6, their previous good employment records with MHS and favourable performance reviews should have been factors in their favour.

In the context of quality improvement and nurse shortages, it is remarkable that management went straight to first and final warnings without considering other more suitable action.

In the case of Nurse N3, the fact that she was new to the ward, that her actions were known and even approved of by more senior members of staff, and that the position of Nurse Unit Manager was held by a succession of personnel during the period in question, were all relevant mitigating factors. Without any record of the decision making process, it is simply not possible to determine whether those factors were taken into account or not.

Documentation

The SWSAHS Human Resource Manual requires at 5.1 (i) and (k) that accurate notes are kept of the fact finding process and that both the investigation and its results are fully documented. At 5.9 it states *'when allegations against an employee are proven all documents (including audio tapes) are to be filed on the employee's personnel file within sector human resources /employee services.'*

Most of the documents that form the basis for the suspension action, the fact finding investigation and the disciplinary action are not included in the disciplinary files. Some statements and records of interviews do appear in the 'Other Papers Folder Documents Vol 6'. Other documents, such as the records of interview or statements taken from other nursing staff on the Camden Hospital medical ward about the processes initiated against Nurse N3, do not appear anywhere.

Some of the documents that are on the files are clearly inadequate. For example, the reason given by the General Manager for suspending the nurses and for deciding not to let them return to the operating

theatre was that staff she spoke to were in fear of their own safety and the safety of their families. There is no document that records any person making that claim. The only threat recorded in the 19 April 2002 statement is the threat of defamation – but there are no details as to who made the threat to whom, when and where. There is nothing in the papers that suggests that Nurses N2 or N4 ever made threats to anyone. The conduct actually recorded against them relates to typical workplace disputes or grievances of the type listed in the SWSAHS grievance policy such as claims of unfair treatment, rudeness and lack of courtesy. Interestingly, Nurse N6 documented in an incident form a threat by one of the three nurses who made complaints to the General Manager to *'bring Nurse N6 down'*.

This lack of documentation is a serious breach of policy particularly when you consider the severity of the action taken by management and its impact on an individual's right to work and their professional standing.

Relationship between disciplinary action and MHS organisational goals and management culture

All the matters reviewed in this part of the report occurred in the context of delivering patient care. Patient care at MHS and throughout the NSW health system is supposed to be delivered within a quality and safety framework. We were given the MHS 'Quality Policy Statement' dated December 1999 signed by the General Manager and documents relating to clinical governance both before 2002 and since 2002. These documents included the clinical governance action plan 2002 to 2005.

The MHS action plan defines clinical governance as 'the process whereby the Health Service is responsible for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care flourishes' (page 4).

The objectives of the action plan are:

> *'To promote a shift in health from 'high risk' to 'high reliability' with a strong culture of continuously looking for ways to do things differently and better. The Health Service will lead work on culture change through improving systems and processes. This will not only involve working with doctors, nurses and other health care professionals to improve systems but also consumers, health care managers, and health authorities.*
>
> *A culture of safety in health care will be reflected in a system that:*
>
> - *is patient centred*
> - *supports multi-disciplinary team approaches*
> - *has a culture of learning for quality and a willingness to share information*
> - *recognises the inevitability of error and system failure and actively works to minimise the impact and repetition of errors.'*

The key features of the plan are noted as:

> *'i) Improving patient safety, monitoring adverse events;*
>
> *ii) Improving communication between management and clinicians.'*

In our view, the approach adopted by MHS in dealing with the four nurses, particularly the way the disciplinary processes were used, did not reflect a patient care focus or fulfil the objectives of the 'Quality Policy Statement' or the clinical governance action plan.

Staff climate survey

The staff climate survey that was used as part of the MHS investigation is one of the quality tools used by health management, area health services and boards to identify areas of staff concern that may need attention. The survey is confidential.

In using the survey, health organisations need to acknowledge that management is responsive to staff concerns, surveys will be confidential and only be used for the purposes for which they are intended, and will only capture accurate and reliable information.

The way in which MHS used the Stow report and the climate survey in disciplining three of the nurses seems to have had the predictable outcome of making staff reluctant to participate in that quality activity and undermined their confidence in management. It showed a lack of insight by management into the requirements needed to implement a quality improvement program.

The climate survey indicated 94% of staff in the operating theatre were satisfied with their workplace. The MHS investigation carried out placed an incorrect construction on the outcome of the survey and raises questions about the reliability of the findings.

The incident in the operating theatre involving Ms Z (Incident 1)

This incident resulted in Dr D1 lodging a grievance against Nurse N2. Both Nurse N2 and Nurse N6 claimed that they were acting in the interests of patient safety, due to the lack of available equipment and staff, as well as responding to the patient's concern and the distress of the patient's mother. Their detailed explanations of their actions to support the patient's mother and the child herself appear to have fallen on deaf ears. Their actions were held to constitute harassment of Dr D1 for which they were sanctioned.

This sort of approach reinforces the hierarchical positions of doctors in clinical teams when safety and the MHS Action Plan demands a team based approach. The approach is inconsistent with the objectives of the MHS Action Plan.

The clinical review panel who examined this incident supported the concerns of the nurses about the safety of proceeding with the operation at Campbelltown Hospital and noted that it was the actions of the nurses that prevented the operation proceeding.

Management need to provide acceptable and non threatening mechanisms to resolve care related disputes within teams. Complaints or issues by staff about care should be seen by both senior clinicians and administrators as opportunities to identify and rectify problems, rather than as criticisms or harassment.

Clinical governance is a relationship between key management and health practitioners - not a power struggle between doctors and nurses to see whose position and authority prevails.

Even if the nurses were wrong in their assessment of the safety of proceeding with the proposed procedure, it was a disagreement within members of a team about quality and safety issues. The investigation by the Director of Medical Services and the Quality Manager identified a number of useful means of learning from the incident and improving patient care but inappropriately singled out the two nurses for possible disciplinary action, apparently for how they raised safety and care issues with a medical officer. The recommendation focused only on the concern of the doctor about how she should be spoken to rather than the doctor's performance in communicating with the family and interacting with the team.

A significant concern is that MHS's response did not proceed from a patient care and safety perspective after the Director of Medical Services's investigation was completed. In Nurse N6's disciplinary interview, the senior managers conducting the disciplinary process eventually conceded that there was no intention on Nurse N6's part to offend Dr D1- but they still held the complaint was substantiated as a form of harassment. They neglected the question of the robustness of the clinical team and how management can support the development of respect and cooperation within clinical teams.

It would appear that the dispute between Dr D1 and the nurses fell into the category of a staff grievance rather than a disciplinary complaint. There is no indication on the available documents why it was proceeded with as a disciplinary matter. Indeed, the process that the CMO had herself invoked was the staff grievance process.

Nurse N2

A concern of Nurse N2 was that a male wardsman stayed in theatre when female patients were exposed and he was not required to be present. This appears to have arisen out of her concern for patients' dignity. Her conduct in raising it with the manager was made the subject of a disciplinary charge, even though it seems that the wardsman concerned did not complain about the matter.

It was eventually found that Nurse N2's conduct was inappropriate rather than harassment, but no reasons were given for this finding. As Nurse N2's concern was for patients' dignity, it would have been far more appropriate for the matter to be dealt with at a local level by the team supervisor. They could then have achieved a solution that met both the needs of patients and the staff concerned rather than escalate the issue into formal disciplinary action.

Nurse N2 was found guilty of a charge of harassment in relation to the introduction of sponge bags. She introduced the sponge bags to try to improve the method of counting sponges in the theatre. She went through the appropriate channels and asked for approval to trial the sponge bags. She also tried to explain the benefits of the new procedure to other staff. She became understandably upset when the equipment was not properly trialled by some of the theatre staff and eventually the sponges went missing from the theatre complex.

We accept that some aspects of the introduction or trial of the new equipment may have upset some staff and resulted in differences of opinion about the process being trialled. However, these personal feelings could have been addressed more constructively using the range of informal procedures that public sector managers are encouraged to use to resolve disputes. Disciplinary procedures are an appropriate way to deal with clearly unacceptable conduct of an individual employee that is not amenable to informal resolution - but they were not appropriate in this case.

This was a delivery of care issue within a particular team. It concerned particular equipment that some staff wanted to use and others did not. It would have been more appropriately addressed by management from a quality and safety perspective by asking what was in the best interests of patients and how the team could best effect that- not by pursuing the issue of who was upset with whom and apportioning blame and punishment through a disciplinary process six months after the event.

It was also an important learning opportunity for Nurse N2 in terms of the successful implementation of trial and change. Management by its actions did not support the nurse to become a better team leader and to learn about effective implementation and team behaviour.

It is clear that the Campbelltown Hospital operating theatre complex had benefited over the years from Nurse N2's commitment to providing a quality service, acting as a team leader, being available to do on

call work, and coaching and educating staff in her position as a clinical nurse specialist. She deserved to be treated with more respect and fairness in this case. The real issues were differences of opinion about work practices and personality clashes that could have been dealt with in a much more practical and less escalating way.

Nurse N3

Nurse N3 came to management's attention when she acted beyond her scope and role as an enrolled nurse under the direction of, and with the knowledge of, registered nurses at the Camden Hospital medical ward.

Nurse N3 had only just started work on the ward and there had recently been two changes of nurse unit managers. She had worked extensively in other health organisations where she has stated she undertook procedures that were not normally expected of an enrolled nurse. At the time she was still learning the routines, procedures and protocols of the medical ward at Camden. In each of the cases for which she was disciplined, Nurse N3 was trying to help patients who were in need or distressed.

It is clear that the conduct of Nurse N3 in providing the treatment she did in the identified patient incidents went beyond her professional role and training. It was also in breach of MHS clinical protocols and accepted standards governing the role, skills and training of enrolled nurses. There are recognised risks to patient health and safety associated with each of the clinical interventions Nurse N3 engaged in. It was inappropriate for Nurse N3 to continue to perform these types of procedures or practice beyond her scope or role and MHS and the hospital needed to address these issues with her. However, the fact finding and disciplinary interview emphasised that Nurse N3 had broken the rules rather than she had potentially compromised patient safety.

Given that the goal of both MHS and Nurse N3 was to provide care to patients, it is disappointing that there is little discussion of patient safety, patient focus and staffing issues by the managers conducting the interviews. Had the risks to patients been carefully articulated and the reasons for MHS procedures explained to her, Nurse N3 may have been more accepting of the process. It was suggested that the practice of ENs acting outside their designated responsibilities occurred in other hospitals. It was also suggested that it occurred routinely across the health system because of work arrangements and resources. There are systems issues which should have been explored by MHS before it focused on individual accountability.

We accept MHS's comments about the seriousness of the matter being the reason the disciplinary route was taken. However it would have been preferable to see a process whereby more informal processes were at least considered, especially since Nurse N3 was led to believe her actions were approved by the various other more senior staff she was working with. Also, MHS had been aware there were issues relating to poor morale, inadequate skill mix, alleged bullying and harassment and a lack of leadership in the medical ward since receiving the culture survey report completed by the Nurse Manager in April 2002. This context, and MHS's responsibility to provide Nurse N3 with appropriate supervision, should have been acknowledged when dealing with the complaints about her. They should also have taken into account that the registered nurses who supervised Nurse N3 apparently urged her to perform the procedures and there was a power imbalance when she was working with these registered nurses under their supervision.

There is also no evidence to show that MHS responded to the root causes Nurse N3 identified for her actions.

Nurse N4

Nurse N4 was found guilty of harassment involving *'obstructive and argumentative behaviour towards an anaesthetist'.* This relates to the incident on 18 April 2002 where initially Nurse N4 complained about Dr D1's behaviour, alleging that Dr D1 was uncooperative and rude when Nurse N4 tried to raise certain matters with her in theatre. Dr D1 allegedly slapped her on the wrists. Nurse N4's account was recorded in a detailed report she wrote out on the day. She addressed her report to the operating theatre manager and requested an opportunity to discuss her concerns with the manager and Dr D1.

There are no documents on the file or in the fact finding report that suggest Dr D1 was interviewed about the matter or asked to make a statement. The only evidence in the documents is a half page, subjective and incomplete account in Nurse N17's statement where it is recorded *'with regard to the incident involving N4 and Dr D1 on 18 April 02, I believe N4 goaded Dr D1 right from the first instant of the day'.*

Nurse N17's version is silent on the issue of whether Dr D1 slapped Nurse N4 on the wrists. There were also three other personnel present. Once again there is nothing in the documents that would suggest those witnesses or the patient were interviewed about the matter.

In Nurse N4's version, she spoke to Dr D1 about two matters that occurred on the morning in question. The first matter was Dr D1's attempts to insert an epidural for a patient requiring a caesarean section which upset the patient. Nurse N4 noted that she was physically supporting the patient who jumped each time Dr D1 inserted the needle and complained that it felt like an electric shock through her vagina. Nurse N4 felt that it was an involuntary response and explained this to Dr D1 away from the patient. The second matter concerned her advice to Dr D1 that she was not going to open a laryngeal mask but simply have it ready. This was in line with current instructions aimed at reducing the need to re-sterilise limited use equipment. After several further attempts to place the needle, Dr D1 abandoned the attempt and decided to give the patient a general anaesthetic. Dr D1 allegedly slapped Nurse N4's hands after the patient was intubated when Nurse N4 said she was moving to inflate the cuff. Nurse N17 stated Nurse N4 released the cricoid pressure she was applying to the larynx too early during the intubation.

Despite their importance, these two events were not explored during the fact finding and disciplinary interview with Nurse N4. It was simply put to Nurse N4 that she had a problem with Dr D1. Despite the lack of investigation and Nurse N4's defence of her actions, she was found guilty of unspecified bullying and harassment of Dr D1.

As in the Ms Z incident, the finding of bullying and harassment is made in circumstances where the nurse was acting as the patient's advocate when Dr D1 was persisting with her unsuccessful attempts to insert an epidural on a distressed patient. In this context the disciplinary action by management was inappropriate and damaging for Nurse N4 and the workplace.

As Nurse N4 stated in her interview with the Commission, she had provided dedicated service to MHS over a number of years. She had contributed to the operating theatres by her commitment to her own learning, managing the education portfolio and acting as a clinical nurse specialist. She had made herself available for on call after hours work which at times involved coming in on weekends and at night. She thought she was a valued staff member. However, the treatment of her in relation to the allegations led her to believe she was not valued at all by her employer.

Nurse N6

When Nurses N2 and N4 were suspended, Nurse N6 had been the nurse unit manager of the Campbelltown Hospital operating theatre complex for a number of years. When issues arose about the workplace she supervised, senior management made decisions about the appropriate action to take without consulting her at all.

From the documentation, it does not appear that any specific complaints were made about Nurse N6 by the three nurses who met with the General Manager. She had an excellent work record within the theatre and her previous performance reviews were favourable. However, based on the conclusions and recommendations of the Stow report, a decision was made to subject Nurse N6 to disciplinary action about the way she had managed the operating theatre complex. It was not appropriate to use the Stow review and report in this way.

The charges were found proved despite the vagueness of the allegations. The basis of the finding, although unclear appears to be that as manager she was responsible for a small percentage of staff who were unhappy in the workplace and your staff had been suspended and disciplined. This was unfair and inappropriate.

One of the goals of clinical governance is to promote better communication between clinicians and management. MHS's approach to a perceived problem within the operating theatre complex was to not consult with Nurse N6 at all, to isolate her from the processes that were directly affecting her area of responsibility and adversely affecting staff morale and, ultimately, to punish her with the first and final warning and the threat of dismissal. This action was based on a recently formed and flawed view that she had failed to effectively manage the team. It was also flawed because procedural fairness had not been accorded. The action was also taken in circumstances where Nurse N6's previous performance appraisals were favourable and the theatre complex as a whole was rated highly. This 'rating' was based on interviews with Nurse N6 and other staff and on objective criteria such as external accreditation processes, staff turnover and retention. The action taken against Nurse N6 and the process involved was both unfair and flawed.

Although it may have been perfectly valid for management, after receiving the Stow report, to decide that it needed to focus on the relationships within the team including Nurse N6's leadership and reinforce organisational values such as mutual respect and courtesy, there were the usual avenues available to management. They could have used supervision and performance management of Nurse N6 over time to achieve their goals rather than embark upon a formal disciplinary process.

Lack of consistency in application of policies

On 18 April 2002 Nurse N4 lodged a report which stated, among other things, that Dr D1 slapped her on the wrists in the operating theatre. It is of concern that serious disciplinary processes were applied when allegations of bullying and harassment were made about nursing staff but an allegation of assault, bullying and unprofessional behaviour by a career medical officer appears not to have generated the same response by management. It is therefore understandable that management's treatment of the nursing staff was seen as unfair and singling them out for disciplinary action.

Similarly, Ms Z's mother complained about Dr D1's conduct when interviewed by the Director of Medical Services and the Quality Manager. Ms Z told them that Dr D1 had rung her repeatedly at home, not about Ms Z's health, but to ask her to write a letter to administration supporting her conduct. This seemingly inappropriate conduct passes unremarked on in the report and no recommendations are made for any corrective action concerning Dr D1's conduct or provision of care.

The link between incident reporting and subsequent disciplinary action

In the complaint from the Director-General, it was alleged that MHS management minimises incident reporting by bullying and intimidating nurses who report adverse events. We have not identified any direct or causal relationship between incident reporting by the four nurses and subsequent disciplining, intimidation or bullying by MHS management.

In relation to Nurses N2, N4 and N6, the event that appeared to trigger the action against them, apart from the grievance lodged by Dr D1, was the meeting between the General Manager and the three other nurses on 19 April 2002. There is no evidence linking the incident reporting by them to the subsequent disciplinary action taken by MHS. However, Nurses N2, N4 and N6 were found guilty of disciplinary offences and action taken against them subsequent to their actions in raising and acting on patient safety concerns on two occasions. The incident involving Ms Z on 15 January 2002 and the patient who underwent a caesarean on 19 April 2002.

Although Nurse N3 did lodge a series of incident reports, they post date her involvement in disciplinary procedures as can be seen from the following list of dates.

17 June 2002	fact finding interview
4 July 2002	disciplinary interview
13 July 2002	incident the subject of the undated and unsigned incident report of Nurse N3
14 July 2002	two incidents the subject of undated and unsigned incident reports
19 July 2002	incident the subject of an undated and unsigned incident report of Nurse N3
20 July 2002	incident the subject of an undated and unsigned incident report of Nurse N3
26 July 2002	incident the subject of undated and unsigned incident report of Nurse N3
27 July 2002	incident the subject of undated and unsigned incident report of Nurse N3.

In a document provided to the DOH and the Commission, Nurse N3 outlined a series of occasions when she was concerned about aspects of patient care at Camden Hospital. She relates discussing her concerns with a number of her nursing colleagues and medical staff as well as her nurse unit manager and records a variety of responses, mainly negatives. She also records feeling that some staff were hostile to her simply because she was an enrolled nurse.

In relation to Nurse N3's failure to obtain a different position within SWSAHS in 2002, we are not privy to the decision making process of the selection committee in question and are therefore not able to conclude that her failure to obtain that position was related to her conduct in raising issues of patient concern while employed at the medical ward at Camden Hospital. MHS has explained that it was because she was required to nominate further referees.

Nurse N1 raised concerns that she was bullied and harassed by managers and other staff at MHS because she lodged incident reports and raised patient care issues. She states she is currently unable to work within MHS because of the stress caused by management's actions and her continuing concerns about patient safety. Management and other staff responses to incidents Nurse N1 raised are dealt with in our investigation into the clinical incidents in Part 5. Nurse N1 was not disciplined by MHS.

A culture that does not support open disclosure

Two of the incidents we reviewed, the incidents concerning Ms Z and the caesarean patient involving Nurse N4 and Dr D1, show that where nursing staff raised patient safety issues with other team members they have subsequently been subjected to disciplinary processes and found guilty of bullying and harassment.

The effect of MHS's actions in finding Nurses N2, N4 and N6 guilty of disciplinary charges in relation to their dealings with a medical officer about patient safety concerns was a failure to support a culture of open disclosure. A very likely consequence of these actions is that other MHS staff will feel discouraged from raising concerns in similar circumstances. Staff may perceive that if they raise patient safety concerns they will suffer the same fate as Nurses N2, N4 and N6.

We do not believe that this was the result management intended. The materials suggest that their intention was to deal with the allegations of bullying and harassment. The problem was that MHS management, in their response to the incidents reviewed, displayed a narrow focus on assigning blame and a lack of knowledge, skill and possibly experience in investigating and managing staff complaints. They also failed to proceed from a patient focused, quality and safety perspective. This is also demonstrated by their handling of Nurse N3's case where there was little or no examination of the factors and circumstances that led her to step outside her role as an enrolled nurse in an attempt to assist patients in distress.

6.8 COMMENTS AND RECOMMENDATIONS

We propose to make the following comments and recommendations, under s.42(1) of the *Health Care Complaints Act 1993*, to enhance the capacity of Macarthur Health Service to deliver quality health services and deal appropriately with staff in the future.

Our comments

1. SWSAHS policies on disciplinary action and performance management were generally appropriate and accorded with Department of Health policies.

2. Although the policies were appropriate, MHS breached the policies by not correctly or properly applying them in taking disciplinary action against Nurses N2, N4 and N6. These breaches included failing to undertake a fair, impartial and complete investigation and failing to provide procedural fairness.

3. There was a failure to adequately document the suspension, investigation and disciplinary processes concerning the four nurses. Statements and interviews, action taken and the reasons for it were not properly documented and this was in breach of SWSAHS policies.

4. The disciplinary action taken against the four nurses was heavy handed and confrontational and did not consider all the relevant factors including subjective mitigating factors. It is even questionable whether there was sufficient basis to proceed to disciplinary action against Nurses N2, N4 and N6. The problems identified by the Stow report could have been better handled by other processes and strategies such as grievance procedures, staff training and supervision and performance management.

5. Once adverse findings were made against Nurses N2, N3, N4 and N6, other options should have been considered rather than issuing first and final warnings.

6. MHS needs to provide acceptable and non-threatening mechanisms to resolve care related disputes within teams. Complaints or issues by staff about care should be seen by senior clinicians, managers and administrators as opportunities to identify and rectify problems, rather than as criticisms or harassment.

7. The effect of MHS's action in disciplining Nurses N2, N4 and N6 in relation to their respective conduct involving Ms Z and the caesarean incident was a failure to support a culture of open disclosure – they judged the nurses actions as wrongful. A very likely consequence of this action is that other staff will feel discouraged from raising concerns in similar circumstances. This is counter productive to the aims and goals of clinical governance, open disclosure and promotion of quality and safety in health care.

   In their handling of the two clinical incidents, MHS management displayed a narrow focus on assigning blame and a lack of knowledge, skill and possibly experience in investigating and managing staff complaints. They also failed to proceed from a patient focused, quality and safety perspective.

8. Prior to disciplining health practitioners, management need to identify all contributing causal factors before allocating individual responsibility.

Our recommendations

We recommend that:

6.1 The NSW Department of Health (DOH) reviews the disciplinary action and processes taken by Macarthur Health Service (MHS) against the four nurses who underwent formal disciplinary action as a matter of urgency.

6.2 South Western Sydney Area Health Service (SWSAHS) and MHS offer to engage in mediation with the nursing staff who raised concerns with the DOH to try to resolve their complaints and concerns.

6.3 The Institute of Clinical Excellence (ICE) work with DOH to incorporate the application of clinical governance and the requirements of a culture focused on quality and safety into DOH's statewide human resources framework.

6.4 DOH develop and support the use of a statewide education and training package for area health services to educate senior health service managers in grievance, performance management and disciplinary procedures. The package should be linked to quality and safety frameworks to ensure consistency in the application of policies and procedures.

6.5 SWSAHS reviews and further develops all human relations policies, procedures and training relating to disciplinary action, suspension, grievances and performance management of staff and the application of these to make sure that:

- all senior managers have education and training in the application of performance management procedures and disciplinary procedures, with an emphasis on incorporating clinical governance and quality and safety frameworks into such procedures
- there is ongoing monitoring by SWSAHS of all disciplinary action of MHS staff until SWSAHS is satisfied that senior managers at MHS have a thorough understanding of disciplinary policies and procedures and apply these consistently, according procedural fairness at all times
- there is appropriate consideration of principles of clinical governance, the requirements of a culture focused on quality and safety, and the need for a safe, supportive and fair environment for incident reporting
- there is procedural fairness at all points in the decision making
- there is clarity about the factors to be taken into account when deciding whether a staff member's continuing presence at work compromises or prejudices the health service, other staff or patients
- there is a process of consultation with human resources personnel, the employee's direct supervisor and the employee, where practicable, before a decision to suspend is made and the reasons for suspension and all steps in the suspension process are clearly recorded.

Contents

7.1 INTRODUCTION 182

7.2 QUALITY AND SAFETY IN HEALTH CARE 184

7.3 CLINICAL GOVERNANCE 187

7.4 PERFORMANCE MANAGEMENT AT MHS 194

7.5 INTERNAL AUDITS AT MHS 197

7.6 INCIDENT REPORTING SYSTEMS 199

7.7 CONSUMER COMPLAINT MANAGEMENT 212

7.8 RISK ASSESSMENT AND MANAGEMENT 215

7.9 CONSUMER PARTICIPATION 216

7.10 SERVICE PLANNING AND CHANGE MANAGEMENT 218

7.11 DEVELOPING POLICIES, PROCEDURES AND GUIDELINES 226

7.12 PROFESSIONAL DEVELOPMENT, EDUCATION AND TRAINING 228

7.13 LEADERSHIP, MANAGEMENT AND ORGANISATIONAL CULTURE 230

7.14 ORGANISATIONAL STRUCTURE 239

7.15 WHISTLEBLOWER ISSUES 243

7.16 OUR CONCLUSIONS 247

PART 7

Systems for quality and safety

Systems for quality and safety

7.1 INTRODUCTION

This part of the report concerns the following systemic and organisational management issues raised in the complaint:

- lack of adequate quality and safety systems
- lack of effective clinical governance, risk management or performance monitoring
- ineffective incident reporting or investigation systems
- a culture that does not support open disclosure of errors or adverse events
- management that minimises incident reporting
- inadequate systems to monitor performance and to respond to performance issues
- failure to address serious ongoing management and clinical problems which have resulted in serious adverse events.

Many of the problems at MHS identified in this part of the report are attributable to a flawed or underdeveloped system of organisational management and clinical governance. In this part we discuss the gaps in the clinical governance system at both SWSAHS and MHS. We also review the key quality systems necessary for effective clinical governance and culture within the acute care continuum at Camden and Campbelltown Hospitals. These include performance management systems for individuals as well as services, internal audits, incident reporting systems, risk assessment and how consumer complaints are managed.

We used a systems review panel to help us assess the organisational, management and systems issues raised in the complaint. This panel was made up of independent, well respected clinical and management leaders in the health system and a consumer representative, and was facilitated by two experienced senior officers from the Commission. Part 4 details the methodology we used and the members of the panel.

There is general consistency between our findings and recommendations and those of the DOH review. They took the view that the key challenge was to make a major commitment to improving the culture, leadership and workforce issues confronting MHS and SWSAHS. You will find this a recurring theme throughout this report also. We support the recommendations from the DOH review being implemented in tandem with the recommendations we make in this report.

There is a growing body of international and Australian knowledge that has led to the evolution of the concept of quality improvement in health care. Specific techniques to identify risk factors, investigate and analyse incidents that result in harm to patients and support appropriate improvement in practices are developing. The techniques allow health services to provide consistent, high quality care by actively managing known risks as well as having systems to identify new or emerging risks. Incidents that result in harm to patients are known as 'adverse events'. The term includes incidents that may be the result of a 'clinical error' or 'mistake'. A quality improvement framework requires the routine examination of all incidents resulting in harm (death, disability, injury, disease or suffering).[1] The vast majority of these events are not the result of a single act by an individual health professional, but are likely to be the result of failings by complex systems of care. Prevention of adverse events depends on identifying the deficiencies of the system that allowed the adverse event to occur and taking appropriate remedial action.

With this in mind we focused on the responsiveness of MHS to adverse events, both reactive and proactive. A proactive approach covers a range of strategies and tools including risk management, policy and practice guidelines, and education and development. These strengthen the care delivery system by supporting better practice. The capacity of MHS to know about, learn from and act on adverse events is also critical to the delivery of safe care. Robust reactive systems, embedded in a reporting and learning culture, acknowledge that adverse events occur and have effective incident reporting and complaints management systems.

Clinical governance ensures appropriate policies, structures and monitoring systems are in place to ensure a consistent standard of safe high quality care of patients. The responsibility for clinical governance is vested in area health service boards and executive management. Traditionally, the corporate governance function and the clinical care functions of area health services have not been well connected.

Responsibility flows throughout the health care system for clinical governance - at the state, area, health facility and point of care. Clinical governance relies on partnerships between management, clinicians and the community.

We tested and reviewed clinical governance structures and processes in the emergency department (ED), operating theatre (OT), intensive care unit (ICU) and medical wards at both hospitals. These clinical units were highlighted in a number of issues raised by current and former staff members.

Although we made all reasonable attempts to maximise our availability to a broad range of staff in certain operational areas, we did not cover all operations of MHS nor were we able to meet with all members of staff and management. Consequently, conclusions have been drawn with the explicit understanding that what we found may not apply to the organisation as a whole. However the issues identified do need to be addressed in the four areas reviewed and it is likely that our observations have broader application to other areas of MHS.

Our conclusions, comments and recommendations are contained in the various sections of this Part and have taken into account the SWSAHS submission in response to our preliminary investigation report.

7.2 QUALITY AND SAFETY IN HEALTH CARE

Introduction

The health system must deliver the best possible outcomes for patients within the constraints of available resources. People expect the best possible health care. To provide safer and better care the NSW health system has developed the quality and safety framework that has become central to delivery of care. We used this framework as a basis for the systems review.

SWSAHS and MHS have embraced this framework and developed policies and procedures reflecting the importance of quality and safety to patient care.

Recent developments

It is helpful to trace recent developments in quality and safety ideas and the reasons for them.

A number of recent studies, investigations and inquiries into health care in Australia and overseas have highlighted the need for clinicians, managers, policy makers and educators to look carefully at the quality and safety of care now being delivered by health services in New South Wales.

Some of the key issues include the importance of clinical governance and developing partnerships between medical staff and management to build a quality culture, and the need to monitor the quality of health care as regularly as the organisation's financial operations.

Studies in the US, UK, Australia and New Zealand about the level of adverse events in hospitals have found that adverse events occur for approximately 10% of people admitted to hospital.

In 1995 the 'Quality in Australian Health Care Study'[2] was commissioned as part of the Commonwealth Government's review of professional indemnity arrangements for health care professionals[3]. It found that there are clear variations in the quality of care provided. Approximately 16% of inpatients in Australian hospitals experience an adverse event, with just over half of these preventable. Interventions intended to provide diagnostic information or treatment for particular conditions can inadvertently produce harm to patients and this risk is particularly high in the acute hospital environment.

The message from these studies is that a key to reducing adverse events is to investigate the event and look at the systems of care that may have caused it and left too much room for error.

In 1996, the then NSW Minister for Health established a ministerial advisory committee to address the issues raised in the health care study. The DOH then produced a policy statement called 'A Framework for Managing the Quality of Health Services in New South Wales'.[4] In this policy the notion of quality was distilled into six 'dimensions of quality' - safety, effectiveness, appropriateness, consumer participation, access and efficiency[5] - and five cross dimensional requirements - competence, information management, continuity of care, education, and training for quality and accreditation.[6] This quality framework has provided the foundation for quality and safety systems in health services in NSW since 1999.

In the early 1990's an evidence-based medicine movement was developing in North America and rapidly became international. The Committee on the Quality of Health Care in America was formed in 1998 and in its initial report highlighted the fact that many thousands of adverse events occur in health care that could be avoided by a truly high quality health system. In its second report 'Crossing the Quality Chasm: A New Health System for the 21st Century'[7], the committee recommended that changing systems of care were necessary to meet the demands for better quality as quality is a system property and priority. The new health care system must be *'evidence-based, patient-centred, and systems orientated'*.[8]

In the United Kingdom a similar impetus is apparent. In the period since the inquiry into the clinical incidents in the paediatric cardiac surgical unit at the Bristol Royal Infirmary in 1999, a statutory duty was imposed on National Health Service (NHS) trusts and primary care trusts to assure and improve the quality of health care that they deliver. The duty also extends to ensuring the regular monitoring of the quality of care with the same rigour as the health organisation's financial regime. In practice this duty is met by the implementation of clinical governance, which has become the cornerstone of the modernisation agenda of the NHS in Britain. To support the development and implementation of clinical governance in Britain, the NHS Clinical Governance Support Team was established in 1999 and now forms part of the 'Modernisation Agency'. It acts as a focus of expertise, advice and information and offers a training and development program for clinical teams and NHS organisations.

In January 2000, the Health Ministers from the States of Australia and the Commonwealth established the Australian Council for Safety and Quality in Health Care. It was set up to lead and coordinate national efforts to improve the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error. The Council reports annually to the Health Ministers. In February 2001 the Council launched its first 'National Action Plan 2001' which outlined four priority areas.

These areas were:

- better use of data and information throughout the system to support safer patient care
- strengthening mechanisms to ensure safer clinical and organisational environments
- actively promoting opportunities for consumer feedback and participation
- redesigning systems and processes of care to promote a strong culture of reliability and safety.

The Council's 'National Action Plan 2002' focused on a further four specific key areas for patient safety. These were:

- reducing patient harm associated with medication use
- reducing patient harm resulting from health care associated infection
- coordinating national action to learn from serious adverse events
- developing national standards to support more open disclosure to patients and their carers.

In Canada, a National Steering Committee on Patient Safety was set up to provide a national integrated strategy for improving patient safety in Canadian health care. In 2002 it produced a report entitled 'Building a Safer System'[9] to provide the basis for clinical governance to be incorporated into the Canadian health system.

The focus on clinical governance and a quality culture is also clearly emerging in New Zealand. In 2002 the New Zealand Health and Disability Commissioner issued the report of an investigation into the Southland District Health Board Mental Health Services. In the section on 'Management and Leadership' the Commissioner identified the critical need for an effective partnership between managers and clinicians:

> *'A successful partnership requires a willingness to build a partnership on both sides based on common goals, and a commitment to clinical and financial accountability and to better health outcomes for patients. Developing a partnership between clinical leaders and management is a key factor in building a quality culture within the New Zealand health system.'* [10]

As in the UK, North America and New Zealand several significant inquiries and investigations into issues of quality and safety at a systemic level have also assisted in focusing the community, government and the health system efforts on clinical governance and a framework for improving the quality of health care provided to Australians. These include the 'Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital 1990 – 2000' in Western Australia and the Royal Melbourne Hospital Investigation commissioned by the Health Services Commission in Victoria.[11]

These state, national and international developments make it clear that health care provision is complex and carries risks of patient harm. Improving the quality and safety of care for people and the clinical governance systems are essential for a health organisation that wishes to reduce harm and waste.

Quality and safety in patient care is a fundamental and primary obligation of all health services.

7.3 CLINICAL GOVERNANCE

Introduction

This section outlines more fully the concept of clinical governance - how it has been introduced in NSW, how it relates to quality and safety, and how it works at area and local health service level.

Clinical governance provides a framework for organisations to continuously improve the safety and quality of their services. It creates an environment in which excellence in clinical care can flourish and patients receive the highest quality of care possible. A culture of openness, honesty and trust, strong leadership, a consumer focus and robust organisational structures are critical foundations for effective clinical governance.

Clinical governance covers an organisation's systems and processes for monitoring and improving services and provides a way to integrate previously disparate and fragmented approaches to quality improvement in health. It also links care and treatment improvement initiatives at the clinical team level directly to the governing body, the management and the financial divisions of the organisation. Although efficient financial stewardship of a health service's budget is important, the focus on the quality of care and care outcomes is equally important and must drive the financial decision making. To achieve this there must be direct links between decision making at the corporate level and decision making at the clinical unit level where care is delivered to patients.

The four principles that guide the development and maintenance of clinical governance are:

- building a culture of trust and honesty
- fostering an organisational commitment to continuous improvement
- establishing rigorous monitoring, reporting and response systems
- evaluating and responding to key quality and safety related aspects of organisational performance.[12]

Some key practical components of clinical governance include:

- Systems to monitor and assess risks of harm and ensure that information is reviewed and analysed, lessons are learnt, critical actions taken to reduce or eliminate the risk, and the potential for improvement evaluated.
- Systems for organisational performance reviews, internal audits, incident reporting, consumer complaint management, risk assessment and management, clinical and peer review programs and clinical and organisational system research.
- Organisational decision making mechanisms such as clinical quality and review committees that review practices and act to change them if improvement is needed.
- Sound and well disseminated evidence based standards, policies, procedures, clinical guidelines, pathways and protocols that support safe, consistent care and are reviewed as issues arise.
- Staff (including VMOs) performance management, credentialing and development programs with unambiguous pathways to conduct, health and performance actions being taken by management.
- Targeted educational and development strategies aimed at changing entrenched cultures and embedding a culture focusing on quality improvement.
- Resources and information systems to support all the above.

Clinical governance in NSW

The DOH has produced a number of policy statements that area health services need to consider in their formal planning for clinical governance. Two key documents are 'A Framework for Managing the Quality of Health Services in New South Wales' and 'Corporate Governance in Health Better Practice Guide'.[13] These were developed to help area health boards understand their corporate governance responsibilities and introduce the notion of clinical governance and its centrality in providing consistently high quality health care.

The NSW quality framework states that boards of area health services should ensure that effective systems are in place to:

- provide an environment that fosters quality
- monitor the quality of care
- provide a regular report to the board on the quality of care
- minimise the risk of and identify deficiencies in the quality of care and effectively address these deficiencies.[14]

The framework also identifies that a cultural change is required in both health care delivery and management if clinical governance is to have improved outcomes for health consumers. This 'cultural change' includes an increased valuing of the input of health consumers, communities more generally and general practitioners. Area health services also need to facilitate and monitor the application and evaluation of best practice guidelines so that health treatment and care is based on the best available evidence.

The following are the essential components of clinical governance for NSW area health services:

- there is an area quality committee or council that is a committee of the area health board
- the quality council is chaired by a board member and clearly identifiable as the peak quality of health care committee for the area
- the objectives of the council reflect the principles of the quality framework
- the eleven performance areas in the framework are adopted by the council
- a key function of the council is to provide a report to the area health service board accurately reflecting the quality of health care being delivered in that area
- the council reports regularly to the DOH using the determined core set of quality of care indicators and reporting framework
- the council and area health facilities will act on the data received from the quality of care indicators to improve the quality of health care
- identified needs are reflected in annual quality plans
- formal and regular links exist between the council and key consumer groups and between the council and the divisions of general practice
- council membership reflects the active involvement of the area health service board, consumers and general practitioners
- the reporting lines identified in the quality framework are adopted by each area health service.[15]

Although the clinical governance framework was introduced in 1999 and many of the elements are not new to the health system, most area health services are in the early stages of implementation. Considerable work is required to identify effective approaches to support the implementation of clinical governance in practice.

Clinical governance in South Western Sydney Area Health Service

Our investigation showed that SWSAHS embraced the notion of clinical governance and have developed far reaching structures and operational plans within the area. The corporate plan includes the development of area wide clinical councils - this structure is continuing to be refined with the development of the clinical advisory council reporting directly to the area health service board.

A document called 'Report Self Assessment of SWSAHS Quality Framework' dated 24 January 2003 was provided to the Commission by the Chief Executive Officer (CEO) SWSAHS to give 'a reasonable picture of the current position in relation to health services within SWSAHS'. In this document, clinical governance is considered to be one of the most important reform initiatives arising from the 2000 report of the NSW Health Council called 'A Better Health System for NSW'. It also states that the release of the quality framework led to SWSAHS reviewing the way they managed their clinical quality improvement activities and making some key changes. These included adopting an area wide approach to clinical quality and the establishment of the clinical council.[16]

The CEO of SWSAHS stated that, *'the main features of an effective clinical governance system for the area would be:*

1. *Acceptance and understanding of the area's purpose, values and leadership throughout the organisation, that promotes a culture of cooperation and teamwork between clinicians, administrators and other health staff, based on trust and respect, which sustains effective clinical governance. A key element of this culture is an ethic of service to patients and the wider community.*
2. *Effective clinical governance structures, processes and infrastructure at area and health service levels.*
3. *Systematic introduction of appropriate quality improvement methods for all staff including best practice guidelines, evidence based practice, clinical audit, peer review etc.*
4. *Information systems that enable staff at all levels of the organisation to have access to information that is relevant to decision-making regarding clinical service provision and priorities.'*

The nurse informants dispute that all these are in place, alleging that what happened to them is testament to statements 1 and 2 being inaccurate reflections of reality.

The CEO regarded the establishment of the SWSAHS clinical council as being integral to the clinical governance agenda as it is responsible for making recommendations to the board of directors about health service planning, development and service standards. In February 2002, the council produced a strategic plan for clinical governance that heavily influenced an area strategic review and resulted in new area clinical council and clinical advisory councils being established for each sector. MHS is one such sector within the area. The review also led to the priority of a 'safety culture' that facilitates open reporting and analysis of adverse events and near misses. The council has established working parties to provide it with expert advice in various specialist areas.

Clinical advisory committees have been set up to provide advice on clinical governance in specific health

priority areas that reflect the Australian Council's national health priority areas. Some committees are currently developing standards for quality by preparing clinical guidelines or models of care based on research evidence or existing best practice guidelines.

The CEO also saw accreditation as one of the frameworks for improving the quality and safety of health care. All sector health services and the corporate office of the area have been accredited by the Australian Council on Health Standards (ACHS), including MHS which was preparing for a survey during the course of this investigation. This was subsequently conducted on 24 – 27 June 2003 and the health service was granted accreditation status.

One of the nurse informants alleges that accreditation is not a reliable indicator of sound clinical governance. Her view is *'MHS has been accredited in the past and looks 'perfect' on paper.'*

Clinical indicators have been recently developed by SWSAHS, in accordance with the quality framework, although the CEO acknowledged that the mechanism for area wide data collection still needs some streamlining.

Clinical governance in Macarthur Health Service

MHS developed their clinical governance action plan in tandem with the development of the SWSAHS clinical governance plan. It is a detailed plan that reflects all aspects of safety and quality improvement in health care. MHS are to be recognised for the amount of work and effort that has been put into this plan.

Clinical governance is appropriately seen within MHS as driving quality throughout the organisation rather than being an add-on to other quality initiatives. A document called 'Macarthur Health Service Clinical Governance', produced by the General Manager MHS, states that MHS is committed to building quality health care through the framework of clinical governance. To accomplish this goal, departments were restructured to form continuums, the title and role of the director of medical services was changed and a position of clinical decision support manager was created to highlight the importance of clinical governance to MHS. In 2002, the clinical advisory council and community participation council were established to provide advice for management on clinical issues and community participation.

The first MHS clinical governance action plan (2002-2005) was developed during 2001-2002 following extensive consultation. Forums were held with staff, clinicians and the community to identify issues that were impacting on their ability to provide and receive high quality safe care. To support the consultation process, the Director of the Quality and Clinical Policy Branch of the NSW DOH and the chairperson of the Australian Council on Safety and Quality in Health Care conducted a session on clinical governance for safety and quality in health care. Key stakeholders endorsed the plan including the Macarthur health community participation council, the clinical advisory council and the MHS executive.

However, one of the nurse informants suggests that the consultation process was flawed in that attendance was by invitation only with the selection being made by senior management.

The action plan incorporates the four priority areas identified by the national council and outlines the initiatives to be taken by the clinical advisory council, the MHS executive and the community participation council. The plan indicates that some systematic changes will require 3-5 years to be put into place so it is a working document that will be reviewed and updated every six months. It provides practical solutions that can be acted on immediately as well as *'action to put in place long-term systematic changes that will support safer practice into the future'.*

Some priorities identified in the MHS action plan include:

- feedback and involvement of staff and the community
- multidisciplinary teamwork
- enhanced consumer focused care
- continuous quality improvement
- the availability of information and data in a variety of mediums appropriate and accessible to staff, patients and the wider community.

MHS informed us that they are currently developing a clinical governance implementation plan that will provide a flexible guide to the changes required and include *'strategies to support the organisation with the change process, education and systems design'.*

The General Manager's report stated that the main outcomes to be achieved from the implementation of clinical governance are based on the key pillars of the clinical governance framework. These are better communication, recognition and focus on systems error, teamwork both professional and patient focused, greater accountability, improved quality and safety, and the development of an environment of excellence. According to this report, the MHS executive understood the links between management, clinicians, the community and other service providers that are necessary to create a culture that is open, team based and focused on clinical excellence with the resources available to support cultural changes within MHS.

The appointment in May 2001 of the Director of Medical Outcomes strengthened the design and implementation of clinical governance, the clinical leadership of medical staff, training and education, and the recruitment and retention of medical staff.

There is significant evidence within MHS to suggest that large parts of the clinical governance action plan are being implemented. Many of the quality reports reviewed demonstrate significant collation of data that is in line with the ACHS clinical indicators program reporting formally through to the area health service. The formal loop of clinical reporting to the board is by exception at the discretion of the area CEO, although the key performance indicators are to be discussed at the clinical advisory council for which board members receive the minutes. However, it is unclear whether the information is provided in such a way for the board to know if a satisfactory level of quality service has been attained within their area. This is due in part to a statewide lack of performance indicators to evaluate the performance of quality systems.

In August 2003, MHS conducted a review of the milestones and expected outcomes of the clinical governance action plan and found that 27 of the 62 identified milestones were either achieved or substantially progressed. This is significant progress considering the plan was not approved until mid 2002. Promising results have been associated with performance management of doctors, local education sessions, uptake of the Clinician's Toolkit[17] and the establishment of multidisciplinary review teams.

Clinical governance and adverse events

Clinical governance links quality related data, relationships and activities across an organisation both vertically and horizontally. MHS provided the following in response to our request for information about how adverse events are acknowledged and openly discussed throughout the organisation:

- *'Direct contact with patients and family members. In the case of a serious adverse event and for a large number of our complaints, we seek to resolve issues through personal contact with patients and family members. This allows for immediate acknowledgement of the situation and identification of strategies to remedy the situation.*
- *The acute services review team review cases that involve a series of flags. This process includes the identification of changes to practice that would improve quality and safety of health care in Macarthur.*
- *The results of root cause analyses are provided to the Clinical Advisory Council, including progress reports on the implementation of any recommendations.*
- *Continuums are provided with data on patterns in complaints and problem/incident reports for provision to staff and development of strategies to improve performance.'*

These are relatively early days for clinical governance and although this list represents a reasonable beginning it highlights the need for further development before the aims of clinical governance in relation to learning from adverse events are achieved.

Our conclusions and comments

We consider that MHS should be recognised for the amount of effort they have put in to developing a comprehensive approach to clinical governance within their health service. However, our findings in relation to the incident reporting systems, clinical management, the follow up of clinical incidents, performance management and the disciplinary processes in this investigation suggest that the acceptance and implementation of the plan is not yet adequately embedded into organisational culture and practices. With the commitment to a five year plan, there is a need for shorter term safety interventions to deal with the problems that currently make assessment, care and treatment for some patients unsafe.

Effective clinical governance is predicated on strong leadership at an organisational and clinical level and a skilled and sufficient workforce. Until the clinical leadership and workforce issues are addressed and a broader approach is taken to clinical services planning across the area, some of the best plans and policies will not be able to be fully implemented.

This aspect of the challenges that face SWSAHS and MHS has been well outlined in the findings and recommendations of the review commissioned by the DOH after receiving the preliminary report of our investigation.

The health system is currently learning about, experimenting with and developing the concepts, knowledge, models, culture, structures, relationships, processes, performance indicators and tools associated with clinical governance. Sharing this learning is critical to the system wide uptake of clinical governance and its promised patient safety and quality rewards.

There is a need to address issues of culture, leadership and workforce at MHS so that clinical governance delivers the quality outcome aims of the quality policy statement. The aim is to achieve a culture that is patient centred, safe, open and fair with resources focused on this quality and safety framework.

Our recommendations

We recommend that:

7.1 DOH continue to support clinical governance in the health system and work with ICE to assist SWSAHS and other area health services to further develop and implement clinical governance to foster cultures that are patient centered and safety focused. This should include initiatives outlined in:

- the Safety Improvement Program
- the Clinical Governance Development Program
- the Patient Flow and Safety Collaborative: Towards a Safer Culture Project.

7.2 SWSAHS, with support from DOH, develops a strategic recruitment plan that addresses incentives to attract and retain competent clinical leaders and managers and clinical staff to meet the needs of the community. The plan may include the creation of 'centres of excellence' including research opportunities and clinical specialisation linked to academic centres.

7.3 SWSAHS reflect the strategic importance of the quality framework in budget processes. This resource alignment should continue until DOH is satisfied the framework has been embedded across the health system.

7.4 PERFORMANCE MANAGEMENT AT MHS

Introduction

This section looks at some of the key systems needed for effective and robust clinical governance. It covers performance management systems for both clinicians and services, internal audits and incident reporting systems. We have focused particularly upon the performance management of medical and nursing clinicians and the operating theatres at Campbelltown and Camden Hospitals. There are general conclusions that can be made that have a broad application across the health system.

Medical clinicians

Medical staff are required to participate in a credentialling process before they are able to provide services in MHS. This process assesses their experience and competency and is considered a very important part of the selection and recruitment process.

Locum and agency doctors are expected to provide certification of their competency against a standard form and provide a recent copy of their curriculum vitae (CV). The certification is in the form of a self assessment against a checklist. We were informed by people familiar with the MHS ICU environment that locums would find themselves in situations demanding a level of skill they did not possess despite noting their competency on the checklist. MHS advised that the self assessment and CV was reviewed by a staff specialist before appointment. This conflicts with information provided by ICU nurses that this was done by nursing staff at least until late 2002.

Feedback is given to locum staff on their performance, particularly in the event of underperformance. In the past, locum practitioners have been referred to the medical registration board and a system exists for ensuring that locums are not re-employed if there have been major concerns about clinical practice. One of the informants states that no such system existed.

MHS has recently implemented an improved program of annual performance reviews for medical clinicians. The review covers conduct, performance and behaviour. The review coincides with the five yearly round of re-appointments taking place in 2003. Importantly, new contracts for VMOs require their involvement in research and teaching, quality improvement programs, performance management, clinical leadership, creation of evidence based policies, procedures and protocols and networking with university schools of medicine and tertiary medical services. VMOs seeking reappointment for five years must show relevant continuing education, evidence of regular ward rounds, committee membership, involvement in and commitment to continuous quality improvement and other performance requirements noted in the VMO contract.

We were advised that interviews had been conducted with approximately 95% of VMOs and most CMOs and non-accredited registrars at the time of drafting this report to specify required standards and review performance. It is planned to extend the process to locums over the coming months. The performance management process outlined by MHS must allow for ongoing monitoring of the competencies of medical clinicians. This includes the opportunity to review the actual outcomes of clinical work by particular doctors benchmarked against colleagues and peers with similar case loads.

Performance management of locums, particularly short stay locums, is a greater challenge. This has a particular impact on the department of medicine as a shortage of medical registrars had increased the reliance on locums.

MHS advised us in August 2003 that over the past two years action has been taken in relation to 27 practitioners for performance, conduct and other issues. This includes making 13 referrals to the NSW Medical Board.

Given the issues and findings on the clinical incidents in Part 5 and the lack of support for less experienced medical clinicians at MHS, it is critical that the performance management system at MHS is adequately resourced and formal and robust enough to address the problems identified. We have made a number of recommendations about performance management for medical clinicians in Part 5.

Nursing clinicians

Standard nursing competencies are used across the health service to ensure that nursing staff are able to meet accepted standards. Nursing job descriptions are competency based - performance management processes assess performance against job descriptions and therefore against competencies. This creates a system for staff that supports safe and up to date standards of nursing practice. The informants however state that this is ad hoc.

MHS has performance management processes in place. Its implementation as demonstrated by internal audits is incomplete and requires improvement. Analysis of the clinical incidents found basic competencies such as documentation and recognition of the physical deterioration of patients under their care to be variable.

MHS reports that departmental orientation and induction procedures for staff include statements and development of specific competencies required. Strategies such as pairing experienced staff with new starters helps to transfer knowledge of local policies and procedures and inculcate required performance competencies.

MHS also says that the graduate nurse program is designed to provide skills and experience for new graduate nurses across the organisation and to equip new nurses with specialist skills required for particular areas. This program is designed to promote and recruit staff to areas of greater specialist interest. The program requires further planning and support.

MHS has decreased its use of agency nursing staff by creating its own casual pool. Casual pool staff are recruited through standard selection and recruitment processes. MHS claim that they receive the full nursing orientation and are able to be managed the same as permanent staff. They consider that an effective casual pool is more reliable, cost effective and promotes higher standards of safety and quality because of the ongoing relationship between casual nurses and the organisation. The nurse informants state that there is no or minimal ward level orientation.

A number of recommendations about performance management for nursing clinicians have been made in Part 5.

Operating theatres

A general review of the operating theatres at Campbelltown and Camden Hospitals indicates that the Camden operating theatre team is busy and has committed staff. It appears to provide a standard of care that is at least generally equivalent to similar services in NSW and Australia. However there was little benchmarking activity with like services either within or outside NSW. This means that staff received little or no feedback on how well or how poorly they were performing relative to other services in SWSAHS or other hospitals of similar size and service classification.

It was more challenging to assess performance at Campbelltown operating theatres, given the differing views held by staff and expressions of widespread dissatisfaction and frustration from a number of

sources about performance, management and leadership capacity. Many of these issues are addressed in more detail in later sections on leadership and management.

From a pure performance review perspective, many issues could be satisfactorily resolved for Campbelltown and Camden operating theatres if:

- There was more benchmarking on patient safety and service quality key performance indicators (KPIs) against other hospitals in the area and externally against hospitals with similar service configurations.
- Regular feedback was given to staff on unit level performance against patient safety and service quality parameters and measured against historical unit trends, area wide and peer services.

Our conclusions and comments

We consider that a wide-ranging benchmarking project would help to resolve any poor performance that may exist. This project could compare the MHS operating theatre services with one or more like services within or outside NSW and incorporate key indicators of theatre utilisation, clinical outcomes, staff satisfaction and performance.

MHS said they conducted 492 separate review processes between January 2001 and November 2002 ranging in scope from small projects to reviews of whole services.

Some examples cited included:

- review of operating theatres – 2002
- review of patients receiving wound care services
- pharmacy review – 2003
- counselling services review – 2002.

Aggregated performance data seems to be reported up through the organisation but does not appear to be currently reported back through to all clinicians practising at the bedside or in the community. Given some of the small numbers within each of the KPIs, particularly the ACHS clinical indicators, this is reasonable. However, strategies need to be developed at MHS to encourage clinicians to review the safety and appropriateness of their care regularly and methodically. The purpose is to measure variation in everyday unit performance, care and outcomes across units and services, not merely to deal with extraordinary events.

Consistent investment in developing and applying performance management processes at the practitioner, program and process levels, together with improving the clinical infrastructure of MHS, will over time address many performance concerns identified in Part 5. It will also support the active linkage of clinicians with governance structures.

Our recommendations

We recommend that:

7.4 SWSAHS work with MHS to continue the development of robust performance and clinical review and auditing systems to measure variations in unit performance, care and outcomes across units and services within the acute care continuum that can be benchmarked within the area and externally with other like services. The results should be conveyed to the staff in the organisation.

7.5 INTERNAL AUDITS AT MHS

Introduction

Internal audits are an effective tool for monitoring performance and raising organisational awareness of significant variance. Data from internal audits is provided to team managers, continuum directors, level one committees and the executive to inform ongoing improvements.

The internal audit system at MHS is primarily designed to review the quality and safety systems in place at MHS. We examined these audit processes by referring to the documentation they provided to the Commission. A review of previous internal audit program outcomes for 2000 and 2001 was examined in the context of the MHS 'Quality Manual and Operations Procedure Manual'. We also looked at the audit outcomes for the individual care continuums at MHS.

The quality manual sets out the policy for reviewing the quality system by providing for self-assessment audits. These audits provide objective evidence of the effectiveness of the system against specified requirements. The manual envisages that properly qualified employees will carry these audits out at least once a year.

The manual also states that reports of audit findings will be made available, corrective action will be taken and a re-audit will occur 'at an agreed time' to ensure that the corrective action has been effective. After the completion of the audit, the remedial action to be taken is recorded and a time frame identified. The agreed remedial action required for any non-conformance is to be performed within four weeks after the audit has been completed. If units are not progressing as well as expected, process audits are carried out to identify more specific opportunities for improvements.

Formal internal audit processes operated from the inception of MHS in 1998. Documents provided to the Commission confirm that formal procedures were issued by Campbelltown Hospital in May 1996. These contained management procedures for internal self assessment audits in accordance with standard ISO 9002:1994. Similar procedures were adopted by MHS in 1998. The system remained basically unchanged until 2000 when it was reviewed and improved systems were put in place to manage data obtained from audits and to track outcomes. Annual reviews of the internal audit system have occurred since 2000 and, according to MHS, changes have been made to the areas covered by the audit.

The 2001 internal audit covered performance management, mandatory training, staff identification badges, documenting of emergency procedures, equipment, document control, forms, occupational health and safety, work instructions/protocols, patient identification and emergency trolleys. MHS has informed us that the 2002 internal audit was changed and expanded and includes areas such as access, assessment, care planning, evaluation, staff training, manual (physical) handling and improving performance activities.

We reviewed MHS's 2000 and 2001 'Outcomes of the Internal Audit Program' but the results are hard to interpret and comparisons are difficult to make as the scope and content of the two reports are different. The 2000 program outcomes provided information in sub-categories of individual outcomes and included detailed information that is particularly useful for identifying specific areas of underperformance. The 2001 program outcomes have no sub-categories and some of the categories audited have changed.

Some areas of poor performance in the 2000 audit, such as mandatory training and performance management, were shown in the 2001 report to have greatly improved. Nevertheless, even in 2001,

mandatory training and manager training was still falling short of targets. The 2001 report also highlights some areas where corrective actions were raised to improve equipment, patient identification and emergency trolleys.

Although the outcomes of the 2002 results were not yet available, we were given a copy of the acute services continuum audit report for 2002.

Our conclusions and comments

The overview of department/units in the acute services continuum shows a poor level of compliance with the mandatory training requirements, particularly for direct service providers, although this may be partly explained by inadequate record keeping. The level of training has dropped below the levels measured in the previous year's audit despite the fact that the need for corrective action in this area had been identified. In the area of occupational health and safety and manual handling, the percentage of criteria met had dropped from 64% in 2001 to 33% in 2002. Yet in section 4 of the audit results, which lists the improvement activities identified during the audits, there is no specific mention of this area despite the obvious need for improvement action.

In the area of performance management, the percentage of criteria met had dropped from 45% to 17%. However improvement activities were identified in this area. There was also a drop in the compliance level for managers in some areas. Corrective action for managers has been instituted by MHS.

Despite widespread reporting to management, compliance with performance requirements fell significantly to 17% and mandatory training fell short of target. Both of these areas underpin improved performance and contribute to safe patient care. However we found an inability at MHS to effectively act on problems with key quality systems.

A recent move by MHS to the ACHS EQuIP system for accreditation of health services and a recent expansion in the scope of internal audit may well see further improvement in the future in line with the standard *ISO 9001:2000*. This standard requires that quality systems performance must be continually measured for effectiveness and efficiency and active improvement.

MHS is an organisation claiming to have a range of quality systems and activities. However they do not deliver the desired results. Safe health care is too important to the community to either permit unsupportable claims or the continuation of systems or practices that are not producing desired results. We found that despite audits being in place there was a decline in performance in some areas. It is very important that in improving the quality of care, MHS links audit findings to organisational planning and performance so that improvement in the quality of care is achieved in real terms.

Our recommendations

We recommend that:

7.5 MHS strengthen the links between the annual quality audits and organisational planning and review processes.

7.6 INCIDENT REPORTING SYSTEMS

Introduction

All organisations need to be able to identify system failures and vulnerabilities and take effective action to address any problem areas.

An effective incident reporting system needs to be non-punitive and include a commitment from management to act upon the information received. It is extremely important that staff receive feedback about the types of errors reported, how often they are occurring, and what is being done to improve the systems and prevent future problems.

Some key features of an effective incident reporting system are:

- a focus on near misses or close calls
- incentives for voluntary reporting such as positive feedback on reports submitted at a team level
- confidentiality
- a supportive culture where reporters feel safe and free from retaliation, harassment or punishment
- analysis of incident reports by appropriate clinical experts who can understand systems and identify underlying causes for system breakdown or gaps
- timely analysis of reports and action taken to correct hazards
- systems orientation – the incident report has sufficient information on underlying causes to support causal analysis, and any recommendations focus on changes in systems, processes and resources
- a good system of data collection.[18]

The notion of anonymity in reporting adverse events or near misses within health care is one that is discussed regularly by those interested in safe systems design. There is evidence from the aviation industry that this improves the rate of incident reporting. This is especially so in the transition from a system where the focus has been upon individuals and the 'punishment' of error makers, to one with a culture of openness, trust and honesty that values the reported information and uses it to improve the system as a whole.

Incident reporting – the NSW Health policy context

The DOH has produced guidelines (Circular 97/58) for reporting incidents to it. Although Circular 97/58 identifies broad responsibilities and intended outcomes of a reportable incident system, it does not capture the range of incidents that are of interest to a service based reporting system. Clinician focused incident monitoring has been promoted by the DOH and forms an important part of an overall incident reporting and action system.[19] In addition, the DOH has introduced a severity assessment code to rate incidents and a root cause analysis methodology to apply to higher risk incidents.

Despite these developments, uniform guidelines or models for developing and assessing a service based incident reporting and action system are not yet available in the NSW public health system.

Incident reporting systems at MHS

The policy documents we received from MHS indicate that their previous reporting system was changed in 1996 and has been modified several times since. A database system was introduced in 1999 and has been modified recently.

Since 1997 there has been a separate system for corrective actions. This is now closely aligned to the 'Problem, Incident/Accident, Specific Event' reporting system discussed below. The database has been developed so that each continuum inside MHS has a specific replication of the main database. This enables, among other things, reports and responses to be fed back to the person who raised the issue. Since the introduction of the new procedures in 2002 there has been an increase in reporting of 44% - from 328 to 744 incidents.

In the MHS operations procedure manual dated June 2002, the stated purpose of the reporting system is stated to be:

> *'to provide a systematic approach for all staff to address problems that arise within MHS and to minimise risk in the health service to ensure a safe, secure environment for patients, staff and visitors.'*

The MHS quality manual states:

> *'It is our policy to take action which will reduce or eliminate the cause of nonconformities to prevent the likelihood of a recurrence….Corrective or preventative action is taken to ensure that the cause of an issue is identified and action taken to prevent recurrence of the issue.'*

Under the MHS system, corrective actions are identified or 'raised' by executive directors and continuum quality representatives. There were 29 corrective actions instigated in 2001 and 12 in the next 11 months. There is nothing in the documentation we were given that indicates the basis on which corrective/preventative actions are sought - it would appear to be entirely at the discretion of the directors and continuum quality representatives.

Key positive aspects of the MHS incident reporting system include:

- resources dedicated to support the system
- an IT platform that allows tracking, monitoring and reporting on incidents
- the ability, if a problem or incident extends across service areas, for managers of both areas to document their views if and why something went wrong and suggested changes.

The system also supports the identification of local solutions.

MHS has achieved significant increases in the number of reports submitted by staff, as demonstrated by total reports submitted by year.

Table 7.1 – Number of reports	
Year	**Number**
1999	283
2000	396
2001	324
2002	774
2003	1098 (Jan to Aug)

Data provided by MHS indicates reporting occurs across departments and professional groups.

The MHS problem report form

As a result of combining a number of reporting systems, staff at MHS no longer have barriers to reporting of multiple forms and reporting pathways as in the past. Form CR 198 is used to report all 'problem' incidents except for staff conflict, grievance or performance issues and certain 'reportable incidents'. Staff do however sometimes use the generic problem form to raise such issues.

During discussions with the systems review panel, MHS staff consistently reported that the implementation of the new system was poor. The new forms were circulated and people were told to use them. They felt better provision of information at the time of implementation would have helped them understand and use the system more effectively.

The problem report form includes sections for hand-written comments and review by the initiator and by three tiers of management. A subsequent flow on into a 'corrective action' system is also available. The form allows the person completing it to describe the event and the immediate action in relation to the event, and to provide a recommendation to prevent the event recurring. Reports may be submitted anonymously although it may be difficult to preserve anonymity in a small unit where individuals' issues of concern or their handwriting may be easily recognisable.

A review of problem reports at MHS found 17% to be anonymous. This means that approximately one in five staff chose to submit a report without their name so the option for staff to remain anonymous while reporting problems is an important feature of the system.

In one incident investigated, a nurse submitted report forms anonymously and was later identified by the nurse unit manager who was critical of the nurse. This illustrates the importance of attending to an organisation's culture during implementation of a reporting system. Vestiges of a blame culture can do considerable damage to the trust between clinicians who report incidents and local and senior managers that needs to underpin a reporting system.

We also found a markedly different usage of the form between professional groups. Nurses are the most likely to report a problem using the form while other health practitioners, especially medical practitioners, are unlikely to use the form. They seem to prefer informal reporting mechanisms. We tested this anecdotal information against our audit of problem reports and the assumption was borne out by the results.

This variation in the utilisation of a formal reporting system is consistent with what would be found in many other health care facilities around Australia. Medical practitioners and other health practitioners, such as pharmacists or therapists, are more likely to note incidents exclusively in patient health records or manage identified problems within their professional group rather than using a standard form. This leads to loss of data and means it is not possible to do trend analysis across incidents and 'near misses' that are often recorded by nurses in the standard forms.

MHS should implement appropriate integrated mechanisms for all staff to report their concerns, incidents, issues and problems, including those about the safety and quality of clinical care, the conduct, performance or health of a clinician or manager, or other matter that prevents the effective operation of the health service. This would improve management access to information about all views and allow more informed decisions for continuous improvement to be made.

Reporting incidents

As expected, there was some variation in the local approach to initiating problem reports. Some units considered problems could be managed locally and would not submit a problem report. Others would submit a report if a solution had been identified to support data collection and analysis and wider organisational learning. This illustrates the need for a planned approach to implementing change that incorporates organisational and team cultures.

The nurse unit manager is generally the person responsible for investigating an issue and dealing with the remedial effort required. This could be an individual training issue or a more widespread system issue. The problem report is reviewed by other managers as necessary and then sent to the quality officer for each continuum, if this position exists. The quality officer is responsible for aggregating and collating all incidents for senior management reporting.

However what is unclear is the level of feedback on the analysis of trends and therefore any systematic response. Staff interviewed indicated that they often did not receive feedback either of an aggregate nature or for individual matters of concern that they had reported. If staff did not receive feedback they felt their efforts were to no avail, they lost confidence in management's ability to address quality concerns and they did not feel valued. Some staff compared their situation with that of consumer complainants and could not understand why management thought it was essential to provide feedback to consumers but not to staff. We note that the maternal and child health continuum has adopted a standard practice of providing feedback to staff raising incidents including what action has been taken and thanking them for raising problem reports. MHS advised in October 2003 that this practice has been extended across all continuums.

When responses were provided to staff a common concern was the delay in review and implementing change. This was supported from our review of the clinical incidents in Part 5. This was a significant disincentive for many to contribute to the problem reporting system and undermined the organisation's stated commitment to quality and safety.

MHS advises that a new database is being developed and refined by the quality support unit. Each continuum will have access to the main database which will enable better data entry, control of specific information, aggregate reporting, trend analysis and individual feedback to the person who raised the issue. We support these developments and strongly support that trend data be provided to all managers and staff and a trend analysis conducted on a regular basis. It was noted however that developing the required IT support is hampered by very limited access to IT resources by staff who lack adequate database development skills and experience.

Reporting staff grievances or misconduct

There seems to be some confusion within MHS about the appropriateness of using the problem report form for raising staff grievances or concerns about the behaviour or conduct of other staff members.

Staff from some units expressed a high degree of reluctance to report such incidents at all as they were worried about the potential consequences for them. In any organisation staff need a transparent, clearly understood and confidential process for reporting a range of matters. Although the processes at MHS for reporting clinical incidents or events may be clear cut, the reporting process for grievances or concerns about the health, conduct or performance of individual staff members or clinical teams is ambiguous. These issues can be critical indicators of the quality and safety of care and organisational structure. Many staff were concerned about reporting grievances, poor performance or misconduct using current procedures. This ambiguity is manifest in most incident reporting systems and should be addressed at a state level.

How effectively does MHS respond to incident reports?

In our investigation we considered 68 patient incidents, although patients were only identified in 47 of cases. In many of the incidents a key issue was the adequacy of the MHS management response, including the time taken.

An efficient well-designed reporting system must have the capacity to carry out reviews of the incident reports within a reasonable time frame. In many of the incidents we investigated there were unreasonable time delays and, in some cases, several of the recommendations made by MHS management had not been carried out years after the date of the incident. This is illustrated in Table 7.2.

Table 7.2 - Incident reporting timeframes

Incident reporting process – timeframes	Incidents where dates available (n=42)	Average in days
Date incident occurred to date reported	19	8.7
Date incident occurred to date recommendations for action made	24	167
Date incident reported to date of review forum	12	153
Date incident occurred to date recommended actions implemented	9	203
Date incident reported to date recommendations made	15	155
Date incident reported to date recommended actions implemented	5	227
Date incident occurred to date of review forum	17	150

Table notes:

- The 'date reported' of some incidents could not be identified, therefore could not be included in the figures for the table.
- There were different issues arising in some incidents and these developed different time frames. For the purposes of this table, the issue with the longest time frame has been used as this captures the entire period over which the incident review was finalised.
- In some incidents, recommendations for actions were made although a 'process forum date' could not be identified and therefore could not be included in the table.

The Commission notes a reliance on averages to draw conclusions is not statistically rigorous. Nevertheless we are satisfied that the analysis arising from the data noted in Table 7.2 is reasonable.

Of the 42 incidents where dates were available, 24 were reviewed by MHS and recommendations were made. However we could only identify nine incidents where the recommendations were implemented. The average time between the incident and the date of implementation is 203 days. Of the 17 incidents where dates were available to identify the period between the incident and the review forum, the average time taken was 150 days.

While it is recognised that resources are a real problem in carrying out some recommendations, other recommendations such as education or revising policy are more easily implemented.

For example, to address some incidents involving problems between emergency services and the mental health service at MHS, the management response involved implementing a service agreement between the two branches. Part of that agreement was that the recommendations from the final report of the DOH 'Working Group for Mental Health Care in Emergency Departments' published in May 1998 be considered. The implementation of the working group's recommendations was managed by an action plan prepared by the MHS 'Mental Health in Emergency Working Party' in November 2001. The fact that it took three and a half years to implement departmental recommendations is itself a significant problem. Audits of the action plan's progress found that compliance with the category of 'meets the recommendation adequately' went from 32% in November 2001 to 65% in May 2003. Although this is an improvement it means that, despite departmental recommendations for action being finalised in May 1998, it appears that a plan was only prepared to implement the recommendations after incidents had occurred some three and a half years later. Eighteen months after that the plan has still not been embedded into service practice.

We understand that there have since been significant enhancements to the incident review process. However the system in place at the time of the incidents had significant delays and an inability to track and act on recommendations.

Nevertheless, MHS have made some difficult and major changes to their operations as a result of several problems highlighting deficiencies. For example in July 2002 they directed that acute medical admissions be no longer admitted to the medical ward at Camden Hospital. Some incidents had shown that there was good reason for serious concern with continuing emergency admissions to that unit. Although this direction has been described as 'well understood' by staff, it has not yet been placed in written policy or guidelines. One nurse informant states that staff do not always follow this direction.

Although MHS have provided access to the database in each continuum to enable feedback to occur, various staff have complained that they have received little or no feedback after completing an incident report. The lack of feedback has helped drive suspicion by staff that management did not properly investigate their report or act to minimise adverse events. Some staff also felt that reporting problems led to them being seen by management as the problem. Evidence of this approach was seen in a few incidents where the reporting of a problem led to the reporter being officially criticised - this criticism was then used as evidence in a process that led to the disciplining of some staff. An example of this can be seen in the management response to incident 13. The only feedback that appears to have been given to the nurse who reported the incident was criticism for her action in submitting the problem form. The substance and importance of the incident to quality and safety was not considered until some months later. Even a perception that a collateral outcome of reporting will be personal censure is a significant

disincentive to people using the reporting system.

A similar response can be seen in incidents 1, 11, and 17. This shows that some elements of management still subscribed to the blame culture prevalent with previous reporting systems, even though the current system was trying to eradicate this culture.

In 32 of the 47 incidents where the patient could be identified, the management response was identified as an issue for examination. All but 4 of the 32 incidents were either partially or fully substantiated. The relevant incidents are 1, 2, 4, 5, 7, 11, 13, 15, 16, 17, 19, 22, 23, 24, 26, 33, 34, 39, 41,43, 44, 45, 59, 65, 66, 67, 69 and 70.

In the CR 198 forms completed for the incidents we reviewed, it was noticeable that sections F and G for the manager's and executive director's 'comments, action and plan' were not in all cases completed. A few had comments such as 'see attached'[20] and others had nothing. This indicated that the incident reporting system was not working in accordance with the policy established by MHS and the management of MHS was not fully committed to it. It could also add to the growing suspicion among some staff that there was a divergence between the philosophy of an open safety improvement system and what was happening in practice. At the least it means that certain incidents were not proceeding through the system as they should and this could help to explain some of the delays in dealing with the incidents.

In June 2003, MHS reported to the Commission on the clinical incidents we were investigating. MHS said Incident 13 is an example of the incident reporting system working. It involved a nurse reporting an incident that she clearly believed met the criteria for calling the medical emergency team (MET) but MET was not called. Incident 13 met the guidelines for calling MET and highlighted a lack of clarity or training in the guidelines and therefore a systems failure. However it was dealt with by a manager and agreed to by a director as an example to be critical of the nurse reporting the matter.

Analysing reported incidents

MHS in its response states there is a matrix of strategies that *'are designed to either prevent or at least minimise the risk of the incident occurring'*. However, fundamental to the idea that those strategies will work is the presumption that the incidents have been fully analysed. Examples cited by MHS of appropriate remedial actions being put in place relate to three incidents involving mental health clients - incidents 22, 59 and 60. It was stated that these incidents were less likely to occur again because of:

> *…'the work done to meet the recommendations regarding the management of mental health clients in the emergency department and the service agreement between the mental health service and the emergency department'.*

One nurse informant stated that this service agreement was not implemented in practice. The Commission has been advised that clinical staff have not signed the agreement and have issues with it. Its effectiveness must therefore be questioned.

Incident 22

The patient in incident 22 was 'detained under a schedule' in the emergency department without having first been admitted to Waratah, the unit gazetted under the *Mental Health Act 1990*. Under the *Mental Health Act 1990*, schedule 2 does not permit scheduling of a patient unless the patient is in a gazetted unit awaiting examination or is being transported to a gazetted unit. This means if the patient was being

held under the schedule in ED it may be contrary to the provisions of the Act. Any of the medications given to the patient while in the ED (information provided indicates there were four medications given) without the patient's informed consent may have been problematical. The description in the medical notes of the mental state of the patient at the time indicates the patient probably would not have been able to give informed consent. In the s.43 submission SWSAHS said: *'It should be noted that it is the view of the Centre for Mental Health that emergency departments at hospitals with gazetted mental health units are considered to be covered by the gazettal of the inpatient facility. This removes the stated tension between current practice and the Mental Health Act.'* The Commission received advice that this may not have been the case.

A full review of this incident needed to take account of legal issues but this does not appear to have been done.

An analysis of the service agreement between the mental health service and the emergency department and the policy outlined in MHS policy number 2A.5 indicates that the problems raised by incident 22 have not been clearly addressed and the working group's recommendations have not being fully implemented.

In paragraph 5.4.1 of the service agreement, it states that:

> *'Presentations under the Mental Health Act will be assessed at Waratah House from 0830 to 1700 Monday to Friday and at the Emergency Department outside of those hours.'*

Recommendation 44 of the final report of the NSW Health Working Group for Mental Health Care in Emergency Departments states that:

> *'Arranged psychiatric admissions should usually be admitted directly to the inpatient admission facility, rather than being admitted via the Emergency Department.'*

In an audit in November 2001, MHS reports that this recommendation is met by their policy that all such admissions should go to Waratah unless there is no doctor available in the unit – then the medical admission is to be conducted by either the ward RMO or the ED doctor. This seems inconsistent with 5.4.1 of the service agreement as well as the *Mental Health Act.* It is interesting to note that in an audit of May 2003, only one criterion had deteriorated from the previous rating which was in relation to the implementation of recommendation 44.

Apart from problems in fully implementing departmental recommendations that may relate to resourcing problems, the service agreement highlights the fact that the conflict with the *Mental Health Act* is still being perpetuated by MHS in its policies. The referral and admission of the patient to the gazetted mental health unit part of the hospital would resolve the problem. This conflict is something that is apparently occurring in other hospitals and was not clarified in the working group recommendations. It is a problem that should be looked at by the DOH to clarify what should be happening across the state.

Other recommendations from the working group were that assessing and managing difficult patients and psychiatric emergencies in the emergency department should form part of the training of interns, junior medical officers and nurses (Recommendations 49-52). These recommendations were published in May 1998 and yet, according to the MHS November 2001 audit, they had not been carried out. There were no specific details about these recommendations in the May 2003 MHS audit of compliance.

Incident 59

This incident concerned the admission of a person who had taken an unknown number of tranquillisers with a quantity of alcohol. The person was picked up unconscious by the ambulance and brought in, according to the nursing notes, 'appearing depressed' and 'stating concern about a marriage break-up'. About an hour after arrival the person was found preparing to hang himself. Although the incident was reported as a problem relating to the response of security, a preliminary review of the file shows that the MHS response to an attempted suicide was inadequate. The patient was attended by security at 4am when he was found preparing to hang himself. However at the handover of the shift it was observed by a nurse that security was not present. At 5.30am the psychiatric registrar was contacted and arrangements were made to assess the patient at 7.30am. At 8.35am a CMO scheduled the patient and at 8.50am the psychiatric registrar examined him.

The patient was clearly suicidal but no clinical action was taken other than a call to the psychiatric registrar some 1.5 hours after the suicide attempt was made. There is no evidence that the patient, when initially admitted and presenting as a possible suicide risk or later when he attempted suicide, was triaged or that the appropriate risk assessment guidelines were followed.

Recommendation 38 of the working party calls for the development of protocols in line with the risk assessment guidelines in DOH Circular 98/31. According to the MHS audit of November 2001, relevant protocols had been developed and were due to be documented in the appropriate ED manuals by March 2002. We have not received any information from MHS about this material being incorporated into an education package for staff in the ED.

Incident 60

Incident 60 involved the admission to ED of a patient who had taken an overdose of Duromine and had a grand mal seizure on the way to hospital. The patient was admitted to ICU. Despite being medically cleared for discharge, the patient stayed in hospital because of delays in obtaining a psychiatric assessment. Although the patient was cooperative he appeared anxious to leave but was required to stay in hospital for the psychiatric assessment. A person cannot be held against their will in a hospital unless there is some legal basis to do so.

MHS informed us in June 2003 that *'the current availability of psychiatric registrars on-site on evenings, weekends and public holidays would now prevent incident 60'*.[21] Although this availability may limit the possibility of a recurrence of the problem identified and may also have an impact on other problem areas between ED and the mental health service, there is still a fundamental problem of ED performing functions contrary to the requirements of the *Mental Health Act.*

In several of the other reported incidents, there was evidence of a lack of objective and detailed analysis of the incident and little regard to examining systems failures as part of the major focus of an incident reporting system. Also, there appeared to be little feedback from management to staff after incidents were reported.

We found that the process of incident reporting was not assisting learning across MHS to the extent that it should. There were even some reports from staff that the process was having a negative impact on further reporting.

Problem report audit

We conducted an audit of 50 problem reports provided by MHS in chronological order starting 1 July 2002. The audit process and form we used was reviewed and agreed to by the MHS Quality Manager.

The preliminary results of the audit were reviewed with members of the MHS executive to make sure that there was a common understanding of the assessment process and its results. This led to some changes in the evaluation of specific reports.

The audit showed that, in general, the problem report form was used to describe the immediate circumstances of the event and its aftermath rather than analyse the causal factors. Seventeen percent (17%) of the reports were submitted anonymously. While immediate action taken in relation to the event described may have partially responded to needs (45% of responses), addressed safety issues (34%) or fully responded to needs (26.5%), incidents were unlikely to attract additional corrective action after the initial response. Forty percent (40%) identified corrective action being taken at the primary manager level but this fell to less than 10% at the executive or delegate level.

There is no specific provision in the problem report form to identify the scope or scale of corrective action taken above the direct service level if this is not included as part of a manager's comments. There is also no provision for any continuing process for following up the issue, the remedial action taken or any performance monitoring. The form also does not have any way to record if information has been fed back to the person who reported the issue or to the service team involved or affected. We therefore consider that in the majority of cases (73%) there had been lost opportunities to improve services from reporting of the problem. These lost opportunities ranged from potential quality or safety improvements, team building and cohesiveness enhancements to highlighting and enriching continuing professional learning and development.

The problem report form is designed to work in conjunction with the corrective action request form (CAR form). The CAR form can be used following the need or issue being identified by the executive or delegate who assesses the problem report. None of the forms reviewed as part of this audit led to a corrective action request, although we have obtained other examples where it did. The CAR form seems to be used exclusively by the executive with scope for continuing progress reports to monitor quality or safety enhancements. Again, this form does not specifically allow for information to be given back to the original reporter or to the service team affected. This means that changes or service enhancements are only identified at the executive level and there is a potential that enhancement will not be made where it really counts, at service delivery level.

Our conclusions and comments

On the information available to us, we consider that the incident reporting system is generally accessible, is increasingly being used more widely and has the potential for effective analysis and processing of clinical incidents and events.

Areas for improvement to the system include more effective capturing and dissemination of corrective action initiatives and enhancements at the service level and the sharing of corrective actions and information among all staff affected, including those who initiated the reports. There also needs to be a greater emphasis on recording all observations, actions and improvements to minimise any margins for misinterpretation or the reliance on unfounded assumptions. Most importantly people contributing their observations and problem solving skills to the problem need to consider causal factors. Without this knowledge the system will continue to rely on event analysis and solutions that do not address the underlying causes.

A significant number of staff interviewed felt strongly that, though they raised issues through the previous incident reporting system or through the current problem form, management did little or nothing to address the concerns raised.

A smaller but still significant number of staff were concerned that it could be detrimental for them to submit problem reports. Several reasons were given for this including:

- Pressure from team members not to submit forms. If forms were submitted in this climate staff noted repercussions included exposure to ridicule and loss of trust between team members.
- Clear messages from local management not to submit forms from time to time, for example, *'we can deal with this without involving the hierarchy'* or *'a problem form is not required'.*

A key finding of our investigation is that without a clear and comprehensive safety reporting system that can deal with all the realities of working in a human based, busy, complex organisation where relationships, communication and competence are so critical, staff will feel unable to trust the system to deliver improvements to the quality and safety of patients. Universal trust at MHS did not exist.

We note the advice MHS provided to us in August 2003 that:

> *'Macarthur Health Service policy requires that staff who raise a problem/incident receive feedback as to the outcomes of their report.'*

MHS also outlined the process whereby feedback is provided to the incident reporter. However in the incidents we reviewed lack of feedback to staff was a key failure. By providing more consistent and timely feedback to reporters, staff concerns may be resolved.

Monitoring staff satisfaction with the incident reporting system would also be a very useful way to check if the changes in culture, policy and practice around the system have been successful.

Eradicating a 'blame culture' and building an effective report back system is something that needs to be addressed if a modern safety based reporting system is to be fully operational in MHS.

In the period of the clinical incidents, the problem reporting system did not, on the whole, function in a way that supported safety outcomes.

Our clinical review panels and internal medical advisors were very critical of the leadership and process of review, at both MHS level and SWSAHS level including the CCRC. The panels made the observations that the review forums may have:

- been accepting of the wider care issues 'as a fact of life'
- lacked the expertise to identify key causal factors that required attention
- been under resourced and overwhelmed by the workflow before the committee
- lacked a sense of urgency associated with improving patient safety
- been affected by intra committee conflict or factionalism
- not had models or performance indicators for evaluating the process or committee performance.

We note that MHS has acknowledged the need to strengthen the forums that review problem reports and incidents and has made improvements during the period of investigation.

Our recommendations

We recommend that:

7.6 DOH review the policy framework and best practice guidelines for the Development of Health Services Grievance Management Systems (Circular 99 – 45) and work with area health services to:

- clarify the overlap and boundaries of the quality and safety systems such as incident management systems, performance management systems, grievance systems and disciplinary systems
- develop integrated processes for reporting issues or concerns that may be incidents or grievances, or for staff members raising questions about the health, conduct or performance of other individual staff members, managers or clinical teams
- develop clear channels that provide a local means for staff to raise grievances or concerns of safety
- outline the mechanisms and need for all staff to follow the organisation's reporting systems clearly and consistently.

7.7 DOH continue to develop the proposal to introduce a safety climate survey tool to identify baseline information in relation to the perceptions of frontline staff, boards, area executives and middle management about attitudes and commitment to safety. This tool should be used across the NSW health system and allow benchmarking of results across health services.

7.8 DOH, in collaboration with ICE and area health services, identify models and performance indicators for incident reporting and corrective action systems to enable monitoring and benchmarking by staff, management, health services and the community of:

- the identification and preparation of reportable incident briefs to the DOH
- the timeliness of reporting, review and implementation of corrective action
- the adequacy of the review process and recommendations
- report back to staff and the care team
- the evaluation of improvements achieved.

7.9 SWSAHS and MHS implement appropriate facilitative and integrated mechanisms for all staff to report all incidents, issues, concerns and views. These mechanisms should:

- take into account differing and traditional behaviours of different professional groups
- make it clear that this reporting is necessary to enhance access to information about these risk identifiers so that clinicians and managers may make more informed decisions for the continuous improvement of the assessment, care and treatment provided to patients.

7.10 SWSAHS and MHS review the problem reporting system to ensure that incident reporting has the clear objective and effect of assisting learning and improving the quality and safety of care provided to patients across MHS. They also need to identify the gaps and remove the barriers to open and safe reporting and feedback for staff that were identified in this investigation.

7.11 SWSAHS and MHS conduct routine monitoring through a reliable and valid climate survey of staff satisfaction with the incident reporting system to determine if the changes in culture, policy and practice around the incident reporting system have been successful. The survey should include:

- staff satisfaction with the openness of the reporting system and the safeguards that enable them to report issues freely without fear or favour
- staff satisfaction with the feedback mechanisms through the incident reporting system to inform them of progress, action and outcomes in relation to each report and the method and timing of feedback.

7.7 CONSUMER COMPLAINT MANAGEMENT

Introduction

A consumer complaint management system is a central component of any quality and safety system. It provides a unique consumer perspective on service quality and safety and action that should be taken to address service deficiencies and weaknesses.

Consumer complaints management should ideally be undertaken by an appropriately skilled and senior member of staff who is part of the quality improvement team.

We have reviewed how consumer complaints are managed at MHS including conclusions that can be made about how risk is assessed and managed in the context of complaints.

MHS deals with consumer complaints as a separate process to problem reports. Complaints are coordinated by the executive assistant to the general manager and the general manager personally authorises all correspondence with relevant parties. After a complaint is registered it is referred to the relevant continuum director for investigation and other action. The executive assistant to the general manager assembles a response for the general manager based on information provided by the director. The general manager's direct role in complaints shows a commitment to consumer complaints at MHS. The process is intended to make MHS approachable and responsive to its consumers.

A working group of the Macarthur Health Community Council is conducting an audit of a sample of complaints. They will provide feedback to MHS on what caused the complaint, the adequacy of the complaint resolution process and whether recommendations were acted on. This approach to evaluating the complaints management system reflects better practice.[22] At the time of writing this report the outcome of this audit is not known.

Our complaint audit

We conducted an audit of 21 randomly selected consumer complaints from across MHS. This audit attempted to gauge the quality of responses to each complaint and the adequacy of the internal processes involved in investigating the complaints.

The methodology for the audit was the same that we use to evaluate complaints management by other organisations. The evaluation included whether there was:

- adequate information on file to address the issues raised in the complaint and evaluate the appropriateness of the outcomes
- an appropriate methodology used to investigate or otherwise resolve the complaint
- a logical connection between the information obtained and the findings
- an appropriate response to any identified problems (actions arising)
- an investigation and the outcome - were the issues substantiated, not substantiated or partially substantiated.

The results where investigations were conducted are summarised in Table 7.3.

The audit found that 56% of the investigations were adequate while 44% had insufficient information on file to identify and fully evaluate the methodology, findings and action taken. Examples of inadequate

Table 7.3 – Outcome of investigation of complaints

Category	Number	%
Complaint not substantiated	2	8.00
Complaint substantiated	7	28.00
Complaint partly substantiated	12	48.00
Total	**21**	

methodology, findings and resultant actions were however identified.

It appears that almost 90% of complaints were substantiated or partly substantiated although it was not particularly clear in some files.

Some of the complaints had multiple outcomes - for example information may have been provided and an apology also made. For the 21 incidents there were 54 actions arising. In 84% of complaints information was provided and an apology was made in almost 68% of cases. A staff member was counselled in 20% of cases and staff education was provided in response to 12% of the complaints.

The results are summarised in Table 7.4.

Table 7.4 – Action arising from complaint investigation

Category	Number	%
No action	1	4.00
Policy or protocol change	1	4.00
Apology or other redress offered	17	68.00
Staff member counselled	5	20.00
Staff education provided	3	12.00
Resolution meeting	4	16.00
Information provided	21	84.00
Service to be provided	1	4.00
Community/consumer education/ information	1	4.00
Total	**54**	

In some cases we observed that there may have been insufficient information provided to the consumer. This could be because there had been a resolution meeting and MHS may have considered that enough information had already been provided verbally so did not need to reproduce it in writing. In these situations adequate documentation of the resolution meeting would have been expected including findings and outcomes, whether there was a problem and if there was what was done or proposed to be done about it. This documentation was not present so it was difficult to evaluate whether the complaint was managed appropriately and appropriate actions identified and monitored. However, conducting resolution meetings is a positive development at MHS and an effective way to respond to and learn from health consumers. MHS advised there has been a significant increase in the use of resolution meetings since the period of the audit sample. Between June and September 2003, 19 out of 55 resolved complaints involved face to face meetings with parties.

Our conclusions and comments

Overall, complaints were finalised within 35 days which is the timeframe outlined by NSW Health in 1998 in 'Better Practice Guidelines for Frontline Complaint Handling'.

The audit confirmed that MHS has a commitment to investigating consumer complaints. However, it also reflected our findings from the problem report audit that they tend to focus on resolving individual issues rather than capturing information for systemic enhancements and providing feedback to the staff involved.

Our investigation of the individual clinical incidents, reported in Part 5, found that several of the general manager's responses to complainants were defensive about the issues raised and not entirely open in disclosing obvious issues of poor skill, judgement or care provided to a patient by clinical teams. The responses certainly did not adequately acknowledge what occurred or what specific actions would arise from the complaint.

Given the public debate about open disclosure led by the Australian Council for Safety and Quality in Health Care over the past two years and the recent adoption of the Council's Open Disclosure Standard 2003 by Australian Health Ministers,[23] the approach of MHS to dealing with consumer complaints should be reviewed and improved where necessary particularly to incorporate the new standard. Open disclosure is so important this should be a statewide recommendation.

There is general recognition that consumer complaints should be regarded as 'consumer reported incidents' and managed in an integrated way with an organisation's incident reporting and management system. The quality and safety issues raised in a complaint can then be reviewed and action taken as part of the overall quality improvement cycle. Honest and comprehensive feedback to complainants, staff and other stakeholders about the outcomes of a review and recommendations for improvement is critical. MHS should consider this integrated approach.

Given the significant community concerns about MHS we consider that an on site independent Commission patient support officer may assist the community, consumers and staff to more effectively resolve care related concerns and restore public confidence during this time of development and growth at MHS.

Our recommendations

We recommend that:

7.12 DOH work with the HCCC and the area health services to review and improve the NSW guidelines for responding to and managing consumer complaints. These guidelines should:

- include the principles of open disclosure at the local health service level, based upon the work of the Turning Wrongs into Rights Project
- recognise that consumer complaints are consumer reported incidents
- integrate reporting and recommendations for action arising from complaints with the incident reporting and management system, enabling the quality and safety issues raised in the complaint to be reviewed and acted upon
- develop consumer feedback mechanisms that will enable consumers and other stakeholders to know the progress, action and outcomes for each complaint.

7.13 An additional patient support officer be employed by the HCCC to work exclusively in the MHS region to help rebuild the community's confidence in their health service and more effectively resolve care related concerns.

7.14 MHS appoint a senior staff member who is part of the quality improvement team to be responsible for investigating and resolving complaints.

7.8 RISK ASSESSMENT AND MANAGEMENT

Introduction

Risk management is generally recognised in the health system as an integral part of good management practice. The *Australia/New Zealand Standard on Risk Management (AS/NZS 4360:1999)*[24] requires risk management to be part of an organisation's culture and integrated with the organisation's philosophy, practices and business plans.

Risk management is defined in the standard as:

> *'….a logical and systematic method of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risks associated with any activity, function or process in a way that will enable organisations to minimise losses and maximise opportunities.'*[25]

Integrated risk management models and tools that guide system design and practical application are not widely available across the health system.

Our conclusions and comments

A comparison of the requirements of the standard with the information provided by MHS indicates that overall the organisation has embraced the culture of risk management and is progressively improving in this area. Our comments in this report about internal audits are also relevant here as they highlight some current deficiencies in the risk management area that need to be addressed. These include the need for mandatory education and training of staff and management in incident reporting and risk management.

A review of the SWSAHS 2001-2002 annual report[26] suggests that some elements of the standard are not covered. These elements include monitoring and reviewing the performance of the risk management process and consulting and communicating with external stakeholders. Recommendations in an untitled report to the MHS executive dated 3 September 2002 by a working group, which appears to be a quality team formed to review the structure of committees across MHS, proposed some revised terms of reference for the MHS quality executive committee and indicates progress in this area. The revised terms of reference recommend monitoring several activities including the status of continuum preventative and corrective action reports which assist with quality and safety of care and service outcomes. This is to ensure that certain risk management systems are being identified, evaluated and analysed, trends identified and action taken if appropriate, and customer focus gaps in service delivery identified. The current MHS quality manual also makes provision for monitoring the improvement processes needed and for external auditors to make scheduled certification audits to check that changes and outcomes have been monitored for effectiveness.

Although MHS had many examples of proactive risk management, we were not given any documentation that captured the requirements of the standard. Service risk profiles in particular were not apparent. It was of note that during interviews staff had difficulties identifying those aspects of service provided in their unit that were considered higher risk.

Our recommendations

We recommend that:

7.15 DOH work in collaboration with ICE to develop tools and models to enable the health system to apply the Australian and New Zealand Standard on Risk Management across corporate and clinical governance structures.

7.16 SWSAHS apply the standard on risk management across their entire corporate and clinical governance frameworks.

7.9 CONSUMER PARTICIPATION

Introduction

Consumer and community involvement in the clinical governance change agenda is critical. A particularly important goal, according to Secker-Walker[27], is ensuring *'much greater involvement of patients and users in the process of quality improvement than has been the case in the past'*.

MHS has embraced consumer participation and has started the cultural and organisational shift required to incorporate it into the process of quality improvement.

The NSW government policy on community participation by health care services is set out in 'Partners in Health, NSW Government Response to the Report of the Consumer and Community Participation Implementation Group, November 2001'. The section on local health services requires top level support from the board and senior management of all area health services and a dedicated full time position to work on participation at all levels in the health service. The policy announces a review of existing structures for participation against guidelines set out in the 'Report of the Consumer and Community Participation Implementation Group', 2001. The guidelines support community participation in the full range of health service decisions.

As discussed earlier, 'The Framework for Managing the Quality of Health Services in New South Wales'[28] is another key document to guide area health services on clinical governance. The framework states that *'not only do consumers have a fundamental right to participate in health care delivery, but such input should have considerable benefit'*.[29] The report supports the effective involvement of consumers not only in their own care but also in the *'planning, delivery and evaluation of health services'*.[30]

Macarthur Health Service

The local application of the framework is reflected in the SWSAHS 2001-2002 annual report where, on p10, increased community participation is stated as a priority. A community network of over 100 members set up and working with the community is stated as the area's number one key challenge.[31]

We received glowing reports from those interviewed and were particularly impressed by discussions with representatives of the Macarthur Health Community Council (MHCC). Council members were highly complimentary of the general manager and staff at all levels of MHS for their commitment to consultation and community participation. The council is also conducting a review of the management of complaints at MHS, which reflects a high degree of openness and engagement with consumers.

Members of the MHCC represent the community on a range of MHS committees including:

- the clinical advisory council
- the quality executive
- the finance executive
- some clinical review committees.

Another contributing factor to the development of consumer involvement at MHS has been the employment of a community participation officer.

In our investigation, we were particularly interested in community views about the safety and quality of services provided by MHS at Camden and Campbelltown. Both staff and community representatives indicated that, although concerns about clinical care were raised from time to time, there was continued strong support from the local communities for the hospitals. A representative of the local division of general practice also expressed this view.

There is obviously considerable community concern about the safety of services provided at the hospitals. We have not been provided with recent information from MHS as to whether this is affecting local residents attending the hospitals. Local general practitioners did not seem to have changed their referral patterns because of concerns with the quality of care. In late 2002, as a result of the level of media coverage of issues at Camden and Campbelltown Hospitals, many of the staff interviewed said they had discussed the issues raised with community members and with patients using the hospital.

Our conclusions and comments

MHS is to be commended for the commitment and effort that management and staff have put into fostering strong links with the communities they serve and with community based health care practitioners.

The inclusion of community representatives on peak MHS committees strongly suggests an active commitment to one of the foundations of quality – a consumer focus. It is also an early form of community reporting on MHS quality and safety performance.

7.10 SERVICE PLANNING AND CHANGE MANAGEMENT

Introduction

As part of investigating organisational management at MHS, we reviewed the service planning and change management that existed.

We received the following planning documents from MHS:

- the Macarthur Health Service Business Plan 1999-2004 - a component of the MHS Quality Manual
- the Acute Services Support and Medical Outcomes Business Plan 2002-2005
- the Clinical Information Department Business Plan 2002-2003.

Under the NSW Government Strategic Management Framework strategic direction is set at a sector wide level, corporate planning at the agency level and implementation and service delivery at the program level. Strategic direction documents tend to cover extended time frames such as five year plans. Each level of the process should fit together and be based on the same or a sub-set of common parameters. Each subsequent process should cover a shorter time span, be more detailed and practical, and address local implementation.

Diagram 7.1 illustrates this relationship.

Business planning at MHS

We applied the strategic management framework to the three MHS planning documents and found that each document:

- includes the term 'business plan' in its title without any clear indication of how it links to the other documents
- covers different time periods
- is based on different challenges or directions.

The MHS Business Plan 1999-2004 articulates seven key challenges:

- Working with the community and staff to develop a shared sense of responsibility and direction.
- Working in partnership with other agencies to improve health.
- Ensuring that people in South Western Sydney access health services according to need.
- Making the best use of and fairly allocating existing and incoming resources.
- Developing effective and efficient health services which focus on improved health outcomes.
- Attracting, developing and retaining the best staff.
- Becoming a learning and teaching organisation.

The Acute Services Support and Medical Outcomes Continuum Business Plan 2002-2005 is structured around the four strategic directions of the Australian Council on Quality and Safety in Health Care.

These are:

- better use of data
- redesigning systems and processes
- support for staff
- consumer feedback and participation.

The Clinical Information Department Business Plan 2002-2003 delineates its activities in keeping with NSW Health's four goals.

These are:

- healthier people
- fairer access
- quality healthcare
- organisational capacity.

Each of these plans may have developed historically in response to perceived local or unit needs. However from an organisational perspective it is difficult to understand how the plans work together, which has priority, or how the performance indicators or benchmarks of one could feed into the other let alone into area, state or national planning and evaluation processes.

Our recommendations

We recommend that:

7.17 SWSAHS and MHS review the planning processes at MHS to ensure consistency, compatibility and usefulness of planning tools across each internal level and with external stakeholders. Each measurement indicator used at each level should be overtly linked with the Department of Health's four strategic directions to:

- show how each level is working towards broader health system goals
- facilitate reporting on progress towards the broader health system goals
- justify funding proposals to achieve the broader health system goals.

Planning for the future

The organisational change required to bring about successful clinical governance is a major one. A key problem is that the people involved in the change process will often resist the proposed change.

There are several reasons for resistance to change. They include increased stress, denial, self-interest, lack of understanding, trust and ownership, uncertainty and motivation.[32] Other reasons include inwardly focused cultures, paralysing bureaucracy, parochial politics, lack of teamwork, arrogant attitudes and a lack of leadership in middle management.[33]

Various strategies have been used to introduce change into organisations with differing degrees of success. Kotter in 'Leading Change' shows that strategies for change can often fail in organisations because behaviour is not altered. He delineates eight stages that an organisation has to go through to successfully implement major change. These are – establishing a sense of urgency, creating the guiding coalition, developing a vision and strategy, communicating the change vision, empowering a broad base of people to take action, generating short-term wins, consolidating gains and producing even more change, and institutionalising new approaches in the culture.[34] The first four stages of the process are to *'help defrost a hardened status quo'*.[35] This 'defrosting' process is considered essential to establish a solid enough base on which to proceed.

In a recent report that combines data from three benchmarking studies undertaken in 1997, 1999 and 2002 involving 327 organisations worldwide, the top activity that project teams stated they would do differently on the next project is to implement more effective change management. The greatest obstacle to change (cited six times more often than any other) was resistance to change within the organisation.[36] In another report, where 254 companies shared the lessons learned in change management, one of the key findings was that most companies considered that dealing with resistance to change was the most difficult part of the project.[37]

The Health Council in its report 'A Better Health System for NSW 03/2000', recognised the problems in change management and recommended the establishment of a coordinating body to oversee change management in the health system.[38]

The key to good change management is a strategic plan that outlines the direction of change and the reasons for it. This needs to be complemented by a strong consultation and communication strategy that ensures that staff, the communities served and key stakeholders understand and can participate in the plan and in the various changes to their services and service delivery.

MHS, like health care services across the nation, has been required to adapt to increased public demands and expectations, budgetary restraints, policy initiatives and ongoing cycles of change.

Capital investment and infrastructure development seem to have played a large part in shaping the current direction of change for MHS. Recent change has been guided by the 'Macarthur Service Strategy' 2001. The strategy has been described by SWSAHS as outlining a *'comprehensive process for service expansion that was underpinned by local needs assessment, investigation of service options and resource planning'.* While providing a broad base for planning, it does not include consideration of where MHS sits in an overall area clinical services plan with the clinical leadership links, relationships with tertiary clinical services, educational and research institutions, both inside and outside the area. Also the clinical support requirements such as pharmacy, imaging and pathology for service enhancements or development do not seem part of this. The clinical infrastructure required for each service and an outline

of how this was to be resourced were also not apparent. Without supplementary planning and resource identification an incomplete or inadequate service infrastructure could result.

Both hospitals have benefited from major capital works over the last five years. The model of care underpinning the service delivery plan is less obvious and opinions vary among staff, managers and the community as to how services will evolve. The most obvious example of this is the role delineation between Campbelltown and Camden Hospitals. The logical planning direction would seem to be to consolidate sub-acute services on the Camden site and develop acute services at the Campbelltown site - this was also supported by the greater metropolitan transition taskforce (GMTT) report for both emergency and maternity services.

Given the likely role change of Camden Hospital, there is a need to promote an alternative vision for the hospital. We gained the impression that SWSAHS and MHS management held a 'downbeat' view of Camden Hospital. This is in contrast to the view held by the local community that, not surprisingly, is that this long standing health service that has had strong community support over many years should continue to provide a full range of primary and acute care services. This is a dilemma that most area health services have had to face when decisions about the most appropriate allocation of resources have to be made. They have to provide adequate access to meet the health needs of the community and balance the costs of current technology, current scientific evidence of appropriate standards and the availability of a suitably skilled health workforce. Nevertheless other area health services have worked with their communities and involved them in the debate and decision-making. The Commission and the systems review panel acknowledge that this is a very challenging task, but necessary if rational services are to be provided in a region. We believe that SWSAHS and MHS, by working with the local community, could build a very positive view of the important sub-acute services to the elderly and chronically ill that Camden Hospital currently provides and could provide more of in the future.

We analysed the capacity of MHS to engage in the dynamic process of needs assessment, considered and planned service development and effective management of change from an organisational and clinical perspective by reference to two particular cases which presented themselves during the course of our reviews. These cases both related to Camden Hospital - one was the planned re-introduction of maternity services at Camden and the other related to the medical ward.

Maternity services at Camden Hospital

The systems review panel reviewed planned maternity services at Camden Hospital in response to concerns raised by staff and management about the reintroduction of full maternity services at Camden Hospital, particularly the conduct of emergency caesarean sections.

Two key concerns were:

- The availability of specialist staff and services at short notice in response to unforeseen urgent clinical situations. This applies not only to obstetricians, anaesthetists and paediatricians but also to nursing staff, particularly those in the operating theatre and critical care areas, and support services such as diagnostic and pharmacy.
- The introduction of on-call and call-back arrangements for operating theatre nurses currently on a five-day, business hours roster. Only a few of the nurses currently providing day surgery operating theatre support have training and any or recent experience in supporting emergency obstetric surgery.

A number of staff also referred to the report on metropolitan hospitals released by the GMTT in August

2002. This report recommended strongly that there be clinical integration of maternity services to establish a single service covering Campbelltown and Camden Hospitals. This recommendation was based on a preference to provide higher level services to the community with antenatal, postnatal, gynaecological, obstetric and midwifery services all in the one location.

SWSAHS responded to the GMTT report in January 2003 advising that MHS was *'well advanced in meeting the GMTT recommendations of a single maternity service across two sites'* through the on-call rotational rosters across sites for anaesthetic and paediatric services. Camden maternity unit was to be a 'low risk' unit with patients screened for factors that might exclude admission. When MHS was created as a single management unit and rebuilding work was initiated at Camden Hospital in 1999, the birthing service at Camden was transferred to Campbelltown. However, in response to community interest in having a local maternity service, there were a number of public undertakings that a 'level 3' maternity service would be re-established at Camden after the building work was completed. Re-establishing the unit depended on them being able to obtain sufficient anaesthetic, obstetric and ancillary services.

We considered the documentation provided by MHS and are of the view that this represented a reasonable planning process for clinical care for the renewed maternity service. However, we did express some concerns about the capacity and ability of the staff to provide maternity services. The documentation provided by MHS did not address any needs or skills assessment for current staff at Camden Hospital and did not identify the presence or development of care and transfer protocols. It also did not identify the educational activities available to staff who may need to be involved in emergency caesarean sections or other emergency procedures and may lack the training or experience in these areas. The documentation did not address the level of consultation with nurses and allied health staff since 1999 or the availability of pharmacy and diagnostic services on a 24 hour basis at Camden.

The systems review panel recommended that the SWSAHS board maintain a monitoring role on the re-introduction of maternity services at Camden to highlight the importance of minimising risk through effective and staged planning, change management and service development processes.

The more recent material provided by MHS included information on the management structure and unit performance monitoring. This information reported that the management of the unit is overseen by a management committee chaired by the MHS General Manager. The committee's explicit role is to oversee the operations of the unit and receive reports on key performance indicators and adverse events.

A number of key performance indicators are used to monitor the quality and safety of the unit.

These are:

- the percentage of patients who have elective caesarean sections
- inpatient maternal mortality (ages 15 – 44)
- the percentage of practitioners with a caesarean intervention rate greater than the state average
- the number of term babies transferred or admitted to a neonatal intensive care unit for reasons other than congenital abnormality
- occurrences of adverse events to inpatients
- postnatal transfers back to Campbelltown Hospital or to tertiary/referral centres
- neonatal transfers back to Campbelltown Hospital or to tertiary/referral centres
- infant mortality.

These performance indicators are appropriately included on the agenda of the management committee and within the agreements made with VMOs.

MHS has also advised that there is an extensive clinical governance element in the risk management framework for this service. This has been incorporated into agreements with VMOs providing services at Camden.

The clinical governance component of this agreement includes requirements relating to eligibility for appointment, orientation, teaching and research, quality and clinical care.

To ensure appropriate availability, VMO contracts specify a ten minute on call service - they are expected to be available on site within ten minutes of a call from maternity unit clinicians. The service began in February 2003. The Commission notes the significant investment this represents and its necessity from a safety perspective. However, we consider that the service should be a lower risk primary care maternity service.

Camden Hospital medical ward

Staff associated with the medical ward at Camden have been through enormous change over a very short period of time. These changes have included two physical re-locations, the changing of the team components on at least three occasions, a change in the nurse unit manager on three occasions plus an evolving but not yet defined patient population and role. With the benefit of hindsight, it is easy to identify components of risk to the smooth and effective running of any service with that history and it presents important lessons for any management team about the need to actively manage change. It is not therefore surprising that there has been unrest in some form or another in the Camden medical ward. Lessons can be learned from such a situation.

Managing and responding to change at MHS

The paradigm of clinical accountability has changed from a trust based autonomy of the professions to an increased emphasis on performance review, monitoring and oversight in a multidisciplinary clinical team. However the residual tensions created by some clinicians, particularly medical practitioners, clinging onto the notion of 'clinical autonomy' is a significant barrier to true teamwork.

Medical practitioners are only one part of the clinical care team. Where the number and experience of doctors is less, there is no doubt that nurses and allied health professionals take on different roles to complement the medical staff mix. An especially important element of change in service delivery currently in evidence at MHS, and demonstrated across Australian hospitals over the last three decades, is the evolution of medical staffing models.

General practitioners used to provide a significant component of the care in hospitals and they still do in rural areas. However with the increasing specialisation of medical practice they have gradually been displaced and in metropolitan hospitals they now rarely provide inpatient care. They are though increasingly engaged in 'shared care' where pre and post hospital care is under their management.

The general practitioners have mainly been displaced by specialist visiting medical officers or VMOs who are typically part time employees of the hospital. The VMOs are supported by junior doctors, either trainees (interns, residents or registrars), or career medical officers (CMOs) who may have a number of years experience. These junior doctors and CMOs tend to be full-time employees. In the major teaching hospitals there is a greater proportion of full-time specialist medical practitioners who lead a particular specialty service and who are generally complemented by a number of VMOs, registrars who are senior

trainees in the particular specialty, and sometimes residents, interns and CMOs. MHS has had a notable lack of registrar level medical staff actively engaged in professional college training programs.

The MHS clinical staff mix across the two hospitals reflects these changes and is evolving and changing at a rapid rate. This has brought significant challenges. The DOH review team also highlighted the serious issue of the sufficiency of skills and numbers of clinical staff in the workforce at MHS. There is the need to constantly review and update responsibility for patient care decisions and cope with a substantial number of new staff with different experience, skills and education. This has provoked resistance from established staff to changes in the way things are done and has included a change in roles, work practices, organisational structure and the delineation of clinical privileges.

MHS is currently changing its medical staffing model by introducing more staff specialists in high volume services supported by VMOs, registrars and CMOs. This has had an impact on traditional clinical management models. There is a shift of authority and influence from the VMOs and nursing staff towards the staff specialist and this is undoubtedly creating tensions. Parallel tensions may develop as the nursing workforce incorporates nurse practitioners, clinical nurse consultants and additional nurse educators. Increased specialisation and levels of expertise within nursing may be expected to challenge existing nursing and team structures.

The DOH review team also focused on the need for multi disciplinary teams. As noted in parts 5 and 6 of this report, the tensions and consequences created where there is no cogent sense of a clinical team has been highlighted over and over again in the incidents and issues raised in this investigation:

> *'……..we must learn to be team players. It is patently obvious that modern health care cannot be delivered by any single individual. Even relatively simple treatments now require a broad range of expertise to be delivered effectively, efficiently and safely.'* [39]

The review team went on to highlight that:

> *'multidisciplinary teamwork, within health care facilities and between them, is essential for effective and efficient delivery of health care. This is particularly important in a facility such as Macarthur Health Service where growth in demand for services is occurring at a faster rate than staff numbers and systems development.*
>
> *During the review, evidence of multidisciplinary patient care was found to be established in a few services: paediatrics, obstetrics, palliative care and ambulatory care. Cardiology services are enhanced through links to Liverpool Hospital.'* [40]

Change of this magnitude requires active and guided change management. Communities and staff need to feel that the direction of change is sensible, logical and relevant to their needs and aspirations. They need to understand the change and feel part of it, rather than having a sense that it is imposed upon them without either their input or consent. Different people respond differently to change and to consultation about change. There will always be people who oppose change either because they feel it disadvantages them personally or because they disagree with the direction and logic of the change. However generally people respond better to change if it is explained to them, they have had the opportunity to air their views and concerns, and they feel that they have been listened to by decision-makers.

For MHS the pace of change is unlikely to slacken in the foreseeable future. They will need to continue to grow and evolve and attract new staff to provide the new and more complex services that have been planned for a rapidly growing region. Good change management is an essential ingredient to future success.

Change of the scale experienced across MHS – the creation of a single management unit across the two sites, the enormous physical construction work, the changing models for care delivery and the exponential increases to staff at all levels of the service – requires effective and active change management.

An essential element of change management is the identification and management of risk. The DOH development of guides to role delineation provides one reference for the assessment and management of risk during change, including the continuous change demanded by the rigors of providing safe services. Risk profiles and management strategies are vital to clinical governance as they provide one means of linking and communicating with the vertical and horizontal layers of the health system.

Our recommendations

We recommend that:

7.18 DOH review the role delineation of health services to incorporate a risk assessment/evaluation tool linked to the broader system of clinical risk management. This will assist area health services to assess current services and plan for new services linked to the role delineation of organisations and units. This tool should be available to the community to help them understand the reasons for service levels.

7.19 SWSAHS and MHS develop an area wide clinical services plan and models of care that:

- minimise the duplication of services that require 24 hour coverage and back up support, where time and transport availability make this clinically supportable
- build a robust change management plan
- incorporate mechanisms to ensure the community and staff have the opportunity to actively participate in the debate and discussion around the development of this plan
- clearly outline the roles of both hospitals for staff and the community
- clearly outline what services will be developed where
- include a teaching and research component linked to overall strategies for service and health improvement
- once settled, incorporate strategies for promoting the role of both hospitals in a positive light, with active promotion of the individual identity of each hospital with its local community.

7.20 MHS develop active change management strategies to support and assist staff in dealing with the impact of change at Camden Hospital medical ward.

7.21 The maternity service at Camden Hospital should continue to develop as a low risk primary health care model.

7.22 SWSAHS and MHS maintain a close monitoring role on the re-introduction of maternity services at Camden to identify and minimise risks for families who may wish to use the service.

7.23 DOH, SWSAHS and MHS actively facilitate a program of staff involvement, development and support to review and enable the requisite cultural change that must accompany service development and change of the magnitude being seen in MHS.

7.11 DEVELOPING POLICIES, PROCEDURES AND GUIDELINES

Introduction

As part of our investigation we wanted to look at how MHS researched and developed its policies, procedures and guidelines as part of organisational management and clinical governance.

We were interested in this because:

- a significant proportion of staff seemed to feel isolated from management processes and decisions that affected their working environment
- the philosophical basis of clinical and corporate governance is inclusiveness and maximising staff involvement in decision-making relevant to their work.

Management processes benefit from clear statements of:

- how policies and guidelines are developed
- what higher level policies should be developed at area level
- what constitutes local policies, procedures and guidelines
- an expectation that they will be consistent with the organisation's purpose, philosophy, values and goals
- how interested parties can participate
- implementation and access strategies
- how and when reviews occur.

We reviewed a small sample of policy documents and found them to be an adequate guide to enable staff to provide adequate patient care. Our investigation did not evaluate the scope of policy and protocols. Staff from several clinical areas noted they were not involved in the development or review of policies and were concerned about gaps in clinical protocols in particular. It was noted that MHS did not have the clinical expertise in all areas to develop these. Conflicting information was obtained about the transfer of knowledge and protocols from Liverpool Hospital to MHS. Staff noted key protocols were absent particularly in critical care areas and sharing of protocols across the area was not automatic.

Policy and procedure manuals are generally well structured and controlled in terms of authorisation and review dates. However compliance with policies varies as demonstrated by the analysis of the clinical incidents in Part 5.

To be of value policies and procedures need to be effectively implemented and evaluated. Staff noted that generally new policies are mentioned at team meetings and not usually associated with training. Most were available on the intranet but not all staff have ready access to the intranet. MET policy, mentioned elsewhere in this report, is an example where implementation was inadequate. Despite problem reports noting confusion with the MET policy there was no evidence that the policy was reviewed.

Collaborations

Collaborations are a key research, development and learning tool where a number of health services engage in joint studies and problem solving. MHS is currently participating in the ICE patient flow and safety collaborative. This collaborative brings together clinicians from several hospitals to develop strategies in a number of key areas. These strategies are designed to improve access to acute hospitals and reduce the rate of significant adverse events.

The core aims of the collaboration are to develop clinical protocols and guidelines to address some of the identified high volume, high risk clinical challenges, such as a reduction in:

- the rate of pressure ulcers
- delays in access to specialist consultation
- delays to diagnostics
- delays and blockages in the discharge process.

Staff from MHS are reviewing and measuring their current performance in each of these areas and developing possible strategies to improve performance. They will then present both data and possible strategies to other collaborative participants and evaluate the impact of steps undertaken. This includes a case review of files to provide a true baseline to measure the success of the process.

To date reducing delays in diagnostics is the most developed of these strategies. The review process involved auditing a number of files and interviewing VMOs to obtain a valid measure of the number of cases where diagnostics had been both ordered and reviewed. This data is being presented to other collaborative members and will inform local strategies to improve performance.

Delay in access to specialist consultation will be the next area of focus for this collaboration. It will start with an accurate measure of the actual time taken for VMOs to attend consultations and the outcomes of delays on behalf of VMOs. This study is designed to identify and describe any systemic problems in this area and prompt solutions to improve patient safety. This part of the collaboration has not yet been completed.

These areas for collaborative study and action cover some of the areas of concern identified by our investigation of the incidents. However, there are an increasing number of already developed, evidence based, clinical protocols, guidelines and pathways that can and should be available to all clinical staff, against which variation in outcomes can be measured, reviewed and local clinical practice improved.

Part 5 of this report has recommendations for reviewing and developing clinical policies, guidelines and protocols.

Learning from external reports

MHS reported that they review major external safety reports to determine whether their systems and processes are sufficiently robust to prevent similar situations occurring in MHS facilities.

The King Edward Memorial Report was reviewed by the maternity management committee and they are overseeing the implementation of actions to bring MHS into line with recommendations made in the report. This work has included developing protocols to respond to common serious emergencies in maternity.

The inquiry into the Royal Melbourne Hospital was reviewed by the MHS drug and therapeutic committee to assess its implications and possible learning. A number of initiatives were identified regarding the functioning and evaluation of the drug committee, the documentation of its decisions and the review of the outcomes of processes under its oversight. These tasks are included in the committee's action plan and are currently being implemented.

Our conclusions and comments

Being receptive to the lessons from reviews of other health services is a critical cultural characteristic of a quality and safety oriented organisation. MHS has recognised this and has embarked upon a process of incorporating review and collaborations into reviewing and developing policies, procedures and guidelines.

7.12 PROFESSIONAL DEVELOPMENT, EDUCATION AND TRAINING

Introduction

Many of the issues that we have investigated have implications for the professional development, education and training of individual professional groups at MHS and the integrated clinical teams in SWSAHS.

Ongoing professional development, education and training of health practitioners is critical to skill and knowledge development. High levels of skill, experience and expertise of clinicians is critical to the quality and safety of care given to patients.

Campbelltown Hospital started with all registered nurses so educational resources, such as an education centre, were not part of MHS's initial resourcing. The lack of suitable education and training facilities is a barrier to the number of local courses available to staff. New educational facilities are part of the redevelopment program.

Programs for medical clinicians

MHS medical staff are resourced by a half-time director of postgraduate medical education who reports to the medical director of health services. This position was created in November 2001 and expanded on both the role and the hours of the previous position of director of clinical training. The focus is now on medical education for all staff rather than just a narrow focus on junior medical officers. The position also has a key responsibility of managing MHS's accreditation processes with the Australian and New Zealand College of Anaesthetists and the Australasian College for Emergency Medicine. We support the creation of a dedicated position for medical education and accreditation processes as college accreditation is considered an important endorsement of the quality and standing of any department.

Visiting medical officers are required, through their individual college fellowship or membership, to comply with maintenance of professional standards (MOPS) courses. However MHS advised us that they do not collect a formal record of their activities. We were also given copies of the MHS medical education calendar for 2002 and its draft plan for 2003 which seems to be comprehensive and active with a heavy emphasis on case presentations.

Programs for nursing clinicians

The extensive documentation on training and education available for and provided to nurses within MHS reflects our view that most nurses considered they had adequate access to continuing professional education. Nevertheless some nurses stated that opportunities to access educational opportunities that related to their particular development needs were limited.

Some training is provided in-house in units such as the emergency department where there is a designated position for a clinical nurse educator. Staff in other sections, such as the operating theatres, reportedly have portfolios allocated on an individual basis. Each nurse is considered the resource person for a particular clinical specialty and may run in-house training courses. Nurses in the operating theatres at Camden Hospital told us that they had good access to any ongoing professional education they needed to maintain their clinical competence and had not encountered any unreasonable refusal to fund or approve leave for participation in external courses.

The educational needs of nursing staff are identified through the MHS annual performance management processes. However these processes were not implemented across the organisation at the time of the incidents. When compared with other hospitals of equivalent size, MHS has few nurse educators and no nurse consultants.

Programs for allied health professionals, administrative and other service staff

Training for all MHS staff is conducted through the human resources unit. It includes orientation, mandatory training, multicultural and Aboriginal cultural awareness, occupational health and safety, complaints handling and quality improvement, cardiopulmonary resuscitation and performance management.

MHS provided a record of all training attendance by staff by work position and name of staff member. This detailed a significant degree of training but did not identify the duration of the staff member's employment within MHS, whether staff roles had undergone change (therefore requiring further training) or how the training addressed the needs identified through performance management or another process.

Programs to support quality improvement

MHS provided us with the following examples of education and development programs related to quality.

- A session on quality is included in the orientation program - it covers the philosophical and conceptual underpinnings as well as raising awareness of local operational procedures such as the problem / incident reporting system.
- Quality material is included in departmental orientation processes.
- Five teams of five and three community members had been trained in undertaking root cause analyses for identifying systems errors.
- An evening seminar was held in 2002 for clinical leaders on current frameworks for quality and safety in health care. This was delivered by Professor Bruce Barraclough, Chair of the Australian Council on Safety and Quality in Healthcare and Ms Maureen Robinson, Director, Quality Branch, NSW Health. It included both conceptual work in this area and the application of current resources such as the clinicians toolkit.
- The management development program includes a session on quality management. This is a training program with a high rate of uptake among new and future managers in MHS.
- All departmental managers attended a session on the introduction of ACHS as the accreditation body for the health service. The session focused on the need to be able to measure outcomes and demonstrate quality improvement.
- The development of the clinical governance action plan included consultations where staff were given evidence that systems issues contribute to the majority of errors in health care and asked to identify practical solutions in their own work teams to address them.

Our conclusions and comments

There are a number of recommendations in our report that relate to education, development and training. The DOH review also highlighted the need to foster support and active assistance from associated nursing and medical faculties, schools and specialist medical colleges. Academic leadership can be used to build the clinical skills of those on the ground as well as acting as a magnet to attract senior staff and highly skilled, accredited college trainees.

Management and clinical leaders should focus on matching nursing and midwifery skills and competence to patient need. Management should also support capable staff members with appropriate educational opportunities and consistent and standardised policies, procedures and documentation across all units and sites.

Management and clinical leaders should also seek out and establish the links and networks from wherever available to provide adequate clinical education, support and supervision around the clock.[41]

7.13 LEADERSHIP, MANAGEMENT AND ORGANISATIONAL CULTURE

Introduction

'That high level leadership skills are provided both at a clinical and management level. These should be supported by a knowledgeable and strong, governing board. Without strong and effective leadership, the problems of South Western Sydney Area Health Service are unlikely to be corrected in a sustainable way. The governing board and management must have the capacity to embrace the concept that good leadership empowers teamwork, creates an open and questioning culture and ensures the day-to-day delivery of good clinical governance. The leadership of SWSAHS and its facility the Macarthur Health Service should have the capacity to put great effort into building an open and fair culture that supports reporting of problems as part of the improvement process. Assessment of this issue is a priority for the Department of Health. [42]

The above recommendation from the DOH review team captures the essential elements of the findings and recommendations of our investigation.

We reviewed a small number of discrete units within MHS and gathered our information from select individuals involved in direct service delivery and management. The leadership and direction aspects were assessed on a unit by unit basis, with coverage of both hospitals within MHS. The units we looked at included the operating theatres at Camden and Campbelltown Hospitals, the medical ward at Camden Hospital, and the emergency departments at Camden and Campbelltown. We also reviewed local management and role delineation at Camden Hospital. This still enabled us to identify that leadership was a real issue at MHS.

Camden Hospital – operating theatres

From discussions with nursing staff, senior VMOs and management morale within Camden operating theatres appears good and relationships and communications within the team and across the various clinical disciplines are friendly and constructive. Relations between staff and management are mainly focused at the nurse unit manager level. Communication appears to be open and honest, with relatively free passage of information. Concern was expressed, however, that there was little feedback on or overt management action arising from incidents reported by staff. The main issue of concern at Camden involved the re-introduction of maternity services, the clinical risks and the impact this would have on the nursing staff workforce.

Campbelltown Hospital – operating theatres

The views we obtained from staff and management in January 2003 were clear and strong. As a workplace environment the Campbelltown operating theatres was not a happy place. Strong undercurrents of tension and anger, both among those working within the theatre and between theatre staff and management, were only thinly veiled and emerged readily during interviews. The problems include the fragmentation of the operating theatre team, divisions between staff and management, and allegations of poor performance. The information we obtained highlights the following:

Fragmentation of the operating theatre team

- There are several 'camps' among the nursing staff – pre-existing divisions have been accentuated by the disciplinary suspension and subsequent resignation of two long-standing staff members in 2002.

- Some surgeons and anaesthetists find the environment difficult to work in because they believe nursing staff are inflexible and under-productive.
- There is a lack of clear leadership of the operating team. This is due to perceptions of unit and executive management alignment with one or other of the particular factions within the nursing staff group, the historical context of most of the medical staff having been VMOs with no substantive leadership/management role or time allocation, and concerns about the qualifications or experience of certain levels of management.

Divisions between staff and management

- There is unresolved conflict between significant elements of the team and managers over events leading up to and following the suspension of two long-standing staff members and a lack of direction to resolve this conflict.
- Some staff members are concerned that management may have an agenda to replace staff that raise concerns or who sympathise with former staff members – this is generating a reluctance to report staff and patient safety issues. These concerns are reinforced by understandings about the incident reporting process and the potential for its use as part of a disciplinary process. These understandings appear to have been promoted by the lack of feedback received by staff after they have reported incidents.
- There is a perceived lack of confidence from leaders and managers outside the operating theatres in the leaders and managers of the operating theatre team. There are concerns that theatres are under-performing in areas such as theatre utilisation.
- Staff feel unable to raise grievances or obtain industrial support due to perceived role conflict between management and union/association representatives.

Allegations of poor performance

- Difficulties retaining good staff, high absenteeism and turnover, and difficulty recruiting new staff.
- Low theatre productivity due to alleged late starts, excessive down-time and poor work practices.
- Low morale with several accounts of unprofessional behaviour between staff.

In some cases the situation was complicated because there was no clear separation of the staff grievance process from other issues and concerns, such as staff occupational health and safety or patient safety, raised in the universal problem report form.

In most organisations, staff have four main internal mechanisms for raising grievance type concerns, namely:

- Their immediate manager or other managers further up the hierarchy. MHS senior management professed an open door policy and reported that staff at all levels would feel comfortable to come to them with concerns. However this view was not universally shared by staff interviewed.
- The human resources department.
- Their union or association.
- Their colleagues or external sources of support eg friends, the media or their member of parliament.

Good staff complaint processes aim to identify and resolve grievance issues internally, locally and as quickly as possible.

We identified a particular problem regarding complaints about line management. Staff considered that all avenues of internal grievance identification and resolution were closed because of role duplication and

felt unheard and unsupported by their managers. The managers were also union/association representatives or had continuing strong ties with the union/association, so some staff felt that the objectivity and advocacy role of the union/association was compromised. Staff did not see the human resources department as a useful alternative as it was seen as 'an arm of management'. The only alternative left was to talk to colleagues, an alternative unlikely to lead to resolution or closure, or to take the matter externally.

MHS appears to be an organisation that says they place a strong emphasis on staff accepting responsibility and accountability at all levels. It is claimed that staff are encouraged to air their views about problem issues and problem individuals in their workplace through climate surveys and management has indicated a commitment to act on issues raised. However our investigation of actual practices did not bear this out in a number of situations.

For individuals identified as 'problems', the disciplinary process forms a key component of actions that may be taken. Although climate and staff surveys are intended to be confidential and anonymous it is difficult to guarantee anonymity in a small workplace, particularly if staff are encouraged to identify colleagues.

A significant number of staff interviewed felt constrained about what they were prepared to say in front of management. This would not be an uncommon factor across a wide range of workplaces.

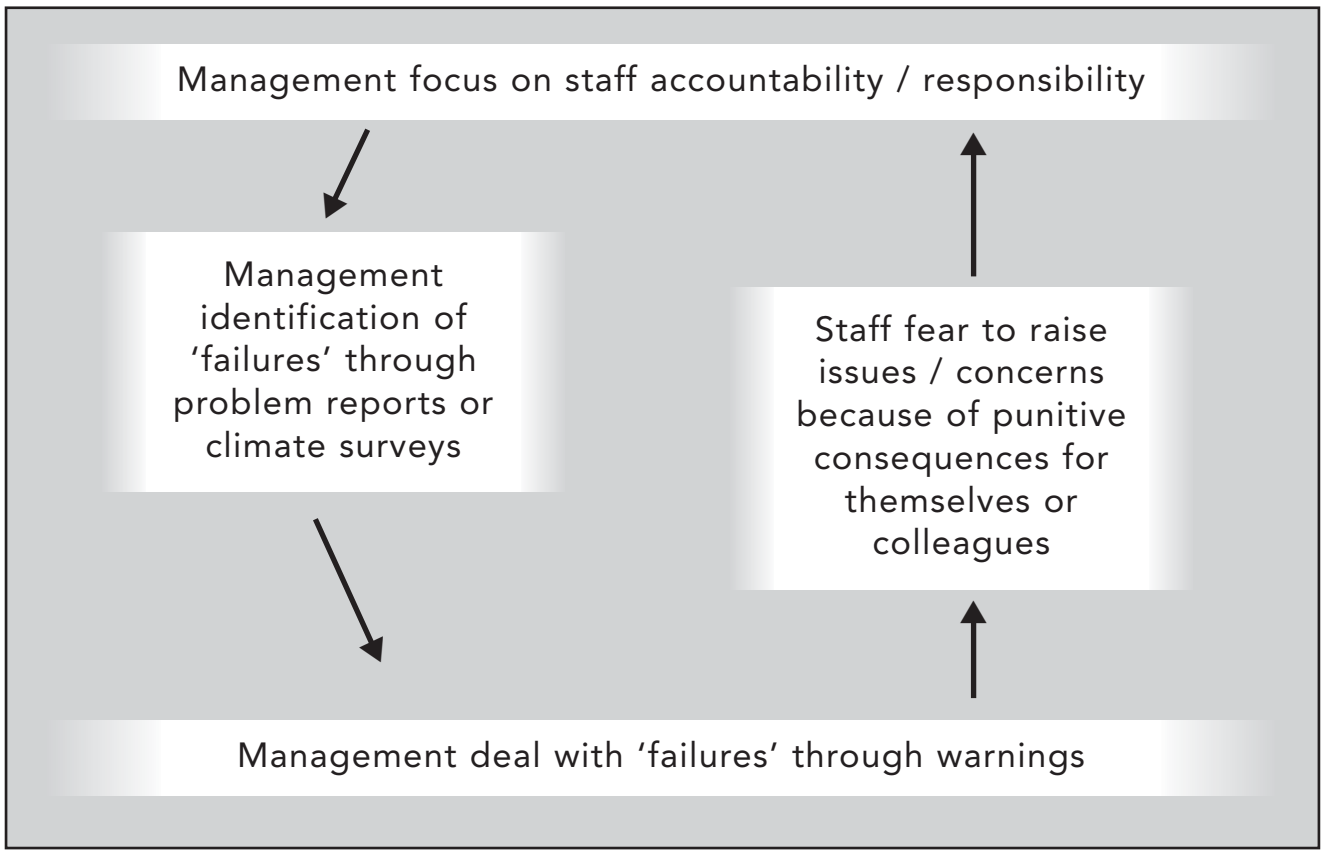
A significant number of staff interviewed felt strongly that, though they raised issues through the previous incident reporting system or through the current problem form, management did little or nothing to address the concerns raised.

A smaller but still significant number of staff were concerned that it could be detrimental for them if they raised negative issues or concerns about colleagues or managers. The reasons given included:

- Pressure from team members not to submit problem forms or raise concerns verbally. If forms were submitted in this climate staff noted repercussions included exposure to ridicule and loss of trust between team members.
- Clear messages from local management not to submit problem forms from time to time, for example, 'we can deal with this without involving the hierarchy' or 'a problem form is not required'.
- Management was committed to eliminating 'bad behaviour' and the principal tool for this seemed to be to identify certain individuals and apply disciplinary processes against them. There was less discussion and evidence of a commitment to identifying good behaviour and encouraging it through a reward and recognition approach, apart from a 'team of the year' award.

A significant number of staff and managers interviewed identified what appeared to them to be an attitudinal and behavioural circle between management and staff – this is represented in diagram 7.2.

Diagram 7.2



Our conclusions and comments

We have no doubt that both management and operating theatre staff recognise these problems and want to take action to improve the productivity and working environment in theatres. Unfortunately the roots of conflict run deep and many of the individual players hold very strong views and beliefs that are hindering progress in addressing problems and establishing a new workplace culture. The focus of the majority of the conflict is the suspension of the two registered nurses in 2002 and their subsequent resignation. However this event may merely have focused many pre-existing problems and tensions without contributing towards their resolution. The efforts of some well-intentioned staff and managers have since foundered on entrenched views on both sides about the process of, and justification for, the suspensions.

We focused on trying to identify practical suggestions for rebuilding the operating theatre team and service from its current state to a high performance team to ensure a high quality of care and safety. There needs to be improved leadership and management within the operating theatres and a focus on objective performance, rather than subjective impressions of who is doing what, with whom and why. This improvement needs to be achieved by positive investment in staff and their skills and performance, rather than through a prescriptive focus on responsibilities, accountabilities and discipline. It requires intense performance management and support, setting of clear, objective and measurable performance goals, active communication, and a commitment to open, honest feedback about performance. It will also involve an attitude of celebrating success rather than punishing failure.

Our recommendations

We recommend that:

7.24 SWSAHS and MHS work collaboratively, using the model of best practice for operating theatres developed by DOH, to:

- develop and implement clear, objective and achievable performance goals for the operating theatre teams
- ensure a commitment by management of necessary support to enable benchmarking across the area and with health services across the state.

7.25 SWSAHS and MHS invest strongly in an ongoing program of team-building for all clinical teams that has a clear set of objectives that have been negotiated with the involvement of the clinical teams themselves. The program should include a conflict resolution strategy that can be implemented to deal with situations where there are differing opinions within a clinical team.

They should also immediately invest in working with the operating theatre team at Campbelltown Hospital to ensure that the clinical team shares values and approaches to consumer focused care, support and advocacy, the roles of the different clinical team members, and attitudes to flexibility, initiative, innovation and cooperation without compromising professional principles.

7.26 SWSAHS and MHS immediately review existing clinical leadership and management structures and positions to:

- ensure that all clinical teams have clinical leaders and managers with the appropriate mix of knowledge, skills and experience to undertake their role
- provide support and supervision from across the area and externally where necessary
- identify where there are gaps in supporting existing clinical team leaders and managers and undertake the necessary further development that may be required or enable a dignified transfer to a more appropriate negotiated position.

7.27 SWSAHS and MHS develop a clear focus on systematically identifying and celebrating positive achievements as well as identifying areas of deficiency and improvement.

Camden Hospital management and role delineation

During discussions with staff from all levels at Camden Hospital, they expressed concern about local management and the impact of the continuum structures and some confusion about the roles of various positions.

For example, the position of nurse manager has no direct line of responsibility and no staff reporting directly to her but she is held accountable for the day-to-day management of the site. It is unclear if this position actually does have the accountability or whether it is a position of support or a resource if other systems fail. Although some staff interviewed indicated that these roles have developed to a point where they are now understood, it would seem that this level of understanding depends on length of service and ability to work productively within an ambiguous environment.

In a complex system such as health care, it is reasonable to assume that clear lines of accountability and reporting are important for it to work in an effective and efficient manner. The accountability and reporting lines for all staff who work at Camden Hospital could be improved and we encourage management to review the possibility of enhancing site management at Camden. Local site management did exist before the re-commissioning of the facility but, with staff indicating that they are unsure of who they report to or providing different answers as to who their supervisor is, this needs to be clarified urgently.

The role delineation of Camden Hospital is a key issue for both staff and the community. We were faced with a wide range of views from staff about Camden's role ranging from total closure of the site through to the re-introduction of the full range of hospital services. Staff availability at Camden has already determined the acuity of patient admission. Many staff advised that they considered Camden to be a 'dumping ground' for geriatric patients within what still appears to be a general service hospital. A large number of staff and community members interviewed assessed the role of Camden in a broader context and promoted a more positive approach, with the idea that Camden Hospital should become a centre of excellence for geriatric, rehabilitative and palliative care. SWSAHS states this does not adequately describe the issues. However, they agree that the issue is a major one for MHS.

Camden Hospital needs its own focus and, if this were achieved, it may be possible to recreate a culture of worth and clinical excellence that could be supported by motivated staff involved in teaching and research. This would in turn generate the opportunity to attract students and staff to the area once its reputation was established. Appropriate marketing of this role to the community would ensure support for such a centre of excellence.

Our recommendations

We recommend that:

R7.28 SWSAHS and MHS need to consider the role delineation of Camden Hospital within the area health service.

Camden Hospital medical ward

Camden medical ward staff raised operational issues caused by patients being on two sites and the cross-site provision of acute care services. In particular, staff reported considerable frustration in arranging appropriate surgical review or investigational activity as patients have to be transferred to Campbelltown Hospital for these services. These transfers take a considerable time to arrange and there may be delays of several hours. This leads to concerns about safety and the quality of care. MHS reports that there are now initiatives in place to improve patient transport between Campbelltown and Camden, funded through the GMTT.

A further system issue relating to the transfer of patients between Camden and Campbelltown was health documentation and its implications for continuing care. Staff at Campbelltown Hospital had the view that as the patients travel between the two sites they should have health care records from both sites, with continuity of the care within the notes. This means that patient care documentation flows on continuing pages and drug orders are on the one medication chart. However, staff from the ward at Camden said that duplication and re-ordering of drugs was a key issue and caused frustration, wastage and potential risks to health and safety.

There is a need for clarity and consistency in this important area of medical and nursing documentation and the prescription of drug therapy. MHS reports there have been initiatives to integrate clinical records across the two hospitals and the process has now been completed and one record is shared. A recommendation relating to tracking patient health care records across the area is in the section on documentation in Part 5.

Emergency services at Camden and Campbelltown Hospitals

The fact that the emergency department is split between two hospital sites requires special comment. Despite the organisational structure of one service on two sites, the reality and the current presentation does not seem to be one of a single, unified service. Staff at both hospital sites are sensitive to the issue of differential access to resources and clinical and diagnostic support services. This is because Camden is assessed as a 'level three' department and Campbelltown as a 'level five' department.

The systems review panel expressed concern about the capacity of ED at Camden Hospital to provide services to the expected standards.

The recent GMTT report for both emergency and maternity services suggested that there should be clinical integration across sites, with the acute component consolidated at one site to enable more effective distribution of expensive diagnostic and treatment resources. On the basis of the interviews we conducted, we support the logic of this direction.

From a patient safety and quality of care perspective, and given the current and likely future workforce constraints, it will be difficult to provide and maintain the necessary minimum level of coverage of experienced and appropriately trained medical specialists, junior medical, nursing and allied health staff to provide full 24 hour maternity and emergency services at both sites. However there is considerable community pressure to maintain these services at Camden, primarily because of concerns about access. This will need to be balanced against clinical risk, how this risk can be managed, and how staff will be attracted and retained. The long-term viability of acute services at Camden seems at best marginal.

A further matter affecting the delivery of emergency services at Camden Hospital is the provision of leadership with the director of emergency being based at Campbelltown Hospital for most of the time. This situation becomes particularly acute when there are difficulties with recruiting staff to work at Camden. The hospital has recently appointed an additional CMO position to the ED at Camden and this was stated to be a major step forward. The director of ED has also done considerable work in attempting to define specific criteria for the treatment and triaging of patients who present to Camden to minimise the potential risks to the quality and safety of health care.

According to MHS, the need to provide appropriate clinical leadership and governance to Camden ED has been addressed in the following ways:

- A medical director of emergency medicine was appointed on 18 September 2000 across both sites. This position is designed to provide clinical leadership to staff in both locations and be involved in in-services and quality activities.
- As additional CMOs are recruited they are contracted to work across both sites. This promotes greater consistency of practice across the sites and ensures that all medical staff have direct access to the medical director. These positions are being filled through the area of need program.
- The department of emergency executive meets weekly to ensure consistent standards of practice across both sites. This group includes the director of emergency medicine, nurse unit managers from both Campbelltown and Camden sites, clinical nurse educators and staff specialists in paediatrics.
- The nursing management structure of the department is currently under review to establish whether a single nurse manager across both sites would improve the consistency of practice.
- The advanced clinical nurse project has been developed to establish a series of standing orders to allow nursing staff to respond to certain presentations in a timely manner with follow up from medical staff. This project has involved significant training for nurses that will further promote consistency across sites. It is based on a similar project designed at Wollongong Hospital and has been extensively reviewed by clinical peers across SWSAHS.
- In addition to the standard mechanisms for measuring performance of clinical services, the ED is assessed against the following performance indicators:
  - waiting times by triage category
  - rates of access block
  - did not waits
  - review of adverse events by the acute services review team.

Although these are all positive developments, they have not provided the on site medical leadership that is required to build a strong safety focused team at Camden ED. We are critical of the delay in taking required action particularly when significant safety issues have existed at least since the late 1990s.

Nursing staff in the ED at Campbelltown Hospital have been prepared, for example, to speak to the director about the quality of after hours locum staff and the director has been prepared to do something about it. This behaviour highlights a very important feature of a safety culture that is developing in this ED. This type of local safety check would be absent if there was not a core of committed, professional clinical staff. Agency staff, rarely used in this department, would have less of an opportunity and may be less inclined to keep management informed on quality and safety issues. This type of valuable feedback is

fragile and must be nurtured. It is a culture that is clearly absent in a number of the clinical areas we reviewed.

Most of the clinical staff in ED felt supported and felt that they were being developed professionally. They feel that their opinions matter and are confident that their safety concerns would be listened to and acted on promptly, at least at a local level. This is an important local safety strategy. MHS says this statement contradicts extremely low rates of performance management for medical staff in this area and reports of insufficient contact with medical leadership. It does show a positive view in this department.

Some staff clearly perceived that there was a strong leadership group in MHS, particularly the general manager, who fought for adequate health care resources for the service. However this is not a view that is universally shared.

The informants and other staff interviewed noted that people who speak up for patient focused care and safety ran the risk of being ostracised by fellow workers. According to reports, challenges to usual practice have been met by rejection by team members and a questioning of the person's right to raise practice concerns. Staff who had concerns and raised them ran the risk of being perceived as a troublemaker or someone who could not be trusted by the rest of the team.

A critical development in the support of an open culture has been the inclusion of more staff in reviewing and acting on problems with care. The introduction of multidisciplinary review forums closer to the point of service delivery invites greater participation and control over improvement activities.

MHS supports the recommendation in Part 5 relating to the redefinition of the role of the ED at Camden Hospital, but wants it noted that strategies such as this have been attempted in the past.

Our conclusions and comments

The DOH review team summarised the key elements of a learning organisation that has the leadership and clinical governance structures in place to create a safe culture for the provision of high quality care.

- An improving organisation has strong leadership and management. It is the leaders of the organisation who determine whether the organisation excels. Leaders significantly influence the culture of the organisation and the values and goals they establish for the organisation provide direction for staff and for organisational behaviour. Patient centred safety focused values need to be paramount.
- Effective leaders create an environment to enable staff to work together to achieve common goals. The leaders shape performance within the organisation by empowering team members, motivating them to excel and emphasising continuous improvement.
- The leaders of the organisation have a prime responsibility for ensuring an appropriate infrastructure is established to support the organisation in providing quality care.[43]

The organisational response to the investigation and the informant allegations by SWSAHS and MHS did not reflect an open learning culture. Although management acknowledged adverse events occurred, the responses to the issues in the complaint and the preliminary report were generally defensive and did not adequately address key issues.

SWSAHS and MHS need to urgently and strongly embrace these leadership principles as a way forward to improve the organisational culture in relation to leadership and management at MHS and the quality of care delivered to patients.

7.14 ORGANISATIONAL STRUCTURE

Introduction

Many of the findings and recommendations in this report relate to the organisational structure of MHS and, more generally, SWSAHS. This section focuses on the organisation of clinical services.

An area of critical concern is that there does not appear to be strong links between MHS clinical services and the tertiary clinical services and clinical educational institutes across the whole of SWSAHS.

Each of the clinical service units seems to have a relatively self contained clinical services system that does not and cannot draw from the larger workforce and pool of knowledge available across MHS and SWSAHS. This 'knowledge' includes clinical expertise, monitoring and review systems, research support, educational resources and ideas.

With the range of resources available across the area – at Liverpool, Bankstown, Fairfield and MHS – clinical services should be seen as regional resources for the area not just local services. This could address some of the real and perceived differentials in the provision of clinical services such as emergency and primary care services, maternity services and intensive care. Clinical governance relies on an open culture that harnesses clinical expertise and has a strong direct connection between the board and clinical service provision. Given that the board of SWSAHS has governance responsibilities across the area, organising clinical services so that the resources can be shared makes sense.

The missing link for MHS seems to be that the primary connection to the board is through the sector management team and some committee representatives to the CEO and the area clinical council. The clinical services and clinical advisory council in each sector are organised in separate cul-de-sacs with their own cultures, gaps and barriers to providing consistently high quality and safe care to their various communities.

Other area health services have developed new models of clinical service delivery that more effectively harness the resources of their area. This allows more consistency in clinical services planning and care provision across the entire area and enables access to clinical and support resources to be driven by consumer needs rather than by what is available at any one particular facility. This latter situation is evident in some of our findings in relation to the disparity in clinical resources between Camden and Campbelltown Hospitals.

We acknowledge that there are challenges in addressing community and staff concerns that some locations may have more favoured status in the receipt of the resources. Any realignment of clinical and support services has to respect the different cultures that exist in the various communities, services and facilities and across professional boundaries. There also needs to be competent leadership at all service sites. It should, however, be possible to have active community and staff participation in developing a contemporary clinical service model that is more open, flexible and rational in its allocation of resources and achieve a consistent level of safety and quality of care.

The MHS acute care continuum covers a wide range of clinical and other services. It includes medical and surgical wards, palliative care, ICU, the department of emergency medicine, operating suites, central sterile stock department, nursing services, after hours hospital management and security services. Supports for the director of the continuum include quality, business and patient flow managers, infection control consultant, nurse manager, professional development and after hours hospital managers. The allocation of a quality manager to resource quality processes and activities within the continuum suggests organisational and continuum commitment to improve the quality of services. This degree of resource commitment is not common across the NSW health system.

The quality executive committee is the peak quality forum within MHS and is charged with the development of a continuous quality system. Membership includes the general manager, continuum directors and quality mangers. The committee had overall responsibility for the effective functioning of the problem reporting system and corrective actions.

Tables 7.6 and 7.7 on the pages following summarise the quality improvement organisational system built into MHS at the time of reporting.

Table 7.6 – Macarthur Health Service's quality management system

	Type	Reporting Responsibility	Records	Feedback
Trends in incidents or complaints as shown by data	Directors monthly reports to executive Reports to committees	Level two committees Task specific cross continuum working parties Directors	Project reports including steps taken and evaluation	Communication strategies including policy changes (amendment pages), newsletters, email and training Management meetings
Assessment of and progress in achieving quality standards	Assessment across the organisation through planning processes in functional areas Input to business planning in teams, especially planning days	Strategic view across the organisation - level one committees with regular reports to quality executive Departmental compliance and implementation – team and continuum plans	Action plans for each function area Team and continuum / business plans	Communication strategies to staff including policy changes (amendment pages) newsletters, email and training Management meetings
Promotion of good clinical governance	Consultation with clinicians Case reports Area and state policy or guidelines changes Clinical audits and reviews Results of KPI analysis	Departments, M&M meetings, clinical review groups reporting through continuum directors Oversight of clinical advisory council and Macarthur community council where appropriate	Departmental and continuum business plans Action plans Project plans and reports	Progress against business plans and periodic reviews Policy change Training Other communication strategies
Compliance with policy and practice	Organisational audit	Quality support unit Executive Level one committees	Minutes of level one committees, management meetings Project reports	Audit results provided to all departments and directors

Table 7.7 – Quality positions in Macarthur Health Service

Continuum	Position	Grading	Major duties	Details of other duties	Comments
General Managers Unit	Associate Director, Quality	HSM 2	Oversight of quality activity and systems for Macarthur Health Service, including accreditation and problem reporting	Supervision of quality support unit staff.	Nil
	Internal Audit Coordinator	HSM 1	Implementation of annual internal audit and support of other organisational quality activities	Nil	Nil
	Administrative Officer	Admin 4	Administrative support for organisational quality activities	Nil	Nil
Acute Services	Quality Manager	NUM 3	Oversight of quality activities throughout the acute services continuum	Nil	Nil
	Acute Services Review Team Coordinator		Implementation and resourcing for the acute services review team	Nil	Nil
Maternal and Child Health	Midwifery Educator	Nurse Educator	Support for all quality activities occurring in the continuum	Clinical education for midwives	Nil
Ambulatory Care	Associate Director, Ambulatory Care	HSM 2	Accreditation, recording and monitoring of problem/incident reports and CARs	Administrative management of Department managers Nil	Quality activity, including variance analysis is well integrated into positions of departmental managers and clinical leaders
Mental Health	Quality Manager	HSM 1	Support and promote quality and research activity across the continuum	Planning, data analysis, reporting	Nil
Aged Care and Rehab.					Nil
Population Health	Associate Director, Population Health	HSM 2	Accreditation, supporting quality projects, recording and monitoring of problem/incident reports and CARs	Supervision of manager, clinical information	Nil
Medical Outcomes	Decision Support Manager	HSM 2	Accreditation, supporting quality projects, recording and monitoring of problem/incident reports and CARs	Leadership for Macarthur Health Service in data analysis, especially case mix data.	Integral to participation in the Health roundtable

Our conclusions and comments

Designating the head of quality as an associate director who reports directly to the general manager provides a clear signal about the importance of quality to the organisation. Reporting to the associate director of quality are continuum quality managers and a finance and corporate services quality coordinator. Integration between the continuums and the quality stream overcomes the potential isolation of quality resources from the clinical team and provides an overall quality team environment and system necessary for continuous development.

The continuum's scope of services, the resources required to respond to external and internally driven change, planning, monitoring and review responsibilities together with the need to substantially improve clinical structures within key service units may create demands that cannot be met in a timely and responsive manner by the current structure.

Our recommendations

We recommend that:

7.29 SWSAHS review the way that clinical services and clinical support services are organised across the area and:

- harness the resources of the area to achieve integration and more consistency in clinical service planning and care provision across the entire area health service
- develop connections and support from outside SWSAHS from tertiary educational facilities, health professional colleges and associations and other area health services while local clinical leadership and resources are being developed
- enable a more functional resource allocation process that is driven by consumer needs and contemporary clinical standards.

7.30 SWSAHS and MHS review the organisational structure, accountability and reporting lines of staff at MHS, with particular emphasis on accountability and reporting lines of staff at Camden Hospital, to support staff and patient care and immediately appoint a site manager at Camden Hospital.

7.15 WHISTLEBLOWER ISSUES

This section deals with whistleblower issues that arose in our investigation and some other allegations made by the nurse informants against MHS management.

This complaint was made to the Commission by the Director-General after four nurses met with the Minister for Health to raise quality and safety concerns about MHS. Other nurses came forward with similar issues during the course of our investigation. The complaint has highlighted consequences for whistleblowers and the narrow options health practitioners have when they have serious concerns about the safety of the health care system and perceive management to be part of the problem.

Each nurse felt that there was a lack of management action in relation to unsafe practices and systems of care at Campbelltown and Camden Hospitals. A number felt victimised after drawing issues to management's attention and by the way in which management responded to their concerns.

Part 6 of this report shows how management used disciplinary processes following incidents where nurses had also raised issues within clinical teams concerning the safe delivery of care. Understandably action taken was perceived as punitive by the nurses and other staff. It is unsurprising that the four nurses involved developed a perception that there was a culture of blame and felt that management's response undermined the achievement of the open and responsive culture necessary for the implementation of any quality and safety framework.

Part 5 of this report gives examples of care within a specific timeframe that fell below an acceptable standard. It also highlights failures in the systems of care. Most incidents were reported through quality systems to management but were not adequately responded to. Many of the allegations made by the nurse informants were substantiated. The clinical incidents portray a health service where at that time the quality and safety framework was yet to be successfully implemented.

This part of the report 'Systems for quality and safety' analyses the functioning of the clinical governance systems including the incident reporting system and provides further evidence to support the nurses' perceptions of a health service that was not responsive to genuine issues concerning patient safety. The environment was ripe for a culture of blame and staff fears of being victimised if concerns were raised.

Our comments relate to the system that existed at the time the complaint was made. We acknowledge that MHS has undertaken significant remedial work since then to improve the infrastructure.

The perceptions of a culture of blame and unreceptive management are reflected in a number of allegations made about senior managers. As mentioned throughout the report, the majority of these allegations have been supported but some have not. One allegation concerned the shredding of documents by MHS managers and administrators that were important to our investigation. This is a very serious allegation as it calls into question the integrity of these managers and administrators. We were generally impressed by the efforts made by MHS to provide us with the documents we needed and there is no evidence to suggest key documents were missing or that there were noteworthy gaps in any of the records or other documents reviewed or obtained by the Commission. We did not specifically investigate these allegations. We referred them to the ICAC. We found no evidence during our investigation to support the allegations.

Other allegations concerned verbal responses by senior managers to one of the nurse informants when she reported failures of treatment and care incidents. These responses included comments like 'tell

someone who cares' or 'stop rocking the boat' and threats to send the nurse to work in Bowral. It is clear from the material and interviews that the nurse concerned was a frequent notifier of problems to management and that management did perceive her as a 'problem'. Given the slow response to address identified concerns and the reappearance of similar problems, it is understandable that the informant made repeated attempts to effect positive change with growing frustration. A review of this nurse's emailed concerns and the responses she received show that senior managers' responses were, on the whole, reasonable. However these observations are not relevant to determining whether individual managers acted in the manner alleged. The managers concerned either deny making such comments or have no record of such conversations.

We are unable to substantiate any of the specific allegations as the nurse's version and the managers' versions of events differ. The lack of evidence to substantiate these allegations supports our contention that there was an ineffective incident reporting system at MHS at this time, a key failure in a clinical governance system. A robust system would provide effective accountability for staff in reporting matters and for management in terms of their responses.

Other allegations were made about the management response to reported concerns about individual clinicians. In the instances known to the Commission the action reported to have been taken by management appears to have been adequate and appropriate, other than they did not provide feedback to the staff concerned. This absence of feedback makes staff vulnerable to the conclusion that nothing or not enough was done to address the concerns that they raised.

The experience of the nurse informants as whistleblowers

Overall we found that quality of care issues extended over time with the knowledge of colleagues and management. The experience of whistleblowers who are health professionals differs little from other whistleblowers.

The informant nurses, although supported by a small group of peers, have experienced attacks on their credibility, integrity and ability. Australian research suggests that nurse whistleblowers stand to risk their organisational and collegial support and standing. A survey of whistleblowing nurses and non-whistleblowing nurses in Western Australia by Ahern and McDonald[44] found that 'nurses who blow the whistle are compelled to act in accordance with their patient advocacy beliefs'. The same study cautiously suggests non-whistleblowing nurses may be responding to a deference to authority and balancing their responsibilities to the patient, doctors and their organisation or they may perceive the seriousness of the cause for concern differently. From the latter position it is almost compelling to see the whistleblower as betraying the trust of colleagues and the organisation in which they work. This was a response conveyed to us during interviews with both the informants and other staff. Given this, it is of little surprise that less than two percent of complaints made to the Commission are from health providers.

The value of whistleblowers

This investigation has demonstrated the value of whistleblowing. We were alerted to concerns about patient care and ineffective safety systems. Our findings and recommendations have the potential to inform and enhance safety within MHS and the NSW health system. Whistleblowers need support and safety to convey their message when other means of taking up their issues have failed.

Our investigation of the clinical incidents identified by the informants substantiated about 70% of their allegations - a significant proportion. Although some of their allegations could not be substantiated, the informants have on the whole been reliable. In a few cases, we obtained no evidence to support their views.

During our investigation we noted the failure by SWSAHS to recognise and respond to the issues raised by these nurses. Their credibility was continually challenged by SWSAHS and MHS throughout the course of most of this investigation. Such an attitude does not promote open disclosure and a quality and safety framework.

The attitude of SWSAHS reinforces our view that, for at least some staff, a culture of blame did exist within the area health service at the time that these incidents took place. Management did not recognise the need to manage staff in a way that allows them to raise their concerns in the knowledge that they will be responded to appropriately and that they are safe in doing so.

Current systems for whistleblowers

The *Protected Disclosures Act 1994* was proclaimed to encourage and facilitate the disclosure, in the public interest, of corrupt conduct, maladministration and serious and substantial waste in the public sector.

The Act:

- enhances and augments established procedures for making disclosures concerning such matters
- protects people from reprisals that might otherwise be inflicted on them because of those disclosures
- provides for disclosures to be properly investigated and dealt with.

SWSAHS's code of conduct states at 17.2:

> *'The Protected Disclosures Act 1994 provides certain protection against reprisals for employees and visiting practitioners who voluntarily report possible corruption, maladministration or serious and substantial waste either to the Chief Executive Officer or other internally nominated authority, or to one of the three external investigative bodies: the Independent Commission Against Corruption, the Auditor General, or the Ombudsman'.*

The nurse informants were unwilling to take their concerns to anyone in management at MHS. They did approach the area health service but, for whatever reason, felt that their concerns would not be taken seriously or acted upon. Given the negative views expressed by SWSAHS and MHS about the informants, their instincts may not have been without a rational basis. The nurses decided that their only avenue was to go to the Minister for Health. This was understandable given the nature of some of the allegations and the fact that the Health Care Complaints Commission is not one of the investigative bodies provided for in the *Protected Disclosures Act 1994.* In the circumstance of this complaint, the reporting channels available to the informants under DOH's 'Policy and Guidelines for the Development of Protected Disclosures in Health Services',[45] were not effective.

This complaint has highlighted improvements that could be made to the present system to allow health practitioners to come forward with their concerns. If they do not feel safe to deal with matters by using the organisation's internal reporting mechanisms, they need an independent body to which they can bring their concerns and be assured of some protection. *The Protected Disclosures Act 1994* specifically refers to disclosures made to the Independent Commission Against Corruption, the Ombudsman, the Auditor General, the Director-General of Local Government and the Police Integrity Commission and the jurisdictions of those agencies. These agencies do not investigate complaints about the care and treatment provided by health services so it would seem both appropriate and desirable for the Health Care Complaints Commission to be added to the list of agencies that can receive protected disclosures. This would encourage health practitioners to come forward to an appropriate investigatory agency with their complaints and give them the protection provided by the *Protected Disclosures Act.*

In addition, the *Protected Disclosures Act 1994* only applies to disclosures made by public officials. The health system has both public and private health practitioners and the Act probably does not cover visiting medical officers employed on contract by area health services or nurses and other health practitioners working in private health care.

Some aspects of this complaint may be covered by the Ombudsman's jurisdiction concerning conduct that amounts to maladministration. Maladministration involves action or inaction of a serious nature that is contrary to law, unreasonable, unjust, oppressive or improperly discriminatory or based wholly or partly on improper motives.[46] However the key focus of this complaint is the effectiveness of quality and safety systems, clinical governance, risk management, performance monitoring, incident monitoring systems and the failure to address serious and ongoing management and clinical problems. These issues properly fall within the jurisdiction of the Health Care Complaints Commission.

The complaint also raises the prospect of a mandatory reporting obligation on professionals to report professional misconduct and significant systems safety concerns. One of the current policy objectives for the health system is to move towards a quality and safety framework that includes open disclosure. There are many institutional and structural impediments to reporting and disclosing clinical mishaps so a mandatory reporting requirement for health practitioners may provide an impetus to those who are reluctant to report for a range of reasons. A mandatory regime may serve to change the present culture in the health system where whistleblowers are perceived as being disloyal.

Our recommendations

We recommend that:

7.31 The *Health Care Complaints Act 1993*, the *Health Services Act 1997* and the health professional registration Acts be amended to provide for mandatory reporting by health practitioners of unsafe conduct, performance and impairment on the part of health providers or management.

7.32 The *Health Care Complaints Act 1993* be amended to protect the identity of complainants in certain circumstances and to provide whistleblower protections for health practitioners in both the public and private sectors.

7.33 Health professional registration boards and health professional associations actively encourage the reporting of unsafe practices on the part of health providers or management and reflect this in their professional codes of conduct, practice and ethics.

7.34 DOH work with ICE to publish and disseminate information to private and public health care providers about:

- the importance of reporting unsafe practices on the part of health providers or management
- the positive contribution of reporting to quality improvement
- the need for a safe reporting culture
- the options available to report, including to the Commission
- what health professionals can do about patient safety concerns if they are not satisfied by management responses.

7.16 OUR CONCLUSIONS

Improving the quality and safety of health care in New South Wales, nationally and internationally has been recognised as a key priority. The Department of Health has set up a quality and clinical policy branch and ICE, both of which support its framework for managing the quality of health services in New South Wales.

Accreditation by the Australian Council on Health Care Standards was developed in 1974, with a focus on improving the structures, processes and outcomes within the health system. The evolution through quality assurance to continuous quality improvement led to the notion of clinical governance emerging in the 1990s, all with the fundamental purpose of improving the quality and safety of care in the health system.

This part of the report provides, in some respects, a report card on the implementation and impact of those efforts at the health service / health consumer interface. The Commission supports the approach taken at the policy level but considers that efforts to implement the clinical governance systems that underpin the safety and quality agenda at MHS, while innovative to date, need to be escalated. This report may also provide a timely and necessary impetus to all health services to review their systems for monitoring and improving the quality and safety of care delivery.

Under a quality and safety framework, health service providers must give priority to both the quality of care and clinical decision making and their budget. The framework recognises the tensions between health administrators and clinicians when clinical care is provided in the context of finite resources. It also supports a differentiation of focus for health service managers so that while capital works and other infrastructure demands are managed, the quality of clinical care receives appropriate attention. Overall service planning is linked to the capacity of the health service to deliver safe quality care.

A focus on the quality and safety of health care is imperative for the health system as well as a reasonable community expectation. It needs to be accompanied by an appropriate framework for evaluation and associated performance indicators that will inform both the community and the health service when key systems or people need remedial action to be taken. There is a danger of organisations claiming to have a range of quality systems and activities but not delivering expected or required results as happened here at MHS. Safe health care is too important to the community to either permit unsupportable claims or the continuation of systems that are not producing the desired results.

The quality and safety of health care is dependent upon a consumer focus, one where plans are aimed at improving delivery to consumers and developed with consumer participation. We found that MHS had good community involvement and consultation but this needs to be supported by a health wide system of reporting to the community.

The quality and safety of health care also depends on a culture of openness, honesty and trust within the organisation and between it and the community. It depends on strong leadership at all clinical and organisational levels. This investigation is a timely reminder that organisations are made up of individuals - it is not only the systems in place but the contribution of those individuals that assure organisational competence and safe quality care.

James Reason discusses the notion of a 'just' culture rather than a 'blame free' culture.[47] We promote this idea of a ‘just’ culture as it recognises that the community has the right to expect that when individuals in the health system are not performing, misconduct themselves or have an illness or injury that prevents

them from performing in a safe and competent way, appropriate action will be taken at that individual level. It also recognises the right of health providers to work in an environment that acknowledges the impact of system failures when things go wrong.

Investment in developing the competence of managers and clinicians is a statewide imperative and needs to be reflected in organisation and individual performance indicators.

Quality and safety for patients also depends on robust:

- process and system design for clinical care and supports
- risk management across all governance processes
- monitoring and action based upon real data relating to organisation performance and identified community needs.

We found that MHS were advanced in their approach and policy development around clinical governance, quality and safety. However we also found that the effectiveness of key quality and safety systems, such as incident reporting and complaints management, had been limited and made ineffective by a range of factors.

These factors include:

- a variability of reporting due to the culture and behaviour of different professional groups
- a culture that does not consistently encourage reporting of quality and safety problems
- a culture of blame reported by some staff
- a lack of feedback when reports are made
- delays in reviewing reports and implementing remedial action
- a failure to monitor and evaluate the implementation and effectiveness of any remedial action recommended
- inadequate resourcing of key quality and safety systems and personnel.

Clinicians and consumers are well placed to recognise failures in quality and safety whether these are caused by the conduct or performance of individuals, by system failures or by problems with management. Incident reporting systems need to capture both clinician and consumer issues and include details of the analysis of the issue, the recommended action, its implementation and evaluation. It is time that consumer feedback was fully incorporated into incident reporting systems across the state. Given the early stages of implementation of the infrastructure for clinical governance and the presentation of this complaint by nurses to the Minister, it is also essential that health practitioners are guaranteed a confidential, protected and independent mechanism outside of the health service to ensure concerns can be aired.

It is inevitable that adverse events and human errors will occur in the delivery of health services but there should never be a resignation to this inevitability to the point where future care and safety could be compromised. Health services such as MHS need to proactively manage those risks and reject complacency and a sense of helplessness to change things.

The recommendations in this report should be implemented in an environment of learning from others and improvement and in a way that reflects the principles of clinical governance. They are designed to

promote safer and better care at MHS and a way forward as are the recommendations of the review commissioned by the DOH.

Our recommendations

We recommend that:

7.35 DOH coordinate the oversight of the implementation of the recommendations in this report by the team commissioned to oversight the implementation of the recommendations in the review commissioned by the DOH.

ENDNOTES:

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INVESTIGATION REPORT

CAMPBELLTOWN AND CAMDEN HOSPITALS
MACARTHUR HEALTH SERVICE

APPENDIX A

Investigation into Macarthur Health Service Incident Review

Incident No 1

Date of Incident Qtr 1, 2002

Summary of Incident **Incident No 1**

In early 2001 Ms Z aged 10 was admitted to the paediatric ward in Campbelltown Hospital at 1200 hours for a closed reduction of a fracture in her forearm. This was not an emergency procedure. The fracture had been set in the ED 5 weeks before. No medical admission was done.

Ms Z was transferred to the OT at 1420 hours. No pre-operative assessment had been done.

Ms Z has a family history of malignant hyperthermia that is a significant risk factor for general anaesthesia. The NUM of the operating theatres, RN N6 contacted the Director of Medical Services who instructed that the head of anaesthetics should be consulted before proceeding.

The anaesthetist for the afternoon emergency cases was Dr D1, an anaesthetic CMO. Dr D1 commenced taking a history from Ms Z's mother, Mrs Z standing at the front door of the operating theatres at about 1500 hours. The corridor was very busy at the time.

While Dr D1 was taking the history from Mrs Z the NUM asked to speak to Dr D1 privately. The NUM expressed her concerns to Dr D1 and suggested that the procedure should be postponed because:
- Ms Z had a possible family history of malignant hyperthermia
- The anaesthetic equipment had not been appropriately flushed out
- A supply of the antidote drug Dantrium was not available
- There was not a VMO anaesthetist on site
- A full pre-operative assessment had not been done
- The surgical procedure was not urgent
- It was more appropriate for Ms Z and her mother to go back to the ward for a proper work up.
- The Director of Anaesthetics was being contacted about the case

Dr D1 continued to take the history from Mrs Z and asked Mrs Z to contact a family member by phone to obtain more details of the family history of malignant hyperthermia. After contacting the relative Mrs Z passed the phone to Dr D1. Mrs Z felt that Dr D1 was rude. She could hear the telephone conversation with her relative and she felt that Dr D1 was getting the information muddled up.

N2 started her shift as the NUM of the operating theatres and N6 asked N2 to take over the matter. N2 asked Dr D1 to discuss the matter in the NUM's office. They disagreed about whether it was appropriate for Dr D1 to continue taking the history and about the reasons Mrs Z was becoming upset.

The Director of Anaesthetics instructed Dr D1 to contact the VMO anaesthetist on call. N2 indicated that the operating theatre could not remain on standby waiting for the VMO anaesthetist to arrive. N2 asked Dr D1 to make the decision to postpone the operation.

N2 sat with Mrs Z until the anaesthetist arrived, then Mrs Z discussed the options with Dr D1 and the anaesthetist. Mrs Z felt that Dr D1 was prepared to put her daughter's life at risk and decided that she wanted her daughter transferred to Liverpool Hospital.

Two days later Dr D1 put in a written complaint to MHS management alleging that the NUMs N6 and N2 had intimidated, degraded and humiliated her in front of the Mrs and Ms Z.

The MHS management investigated Dr D1's complaint and made recommendations in their investigation report two months after the incident. The recommendations covered policies and procedures for pre-operative assessment but also included a formal warning to both N6 and N2.

Nurse N2 submitted an incident report 3 months after the incident. One week later another registered nurse N4 also lodged an incident report about Dr D1. As a result the General Manager of MHS conducted some fact finding interviews. In response to concerns raised by three nursing staff the General Manager decided to suspend Nurses N2 and N4 on full pay.

Allegations by Informants	Location 1	Location 2
Nurse involved in the incident was inappropriately suspended the day after her incident report	Campbelltown - OT	
CMO anaethetist practice was not adequately supervised	Campbelltown - OT	
CMO anaethetist communication with the family was inappropriate	Campbelltown - OT	

Issues Identified by HCCC	Location 1	Location 2
Communication with patients and families	Campbelltown - OT	
Management response to adverse events, including incident reporting	Campbelltown - OT	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - OT	
Coordination and continuity of care	Campbelltown - OT	
Relationships and communication within and across clinical teams	Campbelltown - OT	
Availability of and supervision by senior medical staff	Campbelltown - OT	

Investigation into Macarthur Health Service Incident Review

Clinical Review Panel Opinions	Incident No 1

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

• The incident demonstrates a failure by the consultant to ensure that Ms Z was put through the right channels. The risk of ?? should have clearly identified the malignant hyperthermia preoperatively and the risk explained the risk to Ms Z, her mother and the anaesthetic department.
• The incident demonstrates a lack of a proper pre-op assessment.
• The incident demonstrates a lack of adequate supervision of the anaesthetic CMO.
• The consultant anaesthetist was properly contacted and instructed that Ms Z should not be anaesthetised without a VMO anaesthetist present.
• It was excessively harsh to give the nurses a formal warning for their role in protecting Ms Z from the risk of anaesthetic.
• The NUM acted appropriately when she took the anaesthetic CMO into a private office to discuss the proposed management of Ms Z.
• Under the circumstances, the anaesthetic CMO should have listened to Ms Z's mother's concerns.
• The nurses acted correctly in standing their ground to protect Ms Z.

In relation to management/systems issues the Clinical Review Panel made the following comments:

• There should have been an existing protocol/guideline for patients with a family history of malignant hyperthermia, including how to prepare the anaesthetic machines.
• There is apparently no established practice of pre-op assessment, either surgical or anaesthetic.
• The OT practice does not conform with the ACHS clinical indicator (required for hospital accreditation) requiring that an adequate pre-op assessment is in the patient notes.
• There should be a system of 6 monthly performance review which would have picked up any on-going performance concerns in relation to less experienced staff.
• Nurses have a number of different ways of reporting performance concerns which are affecting patient safety: 'Nurse's Action Statement', 'Incident Form', a letter to management.
• The incident took place during business hours. There should have been a VMO anaesthetist on-site.
• A report was written which missed the 'macro view'. However the recommendations were sound.

Panel Opinion after considering AHS response:
• The facts are in dispute: If the CMO was only taking a history from Ms Z and did not intend to proceed with general anaesthesia then the nurses should not have interfered. If the nurses believed that the CMO might proceed with the general anaesthetic then they were justified in interfering.
• Failure to do a pre-operative assessment does not comply with ACHS standards.
• The CRP did not have all the details of the MHS response to this incident or the HCCC findings, thus they declined to comment on the issue of 'Management response to adverse event'.

Commission Views and Comments	Incident No 1

The Commision makes the following conclusions and comments:

The Commission concludes that the care provided to Ms Z was unsafe and inadequate for the following reasons:

1. The incident demonstrates a failure to recognise and document the anaesthetic risk and ensure that appropriate safeguards were implemented in response. The malignant hyperthermia risk should have been clearly identified and explained to Ms Z, her mother and the anaesthetic department.
a. Under the circumstances, Ms Z's mother's concerns and those of the experienced nursing staff should have been listened to.
b. The case demonstrates inappropriate pre-operative assessment and communication between the surgeon, anaesthetist and other staff.
c. The clinical situation warranted a specialist anaesthetist to be directly involved with the patient's care.
d. The mother of the young patient expressed her distress at the anaesthetic CMO's communication in a letter of complaint to MHS. The communication was described as inappropriate.

2. The Commission concludes that there were a number of systemic and other issues raised by this incident as follows:
a. Apparently there was no established mechanism for senior nurses to express concerns to management about medical clinicians.
b. Apparently there was no mechanism for senior nurses to express urgent concerns about patient safety in relation to a proposed treatment.
c. The incident demonstrates a lack of adequate supervision of less experienced staff. The Commission notes appropriate actions were taken in 2002 when Dr D1 was started on a program of training, education and supervision and counselled in regard to communication skills.
d. There should have been an existing protocol/guideline for patients with a family history of malignant hyperthermia, including how to prepare the anaesthetic machines.
e. There should be a system of 6 monthly performance review to pick up on-going performance concerns in relation to less experienced staff.
f. The Dispute between medical staff and nursing staff in front of the patient and her mother was not well managed. Disagreements are an inevitable part of a multidisciplinary team however appropriate means to resolve these are required.

3. The Commission accepts that the concerns of the family and nurses were not adequately acknowledged by the whole clinical team. Had it been, the nurses assessmentof risk mayhave been alleviated.

4. The nurses acted correctly in standing by their own clinical decision not to allow the anaesthetic to proceed without all the safeguards in place because of the potential life threatening consequences.

Outcomes	Incident No 1
The Issue	**Quality and Safety Concerns**
Communication with patients and families	Substantiated
Management response to adverse events, including incident reporting	Substantiated

Investigation into Macarthur Health Service Incident Review

Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated
Coordination and continuity of care	Substantiated
Relationships and communication within and across clinical teams	Substantiated
Availability of and supervision by senior medical staff	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 2

Date of Incident Qtr 4, 2001

Summary of Incident **Incident No 2**

Mrs I was an 83 year old woman who was admitted to Camden Hospital in late 2001 following a fall. She was in hospital awaiting a bed in a nursing home. Eleven days after her admission a registered nurse recorded in the patient notes that Mrs I's right foot was purple. She added, "Resident Medical Officer to review patient".

The Resident Medical Officer (RMO) reviewed Mrs I one hour later but made no reference to her right foot. A further review by the RMO one hour later still made no reference to Mrs I's foot.

The following day (Day 12) a CMO, Dr D5 recorded a diagnosis of 'Ischaemic right foot' along with a note that the VMO surgeon on-call, Dr D3 "will see patient this week a.s.a.p." Camden Hospital operates as an acute hospital without emergency surgical services being available within the hospital.

The next day (Day 13) another doctor reviewed Mrs I, confirmed the diagnosis of 'Ischaemic right foot' and contacted the admitting VMO physician, Dr D4 (a gastroenterologist) who agreed that Mrs I should be transferred to Campbelltown Hospital for review by a surgeon. Later on Day 13 Mrs I's family arranged a private surgical consultation at 1800 hours by a consultant surgeon, Dr D2 who arranged for Mrs I's immediate transfer to St Vincent's Hospital.

Registered Nurse N1 submitted a 'Problem Report' and an e-mail to the MHS Director of Health Services reporting that she had encountered resistance from the doctors on Day 13 about the need for an urgent transfer for surgical review. In particular N1 identified that the systems in MHS provided no channel of communication for nurses to report urgent clinical concerns about medical management that is adversely affecting patient safety.

The case was reviewed 4 months later by the MHS Acute Services Critical Care Review Committee (ASCCRC), which made 3 recommendations:
1. Request explanations from medical team regarding lack of action on findings
2. Vascular surgeon informed of importance of attending consults requested within a short period of time.
3. Develop guidelines for nursing staff to put into action to prevent recurrence of constant delays in treatment.

The MHS did not provide evidence which showed the recommendations of the ASCCRC had been implemented.

Allegations by Informants	Location 1	Location 2
No independent avenue for nurses to report concerns	Camden - Other	
Inadequate standard of clinical skills in RMOs and locums	Camden - Med Ward	
VMO delay in reviewing the patient	Camden - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
Relationships and communication within and across clinical teams	Camden - Med Ward	
Quality of clinical care provided by visiting medical officers	Camden - Med Ward	
Quality of clinical care provided by nursing staff	Camden - Med Ward	
Coordination and continuity of care	Camden - Med Ward	
Management response to adverse events, including incident reporting	Camden - Med Ward	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Camden - Med Ward	
Patient transfer to higher level units or hospitals	Camden - Med Ward	
Availability of and supervision by senior medical staff	Camden - Med Ward	

Clinical Review Panel Opinions **Incident No 2**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

- The Clinical assessment of Mrs I on Day 11 was done without awareness that the nurses had requested a review for a specific reason ie. Mrs I's foot had turned purple. Mrs I's drowsiness was reviewed but there was no apparent review of Mrs I's notes.
- Nursing staff did not communicate with the RMO after his/her 2 reviews to follow up the requested review of Mrs I's foot.
- Doctor's response quoted in the notes, "this week asap" is internally contradictory and is inadequate.
- There was a medication error. Mrs I was ordered Clexane (anticoagulant) twice a day but it was only administered once a day. Also there is no record of Mrs I's weight which is required to calculate the dose.
- There is no record of any physical examination until Day 6 after the admission. This is inadequate.
- With her history of tranisent ischaemic attacks (TIA) Mrs I should have been given prophylactic anticoagulant medication.
- Mrs I was admitted under a general physician who appears not to have had any input into her care. There was no medical management plan documented in the patient's notes.
- The nursing staff should have implemented an 'Extremities Observation Chart' on their own initiative.

In relation to management/systems issues the Clinical Review Panel made the following comments:

Investigation into Macarthur Health Service Incident Review

• There should be a system to ensure that the medical team performs a complete admission (medical examination) on each patient within 24 hours.
• Nurses need a means to report patient safety concerns when informal channels have not worked.

Panel Opinion after considering SWSAHS response:
• 'Surgical emergency' should be changed to 'Urgent surgical problem' (to be reviewed promptly, 6 - 12 hours max).
• The s.43 response stating that Mrs I was a social admission is completely irrelevant. She was in a hospital and deserved an appropriate standard of care.
• Mrs I needed a timely transfer to a more acute facility.
• The Acute Services Review Committee failed to address the important issue in this incident

Commission Views and Comments	**Incident No**	**2**

The Commision makes the following conclusions and comments:

The Commission found that the care provided to Mrs I was unsafe and inadequate for the following reasons:

1. There were serious breaches of the minimum standard of care in relation to assessment, investigation, treatment and care.
a. The care team's communication was ineffective over 57 hours from the time the ischaemic foot was first recorded in the patient notes.
b. The clinical review of Mrs I on Day 11 should have included the examination of her foot and the findings of assessment and a management plan noted in her medical record.
c. Nursing staff should have contacted a medical clinician to request an urgent examination when the RMO appeared not to have examined Mrs I's foot.
d. Nursing staff failed to make a record of the concerns expressed by Mrs I's family concerning her foot on Day 11.
e. On Day 12 a diagnosis of "ischaemic right foot" which is an urgent surgical problem was made but an urgent plan of action for Mrs I was not developed.
f. Surgical review "this week a.s.a.p" was inadequate in the circumstances. The quality of the information given by phone to the surgeon is unknown.
g. With her history of TIA's and immobility Mrs I should have been given prophylactic anticoagulant medication.
h. Medical staff should have been more alert to the possibility of arterial embolus in view of Mrs I's atrial fibrillation.
i. There is no record of any formal admission or medical examination until Day 6 of Mrs I's hospital stay. This is unacceptable.
j. There was poor clinical leadership demonstrated in Mrs I's care and treatment by senior medical clinicians, both by the admitting physician and the surgeon on call in responding to this urgent surgical problem.
k. There was no medical management plan documented in Mrs I's notes. There should have been a documented plan for the management of Mrs I's ischaemic foot as soon as it was discovered.
l. The nursing staff should have implemented an 'Extremities Observation Chart' earlier than Day 13 and they should have recorded observations every hour instead of once only at 1330 hours.

2. The scope of the recommendations by the Acute Services Critical Care Review Committee was inadequate given the critical systems failures.

3. The factors contributing to the poor care warranted immediate review and corrective action. An opportunity to improve safety was lost by the failure of the incident review system to follow up the actions recommended by the ASCCRC.

4. The submission to the Health Care Complaints Commission by MHS and the SWSAHS was inappropriate in that it suggested that the level of care provided to Mrs I was adequate because she was a social admission and was only in Camden Hospital awaiting a nursing home bed. The submission displays a defensive attitude and an inability to use the review of an adverse event to modify safety systems within the hospital.

Outcomes	**Incident No**	**2**
The Issue		**Quality and Safety Concerns**
Relationships and communication within and across clinical teams		Substantiated
Quality of clinical care provided by visiting medical officers		Substantiated
Quality of clinical care provided by nursing staff		Substantiated
Coordination and continuity of care		Substantiated
Management response to adverse events, including incident reporting		Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars		Substantiated
Patient transfer to higher level units or hospitals		Substantiated
Availability of and supervision by senior medical staff		Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 3

Date of Incident Qtr 4, 2002

Summary of Incident **Incident No 3**

In late 2002, Mrs T, a 78-year-old woman, was admitted to Campbelltown Hospital for a mastectomy of her left breast. She had dementia and lived in a nursing home.

The consent on the Admission Request form states: "Right total mastectomy" and is signed. The surgeon was Dr D2.

Mrs T's 'Patient Transfer' form did not arrive at Campbelltown Hospital with her but was faxed from the nursing home 2 hours before her admission to the ward. The Form has a clear written entry, "Booked for surgery x date Left Mastectomy". The following day Mrs T was transferred to the operating theatre without a nurse escort or a family member.

Mrs T had her right breast removed and it was not until she was visited by her daughter that the mistake was noticed that she had had the wrong breast removed. Mrs T was taken back to the OT immediately for a left mastectomy.

The MHS identified this incident as a sentinel event and implemented a Root Cause Analysis (RCA) investigation four days following the incident.
The assistant nurse manager of Quality Assurance submitted a problem report with briefing notes to the Critical Care Review Committee.
The MHS stated in July 2003 that the RCA action plan was being implemented with regular review of process.

Allegations by Informants	Location 1	Location 2
Management did not respond to nurse concerns	Campbelltown - OT	
No escort nurse to the OT for a patient with dementia	Campbelltown - OT	

Issues Identified by HCCC	Location 1	Location 2
Communication with patients and families	Campbelltown - Other	
Documentation of treatment and care in health care records	Campbelltown - Other	
Quality of clinical care provided by visiting medical officers	Campbelltown - OT	
Quality of clinical care provided by nursing staff	Campbelltown - OT	
Patient transfer to higher level units or hospitals	Campbelltown - OT	

Clinical Review Panel Opinions **Incident No 3**

An independent Clinical Review Panel reviewed the information obtained and made the following comments:
- Responsibility for the wrong side surgery ultimately rests with the operating surgeon.
- The pre-op assessment was inadequate.
- 'R' and 'L' abbreviations should not be used on consent forms.
- Someone should have acted to obtain the missing documents when Mrs T arrived from the nursing home without all the relevant documents.
- After the wrong side surgery was detected, it was inappropriate to immediately operate on the correct side. Mrs T should have been allowed to recover from the first surgery.
- 6 units of blood is a lot of blood for the procedures.
- The surgeon should have immediately recognised the danger of wrong side surgery (patient unable to give her own consent) and taken greater precautions.

In relation to management/system issues the Clinical Review Panel made the following comments:
- The system for pre-op assessments is inadequate
- The system should not have allowed an incomplete 'Request for Admission' to have been accepted.
- The Root Cause Analysis was flawed because it focussed too heavily on the lack of a nurse escort. A nurse escort would not have prevented the mistake.

Panel Opinion after considering SWSAHS response:
- The CRP was very critical of the decision to perform the left mastectomy immediately after the mistaken right mastectomy. The fact that Mrs T needed follow up surgery to address a haematoma on the right side was even more reason not to start new surgery on the left side.
- It would have been prudent for he surgeon to have handed over to a different surgeon when he became aware of the wrong site surgery.
- It should be universal policy that a patient who lacks capacity is accompanied from the ward to the OT either by a family member or a nurse.
- The OT documentation is inadequate. There is no OT documentation of the right mastectomy in the patient records.
- This incident should have generated an incident form.
- There is no medical admission in the notes.

Commission Views and Comments **Incident No 3**

The Commision makes the following conclusions and comments:

1. The Commission concludes that the care provided to Mrs T was unsafe and inadequate for the following reasons:
a. The admission system should not have allowed an incomplete 'Request for Admission' to have been accepted.
b. The pre-op assessment in this incident was inadequate.
c. The 'Patient Transfer' form was received at Campbelltown Hospital 2 hours before Mrs T was admitted to the ward and the patient file accompanied Mrs T from the ward to the operating theatre.

Investigation into Macarthur Health Service Incident Review

d. Mrs T should have had a nurse or family escort from the ward to the OT to ensure adequate identification and confirmation procedures. This is a requirement of MHS policy for people with significant congnitive impairment.
e. Abbreviations on consent forms such as "R" and "L" can be easily misread.
f. An incompetent patient requires greater cognisance by the whole treating team of recognised risks.
g. The decision to operate further without a recovery period was inappropriate particularly as Mrs T developed a post op haematoma on the right side.
h. A different surgeon should have assessed Mrs Tafter the wrong side surgery was discovered to ensure calm, objective decision making.

2. There is no OT documentation relating to the mistaken right mastectomy in the medical records. There is no incident form relating to the incident.

The Commission also concludes that timely implementation of a root cause analysis investigation by MHS management was appropriate.

Outcomes	**Incident No 3**
The Issue	**Quality and Safety Concerns**
Communication with patients and families	Substantiated
Documentation of treatment and care in health care records	Substantiated
Quality of clinical care provided by visiting medical officers	Substantiated
Quality of clinical care provided by nursing staff	Partially substantiated
Patient transfer to higher level units or hospitals	Partially substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 4

Date of Incident Qtr 4, 2001

Summary of Incident **Incident No 4**

Mr E was a 75 year old man who presented to Campbelltown Hospital ED in late 2001 with a swollen right knee and difficulty weight bearing. He had a recent history of multiple revisions of a total knee replacement.

Dr D20 a locum doctor diagnosed Mr E as having a septic right knee following knee surgery and commenced IV antibiotics. Mr E was admitted without Dr D8, the VMO orthopaedic surgeon on call being notified. It appears that Dr D8 was operating at Liverpool Hospital at the time. The VMO roster for Campbelltown Hospital on x date confirms that Dr D8 was the orthopaedic VMO on call for Campbelltown and Camden Hospitals. A copy of the 'Ortho Call Roster' for Liverpool Hospital on x date (obtained from MHS) has another doctor's name crossed out and the name of Dr D8 added to indicate that Dr D8 was also on-call for Liverpool Hospital that day.

On Day 2 the orthopaedic registrar found no sign of acute sepsis in Mr E's right knee and ceased the IVI anitibiotics.

A senior nurse submitted a problem report to MHS management on the day of the incident recommending that policy and procedures be put in place to prevent admission without notification and authorisation of an appropriate VMO or registrar.

SWSAHS Orthopaedic Network had met in mid 2001 to try to develop a plan for a single on-call emergency roster for orthopeadic surgeons as soon as possible. The roster was not in operation at the time Mr E was admitted.

The senior nurse who had submitted the problem report also submitted an e-mail 2 weeks after the incident to senior managers of MHS expressing her concerns about:
. The unavailability of orthopaedic VMOs who were rostered to cover Campelltown Hospital
. The lack of orthopaedic registrars
. The trend towards transferring orthopaedic patients to Liverpool Hospital for their surgery
. The lack of on-call hospital transport
. The lack of policies and procedures to guide decisions about patients needing orthopaedic services

Two months after the e-mail the SWSAHS had a proposal for Emergency Orthopaedic Networking for Liverpool, Fairfield, and Campbelltown Hospitals.

Allegations by Informants	Location 1	Location 2
Inadequate arrangements to transfer patients	Campbelltown - ED	
Patient admitted without contacting the VMO	Campbelltown - ED	
Patient misdiagnosed	Campbelltown - ED	
Inadequate orthopeadic VMO coverage	Campbelltown - ED	
Three problem reports submitted in relation to lack of orthopaedic cover		

Issues Identified by HCCC	Location 1	Location 2
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ED	
Management response to adverse events, including incident reporting	Campbelltown - ED	
Availability of and supervision by senior medical staff	Campbelltown - ED	

Clinical Review Panel Opinions **Incident No 4**

An independent Clinical Review Panel reviewed the information obtained and made the following comments:
• The Hospital admitted the patient but no-one took 'ownership' of the case. All patients should be admitted under a staff specialist or VMO. No orthopaedic VMO existed to take responsibility. No VMO or registrar could even be consulted by telephone. This was the first thing that went wrong.
• Suspected sepsis in the knee is a surgical emergency. It was a reasonable working diagnosis and antibiotics were begun appropriately.
• The first steps in ED were reasonable, but there were no 'next steps'. The necessary consultation tiers did not exist.
• The orthopaedic VMO was operating at Liverpool Hospital. Major trauma hospitals use their VMOs continually. They should not be on call to other Hospitals.
• Management response. The emergency orthopaedic network offered one registrar over weekends. This is inadequate.

Commission Views and Comments **Incident No 4**

The Commision makes the following conclusions and comments:

1. The Commission concludes that the care provided to Mr E was unsafe and inadequate for the following reasons:

a. No one took ownership of Mr E's care and treatment until the orthopaedic registrar examined him the day after admission
b. The patient required prompt orthopaedic review.
c. There was no orthopaedic VMO or registrar available at Campbelltown Hospital. No VMO or registrar could even be consulted by telephone.
d. The orthopaedic VMO was operating at Liverpool Hospital. Major trauma hospitals use their VMO's continually. They should not be on call to other Hospitals.
e. Mr E was wrongly admitted to Campbelltown Hospital under an orthopaedic surgeon who was not contactable and was unaware of the admission.
f. There should have been a protocol in place for situations where there was no orthopaedic VMO under whom to admit a patient. The patient should have been admitted under a VMO physician or surgeon or transferred.

Investigation into Macarthur Health Service Incident Review

2. MHS Emergency Departments require timely access to necessary consultation tiers and in their absence arrange transfer to a facility where they are available.

3. MHS should have provided feedback to N1 in relation to 3 problem reports she submitted.

4. In relation to remedial action taken by MHS to provide orthopaedic cover.
a. Seniority of the registrar is an important factor in assessing the safety impact of the new registrar coverage.
b. On-call arrangements where the VMO potentially covers Liverpool and MHS may not be satisfactory given the high demands placed on an on-call VMO by a tertiary facility.
c. It is of concern that MHS has rejected the suggestion of a need for a 24 hour orthopaedic registrar on-site or a centralised orthopaedic on call service.

Outcomes	**Incident No 4**
The Issue	**Quality and Safety Concerns**
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated
Management response to adverse events, including incident reporting	Partially substantiated
Availability of and supervision by senior medical staff	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 5

Date of Incident Qtr 2, 2001

Summary of Incident **Incident No 5**

In mid 2001, a ten day old baby was taken to Campbelltown Hospital emergency department by his family. He had been suffering with a cough, runny nose and vomiting. The family presented at 1907 hours but were not seen until 2049 hours, 102 minutes later. It is understood that the family approached the desk on three occasions requesting attention. By the time the baby was seen by the triage nurse, he was tachypnoeic, inactive and had blue lips. His oxygen saturation levels were 91%, heart rate was 145 bpm and respiratory rate was 60 bpm. Despite these vital signs he was triaged at category 2, to be seen within ten minutes. Ten minutes later the baby was transferred to the observation ward from where he was taken almost immediately to the resuscitation room.

The paediatric registrar attended and diagnosed severe bronchiolitis with carbon dioxide retention. Oxygen was administered and saturation levels increased to 97%. At 2130 hours, a chest x-ray revealed over inflation of the lungs and some left peri hilar atelectasis was suspected.

At some point the registrar telephoned the paediatric VMO Dr D40 (time not recorded). An IV cannula was inserted and 30 mls of bolus normal saline was administered. Following discussion with the VMO, the registrar outlined a care plan including administration of intravenous ampicillin and gentamicin, repeat arterial blood gases, transfer by newborn emergency transfer service (NETS) for continuous positive airways pressure, nil by mouth and N/2 saline 170 ml/kg, at 15 mls/hour. Capillary gases were pH 7.364 p02 57.9; pCOs 54.7, BE 4.7 and HCO3 31.1.

MHS later advised the Commission that the VMO did not attend the hospital because it was felt that ventilation was not absolutely indicated and the registrar had instituted appropriate management.

At 2155 hours the baby had a respiratory rate of 104/min with tracheal tug.

At 2200 hours the baby was transferred to the special care nursery. On arrival he was described as pink, tachypnoeic with intercostal recession, active and crying. Head box oxygen insitu Fi02 70%, respiratory rate 68, temperature 36.5 and oxygen saturations 100%. BSL was 4.3 mmmol/L.

At 2344 hours the registrar contacted NETS and it was agreed to transfer the baby to an ICU bed in a childrens hospital.

At 0038 NETS arrived and assessed the baby. He was pink and warm in an incubator with head box oxygen 78%. His saturation was 98-100% with increased respiratory rate and chest recession. Reduction in ambient oxygen increased his respiratory effort and it was noted that handling caused increased distress. Consequently, a decision was made to intubate and ventilate before transporting him to a childrens hospital. At 0402 hours, 9 hours after initial presentation at the emergency department, the baby was stabilised and transferred to the ICU at a childrens hospital.

The baby remained intubated in the intensive care unit of a childrens hospital for 2 days. He was then extubated and transferred to the ward.

On the day of the incident, the paediatric registrar completed a problem form reporting the delay in triage. Clinical staff acted quickly. Within five days the MHS internal reviewers had advised the clerk to immediately inform triage of any neonate presentations to ED and recommended the development of a policy for neonates. Six days after the incident, a meeting was held to develop strategies to ensure appropriate triaging of paediatric patients. Key parties were involved including the MHS paediatrician and the Director of Emergency Medicine.

Ten days after the incident the Director of Emergency Medicine confirmed the following changes were underway:
1. Neonates to be triaged within15 minutes of presentation.
2. Upon initial clerk registration, any neonates to be brought to the attention of triage nurse immediately.
3. Reorganisation and simplification of paediatric resuscitation protocols and procedures.
4. The ED paediatrician provided inservices to CMOs and RMOs.
5. Inservices for nursing staff were planned on identifying potentially ill infants.

Despite the initial changes, a formal policy on triage of neonates was not authorised for 15 months. In September 2002, MHS triage procedures were authorised in the form of work instructions stating 'Patients are seen by triage nurse first and then directed to clerk for registration. Family members will be encouraged to give information at the registration desk whilst the patient is waiting for triage.' The work instruction states that infants 1 to 8 weeks are to be triaged in less than ten minutes and are not to be given a triage category of 3 or higher. Children 8 weeks to 10 years are not to be given a triage category of 4 or higher.

During the 15 month period between the incident and the issuing of the MHS triage procedures, a number of staff remained unclear as to the triage policy on neonates, babies and children. Patients also continued to be seen by the clerk before triage.

The Commission has copies of emails dated July and August 2002 from senior staff at Campbelltown and Camden Hospitals which state 'we don't have formal policies re triaging paediatricsÖ informal policies are to triage children higher than adults and never less than level 4.' The emails also confirm that, as late as August 2002, patients at Camden emergency department continued to be seen by the clerk before triaging.

MHS did not initiate any fact finding to ascertain the cause of the delay in triaging this critically ill neonate or the reason the baby was triaged at category 2 rather than 1 when he was tachypnoeic, cyanotic and inactive. In its response to the Commission, MHS considered the triaging of this baby at category 2 appropriate. MHS added that the baby was however treated immediately ie as a category 1.

In July 2003, MHS advised the Commission of the introduction of strategies in addition to the triage procedures.
These included:
1. The appointment of a staff specialist paediatrician to work in the emergency department.

Investigation into Macarthur Health Service Incident Review

2. The introduction of a clinical initiative nurse program (CIP) in July 2002 to improve management in the ED. With a certificate of paediatrics Nurses are rostered to cover morning and evening shifts, seven days a week.
3. Since October 2002, 48 nurses from Campbelltown ED have attended training in triage.
4. The start of the enhanced emergency service satisfaction project in late 2002 aimed at reducing the waiting times for children in ED .
5. The opening in December 2002 of a dedicated area for paediatric patients in Campbelltown ED.
6. Data collection on paediatric patients who 'did not wait' indicating a 50 % reduction between August 2002 and February 2003.

In October 2003, the Department of Paediatrics at MHS advised us that since this incident a number of quality initiatives have been introduced. Based on information obtained from audits over the last five years, the following changes have been instituted:
1. Notes of every child seen in ED are kept for independent audit by a senior staff member the next working day.
2. Extended hours consultant (staff specialist) evening cover from early 2002 ensuring staff specialist or senior registrar coverage until 9 or 10 pm, 3-4 evenings per week.
3. 24 hour paediatric registrar cover from early 2003.
4. Joint audit meeting with NETS, held on an occasional basis to discuss possible problem cases.

Dept of Paeds offered the Commission access to their files recording all transfers and deaths.

Allegations by Informants	Location 1	Location 2
Policy existed but not followed in this case	Campbelltown - ED	
Hospital response to incident inadequate		
Unacceptable delay to triage	Campbelltown - ED	

Issues Identified by HCCC	Location 1	Location 2
Availability of and supervision by senior medical staff	Campbelltown - ED	
Patient transfer to higher level units or hospitals	Campbelltown - ED	
Recognition and response to critically ill patients	Campbelltown - ED	
Management response to adverse events, including incident reporting	Campbelltown - ED	
Quality of clinical care provided by nursing staff	Campbelltown - ED	

Clinical Review Panel Opinions **Incident No 5**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- The clerk saw the patient first for registering - this practice is unacceptable. The patient seems to have been forgotten.
- Triage policies were not being followed.
- The triage Category 2 did not reflect how sick the baby was.
- Patient should have gone directly to high density unit or been transferred.
- Post-triage there was a delay in starting procedures such as intubation and taking bloods.
- NETS should have been called earlier.
- This case, together with some of the other cases, reveals that there was an endemic problem in ED of recognising a seriously ill patient.
- There was a lack of consultant involvement.
- The Hospital response to the incident was inadequate. Neonates need to be viewed first, if safe then complete triage within 15 mins.

The recommendation where the clerk is to alert the triage nurse of babies attending immediately is obsolete if signage and other prompts ensure people present to triage when entering ED.

The Commission's Medical Adviser (VMO) reviewed the MHS response. The Medical Adviser is a former VMO and paediatrician.
The Medical Adviser accepted the information provided by MHS and NETS stating that intubation was not required until the baby showed deterioration after the arrival of NETS, and that the decision to intubate was to ensure safety of transport to another facility, as both reduction or ambient oxygen in the head box and handling caused deterioration of the baby's condition. On the basis of this information the Commission withdraws its criticism that intubation was delayed and should have been done earlier.
Re transfer by NETS. Information indicates that NETS was contacted at 2344 and that they arrived within the hour. The baby was not transferred until 3 □ hours after NETS' arrival, however during this period intubation and stabilisation was being carried out.
The Medical Adviser remained critical of the VMO's failure to attend, stating that the serious condition of this neonate demanded the attention of an experienced paediatrician.

Commission Views and Comments **Incident No 5**

The Commision makes the following conclusions and comments:

The Commission acknowledges the changes outlined by MHS and the Department of Paediatrics, but found that the care provided to the newborn baby was unsafe and inadequate for the following reasons:

1. In relation to his care in the emergency department:
- The family remained in ED unattended for 102 minutes during which time the baby became critically ill.
- The triage nurse assessed the baby at category 2 instead of category 1.

2. In relation to the care provided by the VMO:
. The serious condition of the baby required the assessment of an experienced paediatrician, irrespective of whether immediate intubation was assessed as necessary.

3. The action taken by MHS in response to this adverse incident was inadequate because:
- MHS failed to conduct any form of fact finding to ascertain why a neonate was not triaged until 102 minutes after presentation.
- MHS failed to investigate the circumstances occurring before triage or confirm that the family had made repeated requests for assistance.
- Clinical staff acted quickly to devise triage guidelines for neonates, babies and children, however these were not formally introduced into

Investigation into Macarthur Health Service Incident Review

MHS policy until 15 months after the event. Staff remained unclear on the procedures for managing paediatric presentations.
• MHS did not alter the process whereby all patients are seen by clerical staff before triaging until 15 months after the incident in apparent disregard of the issue being drawn to management's attention

In this case the management response in 2001-02 was inadequate. It failed to put in place measures to prevent further incidents of inadequate care. The changes promulgated by management after notification of the complaint to the Commission are far more likely to reduce the risk of further incidents. Of particular note is the collection of data which is capable of evaluating whether or not policy changes have been implemented and whether the policy is meeting the stated objectives. The Commission approves of such an approach.

Outcomes	**Incident No 5**
The Issue	**Quality and Safety Concerns**
Availability of and supervision by senior medical staff	Substantiated
Patient transfer to higher level units or hospitals	Not substantiated
Recognition and response to critically ill patients	Not substantiated
Management response to adverse events, including incident reporting	Substantiated
Quality of clinical care provided by nursing staff	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 6

Date of Incident No Date Identiied

Summary of Incident **Incident No 6**

The following information was provided by informant.

A surgeon reportedly performed bowel surgery and black tissue was sighted. A resection was not performed, the surgeon deciding to refer the patient to ICU for close observations with the option of a resection the next day.
No date was provided by the informant.

The issue was said to have been referred to management without resultant action.

On 23/5/03 the Commission requested the informant provide any further information to assist the identification of the patient. No further information was made available.

On 12/6/03 SWSAHS advised that identity of the patient could not be established.

Clinical Review Panel Opinions **Incident No 6**

Commission Views and Comments **Incident No 6**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No 7

Date of Incident Qtr 1, 2001

Summary of Incident **Incident No 7**

Mrs D was a 45 year old woman who was admitted to Campbelltown Hospital in early 2001 for an endoscopic retrograde pancreatic cholangiogram procedure under general anaesthetic. Mrs D had been anaesthetised and intubated on the operating table when she rolled off the table and fell onto the floor.

Mrs D was given CT scans, x-rays and examination. No serious injuries were detected. Mrs D's husband was notified about the incident. Mrs D returned to surgery for the ERCP procedure 2 days later.

The Gastroenterologist and the acting Nurse Unit Manager both spoke to Mrs D's husband following the incident. The acting Nurse Unit Manager offered both Mr and Mrs D counselling.

The acting NUM sent an e-mail report about the incident to the DON/Acute Services Continuum on the day of the incident. The DON instructed the NUM to draft a critical incident report to the SWAHS for signature by Medical Director. The General Manager sent an incident report to the Deputy CEO of SWSAHS. Deputy CEO, SWSAHS obtained an expert report from Area Director Medical and Clinical Services 2 months later.

Management recommended that the expert advice was to be passed on to the relevant clinical peer review group to ensure that appropriate procedures, including anaesthetics, are put in place for ERCP to be practiced at Campbelltown Hospital.

The MHS Incident Report concludes, "There will also be a review of the need for these difficult positions to continue, regardless of whether or not extra supports are used". The report does not specify a timeline for this review nor does it allocate responsibility for the review.

MHS advised the Commission that 'Operating Suite Work Instruction 3.15' dated March 2002 is "... in place and working effectively". Item 8. All positions that are not considered directly prone or supine shall have stabilising devices placed on the operating table. For example: A bean bag, velcro straps, and/or lateral supports.

Allegations by Informants	Location 1	Location 2
The doctors did not contact the relatives	Campbelltown - OT	
No process to investigate the incident	Campbelltown - OT	
Nurses felt intimidated to report on the incident		
Doctors took control of the incident reporting		

Issues Identified by HCCC	Location 1	Location 2
Quality of clinical care provided by nursing staff	Campbelltown - OT	
Communication with patients and families	Campbelltown - OT	
Management response to adverse events, including incident reporting	Campbelltown - OT	
Relationships and communication within and across clinical teams	Campbelltown - OT	
Quality of clinical care provided by visiting medical officers	Campbelltown - OT	

Clinical Review Panel Opinions **Incident No 7**

An independent Clinical Review Panel (Operating Theatre incidents) reviewed the documents obtained and made the following comments:

- The panel noted that the patient was not positioned on the table with any tapes, restraints or supports and was left unsupervised. This was regarded as inappropriate and not in accordance with widely accepted Association College of Operating Room Nurses (ACORN) standards.
- It was noted that the patient was having an endoscopy procedure in an operating theatre under general anaesthetic and that such procedures are usually undertaken in x-ray departments under sedation. The panel stated that OT was not the appropriate place to do this procedure as it is not adequately set up and felt this to be an unusual practice. It was also suggested that general anaesthetic in the circumstances was not justified.
- It was also noted that the endoscopist had stated that he didn't want restraints used.
- The Panel noted that there did not seem to be a sense of anyone having overall responsibility for patient safety. There was a view that once the patient is anaesthitised it is the anaesthetists responsibility. Another view was that as the endoscopist had requested no restraints the responsibility fell to him. In any event the lack of clarity resulted in no one being there to assure that the fall did not occur.
- The panel expressed concern at the failure of any doctors or nurses to put in a report about the incident, and equally expressed concerns in relation to doctor/nurse communication that there did not appear to be any follow up or discussion to clarify roles and responsibilities in the circumstances.
- The management response to the incident was felt to be adequate and it was noted that the patient and family were spoken to regarding the incident. It was regarded as positive that the nurses vocalised their concerns.

Commission Views and Comments **Incident No 7**

The Commision makes the following conclusions and comments:

1. The Commission concludes that the care provided to Mrs D was unsafe and inadequate for the following reasons:
a. The patient was positioned on the operating table without any restraints or supports and was then left unsupervised. This was inappropriate and not in accordance with relevant standards.
b. The team failed in their collective responsibility to ensure the patient did not fall.
c. The MHS should have had a procedure in place prior to March 2002 which required patients in unstable positions to have stabilizing devices in place.

Investigation into Macarthur Health Service Incident Review

2. All staff present at the incident should have been interviewed as to why the patient fell off the table.

3. The MHS did not take adequate action to adress the safety issues raised by this incident until the investigation by the Commission. The Commission notes with approval that since this investigation commenced the MHS has implemented new peri operative procedures for supporting patients on the operating table. These procedures should ensure that the same incident could not happen again.

Outcomes	**Incident No 7**
The Issue	**Quality and Safety Concerns**
Quality of clinical care provided by nursing staff	Substantiated
Communication with patients and families	Not substantiated
Management response to adverse events, including incident reporting	Partially substantiated
Relationships and communication within and across clinical teams	Substantiated
Quality of clinical care provided by visiting medical officers	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 8

Date of Incident No Date Identiied

Summary of Incident **Incident No 8**

The following information was provided by informant.

A 54 year old woman presented to the ED 3 weeks after an aortic valve replacement. Some hours after a nurse went to the ED to check on the patient's condition. She was tachycardic, dyspnoeic, had oxygen on and was hypoxic. She had no blood pressure. The nurse said to the doctor that the patient was shocked. The doctor said, "No, she's all right".

The nurse contacted the VMO who ordered that the patient be transferred immediately. The ICU doctor came and ordered IV Haemacel. The patient died the next day from acute renal failure.

MHS informed the Commission they were unable to identify the patient. On 23/5/03 the Commission requested the informant provide further information to assist identification of the patient.

On 12/6/03 SWSAHS advised that the identity of patient could not be established.

Allegations by Informants	Location 1	Location 2
No action taken as a result of the adverse event		
Delay in transfer to another hospital		
Delay in detecting patient's critical condition		
Inadequate Initial Assessment		

Clinical Review Panel Opinions **Incident No 8**

Commission Views and Comments **Incident No 8**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No 9

Date of Incident No Date Identiied

Summary of Incident **Incident No 9**

The following information was provided by informant.

An elderly woman was transferred to coronary care with a Clinical Nurse Specialist (CNS) escort. The nurse found that the patient was dead when she arrived and the nurse escort had not realised this.

MHS was unable to identify the patient on the available information. On 23/5/03 the Commission requested the informant provide further information.

On 12/6/03 SWSAHS advised that the identity of patient could not be established.

Clinical Review Panel Opinions **Incident No 9**

Commission Views and Comments **Incident No 9**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No 10

Date of Incident Qtr 4, 2001

Summary of Incident **Incident No 10**

In late 2001 Mr P, a 63 year old man weighing 200kg, was a patient in Camden Hospital for treatment of cellulitis in both lower legs. Three days after admission Mr P was being bed washed when he suffered a cardiac arrest at 1350 hours. A MET was called and CPR was commenced. The MET team resuscitated Mr P but did not intubate him. He was transferred to the ED at 1435 hours.

Mr P was difficult to intubate and Camden Hospital did not have an anaesthetist on call. A senior nurse contacted Campbelltown Hospital but the anaesthetist refused to provide cover for Camden Hospital. MHS advised the Commission that the anaesthetist at Campbelltown Hospital was not rostered or expected to cover Camden Hospital. Medical retrieval was contacted between 1510 and 1540 hours.

No bicarbonate was given and there was inadequate inotrope support evidenced by his ongoing hypotension and lack of urinary output. For no apparent reason, Mr P's adrenalin infusion was turned off at 1527 hours when his BP was 84/52.

At 1837 hours Mr P still had not been intubated and his third blood gases showed him to be severely acidotic with a PH of 6.9 and a base excess of -18. In the notes it states that Dr D30 was "aware of poor prognosis and understands v. poor quality of life."

The medical notes go on to record, "In view of poor quality of life...no further treatment...Transfer patient to Liverpool".

Careflight arrived at 1850 hours and intubated Mr P. He was transferred to Liverpool Hospital at 1900 hours.

A senior nurse contacted MHS management to express her concerns about the management of medical emergencies at Camden because the most senior experienced people at Camden Hospital were providing unacceptable and unsatisfactory care.

Allegations by Informants	Location 1	Location 2
Dr slow to put in venous access	Camden - ED	
Nurse wanted to transfer patient without oxygen	Camden - Med Ward	
No anaesthetic cover for Camden emergencies	Camden - ED	

Issues Identified by HCCC	Location 1	Location 2
Patient decision making and planning for treatment, and end of life care	Camden - ED	
Recognition and response to critically ill patients	Camden - ED	
Documentation of treatment and care in health care records	Camden - ED	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Camden - ED	Camden - Med Ward
Availability of and supervision by senior medical staff	Camden - ED	Camden - Med Ward
Quality of clinical care provided by nursing staff	Camden - ED	Camden - Med Ward

Clinical Review Panel Opinions **Incident No 10**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- In relation to this incident there appears to be differences in the medical staff's ablity to care for a critically ill patient.
- This whole area was resource deficient. A partial solution could be networking between Hospitals.
- The MET was called but there was no active management.
- There was no anaesthetist on call/available at Camden Hospital.
- There is a lack of documentation about the incident.
- It was noted that the patient was grossly obese, mentally unstable and prone to violence. There was an obvious staff safety issue.
- The overall management of care was unacceptable.

Panel opinion after considering the s.43 submission from SWSAHS:
- The panel notes the response and finds that Mr P should have been intubated.
- The concerns about nursing quality of care relate to recording observations in the charts
- There should be a doctor on duty at all hospitals at all times who has the expertise to intubate patients.

Commission Views and Comments **Incident No 10**

The Commision makes the following conclusions and comments:

The Commission found that the care provided to Mr P was unsafe and inadequate for the following reasons:
1. A patient who has had a cardiac arrest and remains unconscious needs to be intubated as soon as possible. Mr P was in an unstable medical situation and it was inappropriate to transfer him to the ED unintubated.

2. Mr P was poorly managed in terms of acute resuscitation in the ED. The resuscitation was delayed and was far from pro-active. Mr P was not intubated until the retrieval team's attendance in spite of his reduced level of consciousness, his unstable observations and his worsening blood gases. For some inexplicable reason his adrenaline infusion was turned off at 1527 hours and not started again until 1624 hours. This was in spite of pronounced hypotension. No bicarbonate was given for his metabolic acidosis and there was inadequate inotrope support until the arrival of Careflight. There is no documentation about Mr P's urinary output.

3. The staff involved did not appear to be skilled in critical care.

Investigation into Macarthur Health Service Incident Review

4. There was a lack of documentation about the monitoring and the transfer procedure from the medical ward to the ED.

5. The medication charts did not record the amount of adrenaline or fluid received with resuscitation in either the ward or the ED.

6. The incident suggests that the ED team at Camden Hospital were ambivalent about resuscitating Mr P and demonstrates a need for clearer end of life planning and decision making processes. A self contradictory entry in Mr P's medical records clearly demonstrates the ambivalence. It is documented that Mr P should receive no further treatment because of his poor prognosis. The next line records that Mr P is to be transferred to a tertiary hospital.

Outcomes	**Incident No 10**
The Issue	**Quality and Safety Concerns**
Patient decision making and planning for treatment, and end of life care	Substantiated
Recognition and response to critically ill patients	Substantiated
Documentation of treatment and care in health care records	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated
Availability of and supervision by senior medical staff	Substantiated
Quality of clinical care provided by nursing staff	Partially substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 11

Date of Incident Qtr 3, 2002

Summary of Incident **Incident No 11**

In mid 2002 Mrs R was admitted to Campbelltown Hospital with pneumonia. She was 45 years old. During her 4 day admission she had consistently low blood pressure readings (systolic 90-100). On day 3 her blood pressure was taken electronically and was recorded to be 80/48. No MET was called, and the nurse immediately checked the blood pressure using a manual device. The second reading was recorded as 100/60. (MET criteria are for systolic BP below 90). The following day the patient was discharged.

A nurse working on the ward where the incident occurred submitted several unsigned problem forms in mid 2002 reporting failure to call the MET when criteria were met. The problem form was immediately reviewed by the NUM and in September 2002 a report was prepared. The MHS internal reviewer reported that the patient's blood pressure was normally between 90 and 105 systolic and that the patient was asymptomatic. The MHS reviewer concluded that electronic machines can give inaccurate readings, and hence the need to do a repeat manual reading if the original reading is abnormal. The MHS reviewer also stated that the nurse had breached patient privacy by submitting the problem form when s/he had not been on duty at the time of the incident.

In March 2003 the Acute Services Review Committee (ASRC) reviewed the incident. The ASRC recommended that the Nurse Educator conduct mandatory in-services on Code Blue for cardiac arrest.

Allegations by Informants	Location 1	Location 2
Low BP reading required documenting	Campbelltown - Med Ward	
MET should have been called.	Campbelltown - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
Quality of clinical care provided by nursing staff	Campbelltown - Med Ward	
The Medical Emergency Team (MET) at Macarthur Health Service	Campbelltown - Med Ward	
Management response to adverse events, including incident reporting	Campbelltown - Med Ward	

Clinical Review Panel Opinions **Incident No 11**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- Electronic recording devices are not as reliable as mercury BP.
- It was appropriate not to call MET.
- The appropriate trigger for a MET call is the MET criteria in addition to concern about the patient's condition - it is not required to call the MET team when there is no concern about the patient's condition.
- MET protocol in the MHS is poorly understood and implemented.
- Rigid adherence to the MET protocol would mean that MET calls would occur every 5 minutes.
- A MET system needs resources to continue to operate effectively.
- Written and unwritten protocols should be transparent.

The CMO Panelist commented:
- The measurement of BP 80/48 by machine was superseded when checked immediately using a manual method, which is more likely to be accurate. Thus there was no indication for a MET call in this instance.
- The notes recorded on the observation chart are sufficient for any health professional to understand what had occurred; hence further documentation in the patient notes was not necessary.
- The issue of whether there was a breach of privacy by the nurse reporting the incident depends on whether she was involved in the patient's care. If so, then she had legitimate right to read the patient's medical record and subsequently raise her concern when she felt that she was incorrectly managed.

Commission Views and Comments **Incident No 11**

The Commision makes the following conclusions and comments:

1. The Commission conculded that the care provided to the patient was safe and adequate for the following reasons:
a. The low reading was recorded and blood pressure was immediately re-measured using a manual device.
b. There was no need to further document the hypotensive reading because it seems apparent it was not correct.
c. The MET team was not required.

2. The Commission concludes that the action taken by MHS in response to the problem report was lacking because:
a. The only feedback that appears to have been given to the nurse submitting the problem form was criticism for her action in submitting the form.
b. The MHS reviewer stated that patient privacy was breached by the submission of the problem form. This is not technically correct if the nurse was involved in the general care of the patient. Such a criticism is likely to have an unwarranted effect of discouraging health professionals from reporting their concerns and creating an unsafe culture because of this.

3. The matter was not reviewed by the Acute Services Review Committee until 9 months after the incident.

Outcomes **Incident No 11**

The Issue	Quality and Safety Concerns
Quality of clinical care provided by nursing staff	Not substantiated
The Medical Emergency Team (MET) at Macarthur Health Service	Not substantiated
Management response to adverse events, including incident reporting	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 12

Date of Incident Qtr 3, 2002

Summary of Incident **Incident No 12**

In mid 2002, Mrs W was 87 years of age when she was admitted to Campbelltown Hospital with severe knee pain and an inability to mobilise. She had a history of chronic renal failure, polynephritis and ischaemic heart disease. X-rays and bone scans were normal and she was admitted to the Medical Ward. Testing of urine, blood, sputum and chest x-ray did not reveal major abnormalities.

During the 16 day admission Mrs W was regularly seen by the medical registrar and the VMO Dr D45. She continued to complain of knee pain during her stay. Her mobility increased to the point where she was able to mobilise to the bathroom with assistance. The registrar arranged reviews by Rheumatology and by the Rehabilitation Specialist. Mrs W was seen by an Orthopaedic Surgeon and an MRI of the knee was carried out. Mrs W was regularly seen by the Physiotherapist and Occupational Therapist. Her vital signs were charted by nursing 2-3 times per day.

On Day 17 at 0510 hours Mrs W was found on the floor. She had shallow breaths and a pulse was present. A MET was called and the ICU Registrar attended. The patient was intubated and CPR and adrenalin were administered. At 0520 hours CPR was ceased and Mrs W was pronounced dead. Two days later a death certificate was issued listing cause of death from pulmonary embolus.

There is no information to indicate that this matter was reported to management, nor that management conducted a review of the patient's death.

Allegations by Informants	Location 1	Location 2
Patient put back to bed and found dead	Campbelltown - Med Ward	
No acceptable review	Campbelltown - Med Ward	
Patient fell - No MET called	Campbelltown - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
The Medical Emergency Team (MET) at Macarthur Health Service	Campbelltown - Med Ward	
Notifications of deaths to the Coroner and decision making around post mortem	Campbelltown - Med Ward	
Documentation of treatment and care in health care records		
Management response to adverse events, including incident reporting	Campbelltown - Med Ward	
Quality of clinical care provided by nursing staff	Campbelltown - Med Ward	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - Med Ward	

Clinical Review Panel Opinions **Incident No 12**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- Overall general management of Mrs W was acceptable.
- Medical records do not have any record of the fall.
- There was no prophylactic anticoagulant therapy.
- The medical team did not know cause of death. They should have ordered an autopsy.
- There should be a Hospital policy for deep vein thrombosis (DVT) prophylaxis with a checklist for DVT prophylaxis at time of admission.

Panel opinion after considering area health service response:
Re VMO advised that he had considered anticoagulant therapy, but decided it was not required because patient was moblising - There is nothing in the notes to confirm this. The decision should have documented with reasons in the patient notes. This is a documentation issue.
DVT prophylaxis is the only clinical issue of concern.
Re management response - DVT prophylaxis should always be considered. Hospital policy re DVT prophylaxis is required, and this should be the subject of ongoing quality assurance.
Failure to refer to coroner or conduct an autopsy was not a serious issue.

Commission Views and Comments **Incident No 12**

The Commision makes the following conclusions and comments:

1. The Commission concludes that aspects of care provided to this patient were safe and reasonable for the following reasons:
a. Consultations were arranged with relevant specialists and their input was acted on appropriately.
b. A MET call was made and full CPR was carried out for 10 minutes.
c. The fact that the death certificate was not issued for 2 days is not ideal, but is acceptable.
d. With the exception of the failure to document the decision re DVT prophylaxis, the documentation on the file is reasonable.

2. The Commission considers that the following should have been carried out:
a. The decision and rationale that DVT prophylaxis was not required should have been documented in the patient notes.
b. Referral should have been made to the Coroner because the patient was found unexpectedly deceased.

3. The Commission concludes that the MHS response to the incident was inadequate for the following reasons:
a. MHS should have reviewed the case because it involved a patient death
b. The patient's sudden death, possibly from pulmonary embolus, should have alerted the Hospital to issues relating to preventive

Investigation into Macarthur Health Service Incident Review

anticoagulation. This patient's management could have been enhanced if the Hospital had a protocol on DVT prophylaxis.

Outcomes	Incident No 12
The Issue	**Quality and Safety Concerns**
The Medical Emergency Team (MET) at Macarthur Health Service	Not substantiated
Notifications of deaths to the Coroner and decision making around post mortem	Substantiated
Documentation of treatment and care in health care records	Substantiated
Management response to adverse events, including incident reporting	Substantiated
Quality of clinical care provided by nursing staff	Not substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Not substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 13

Date of Incident Qtr 3, 2002

Summary of Incident **Incident No 13**

Mr K a 73 year old man who was admitted to Campbelltown Hospital in Mid 2002 with a right cardiovascular accident (CVA) and a history of diabetes. On admission via Emergency Department the medical registrar saw Mr K, and a medical management plan was documented.

Mr K continued to be seen by a registrar daily to second daily as well as multiple allied health staff including physiotherapist, occupational therapist and patient liaison officer. The patient was also seen by an Aged Care and Rehabilitation consultant.

On Day 19 at 1000hrs BP was 70/42 the patient was returned to bed and immediately seen by a senior registrar who was on the ward. A nitro patch was removed and further BP medications suspended protem. Five minutes later BP was 110/60. MET call was not activated.

Mr K had been having problems with BP being stabilised and his medication had been increased the previous day causing the drop of his BP. Mr K was conscious through the entire incident stating it was caused by the increase in his medication and that this had occurred previously.

This incident was reported by a staff member EN N3 who was not on duty at the time, but who was told about it on her return to duty and who as a result lodged an incident form. This staff member has since been disciplined over breaching confidentiality lodging the incident report.

It would have been appropriate for the Executive or the delegate to finalise the review of the problem report and followed usual procedures. A learning opportunity was missed as a result. The NUM's attitude to safety reporting was not aligned with supporting reporting and learning. The issue of privacy and safety reporting was not explored or clarified. This permitted an untested significant disincentive to reporting to remain. The MET protocol was not reviewed to assess suitabiliy of MET call criteria. If staff were not calling MET because a senior doctor was to hand or patient's blood pressure were normally below the MET BP threshold this, if acceptable, would need to be incorporated into the MET protocol. There is no evidence that this occurred. The failure to review and if appropriate realign porotocols led to a continuation of a perception in some staff that staff were not using MET appropriately which generated patient safety concerns.

When considering if the MHS knew about this incident at the time, it can be seen from avaialble information that the matter was reviewed by the Critical Care Review Committee, but this did not occur until some months after the incident.

Allegations by Informants	Location 1	Location 2
MET process	Campbelltown - ED	

Issues Identified by HCCC	Location 1	Location 2
Management response to adverse events, including incident reporting	Campbelltown - ED	
The Medical Emergency Team (MET) at Macarthur Health Service	Campbelltown - ED	Campbelltown - Med Ward

Clinical Review Panel Opinions **Incident No 13**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

- The MET was not called, which was a breach of protocol.
- There was an inadequate management response - nurse has a right to raise concerns with the system. Reasonable to report when local level reporting not effective.

Reporting, transparency should be encouraged and seen as constructive, compassionate and fair.

Commission Views and Comments **Incident No 13**

The Commision makes the following conclusions and comments:

1. The commission concludes that the care provided to the patient was inadequate for the following reasons:
a. The MET was not called when it should have been.
b. The patient's BP warranted a MET call. If a MET call was not considered appropriate the reasons needed to be documented in the medical records.

2. Firm guidelines need to be established in realtion to MET call procedures. If exceptions exist to calling a MET that are not reflected in the protocol, the protocol requires revision.

3. The Commission concludes that the action taken by MHS in response to the problem report was lacking because:
a. The only feedback that appears to have been given to the nurse submitting the problem form was criticism for her action in submitting the form.
b. The matter was not reviewed by the Critical Care Review Committee until some months after the incident.
c. The problem report was not completed by the Continuum Director or delegate. Such a review may have tested the NUM's view that the reporting nurse should not have accessed patient records.

Outcomes **Incident No 13**

The Issue	Quality and Safety Concerns
Management response to adverse events, including incident reporting	Substantiated
The Medical Emergency Team (MET) at Macarthur Health Service	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 14

Date of Incident Qtr 3, 2002

Summary of Incident **Incident No 14**

Mrs K was 88 years of age when she was taken to Camden Hospital in mid 2002. She had a history of chronic cardiac failure, osteoporosis, alzheimer's dementia and peripheral vascular disease. Prior to admission the patient had required assistance with all daily tasks and during the two weeks prior to admission she had fallen a number of times. The patient was admitted to hospital with swelling and inflammation of the lower legs, and was diagnosed as having cellulitis.

Mrs K remained in hospital for 11 days. Nursing notes indicate Mrs K frequently climbed out of bed, removed her catheter, and removed her nasal prongs. The patient underwent repeat chest x-rays & scans including a brain scan. Recording of fluid balance was commenced from day 3. However, the charts are incomplete. Entry for Day 3 records input as 250 mls. Entries for Days 4 & 6 do not document intake, and entries for Day 7 indicate an unacceptably low input of 310 mls. Entries for days 8 - 11 show gaps in recording and unacceptably low fluid levels.

Mrs K was seen on 11 occasions by allied health professionals, mainly by the speech pathologist who assessed her swallowing difficulties.

On day 10 Mrs K had breathing difficulties, 93% oxygen sats and urine output below renal threshold. An oxygen mask was applied and she was encouraged to increase oral intake. On the morning of day 11 her blood pressure dropped to 87/56. The Medical Emergency Team was contacted and she was identified for transfer to ICU. Chest x-ray revealed pleural effusion and the family agreed that Mrs K should undergo drainage of pleural effusion. However, she should not be put on life support. Several hours later Mrs K died.

The death certificate listed causes of death as cardiac failure, pleural effusion, ischaemic heart disease, cellulitis. Atrial fibrillation, Alzheimers dementia and osteoporosis.

This incident was not reviewed by MHS.

Allegations by Informants	Location 1	Location 2
No review by hospital	Campbelltown - Med Ward	
No urine output for days	Campbelltown - Med Ward	
Patient was mismanaged	Campbelltown - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
Management response to adverse events, including incident reporting	Campbelltown - Med Ward	
Documentation of treatment and care in health care records	Campbelltown - Med Ward	
Quality of clinical care provided by visiting medical officers	Campbelltown - Med Ward	
Patient decision making and planning for treatment, and end of life care	Campbelltown - Med Ward	
Quality of clinical care provided by nursing staff	Campbelltown - Med Ward	

Clinical Review Panel Opinions **Incident No 14**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- The patient was medically reviewed on many occasions.
- It was reasonable not to identify small pleural effusions.
- There were good admission notes.
- The 'not for resuscitation' plan was not documented.
- Patients with both renal and heart problems are very difficult to treat.
- Nursing documentation was poor.
- Fluid Balance Charts were inadequate because they were not completed. The result of these poor practices was significant in this case.

The CMO Panelist commented:
- Initial assessment was very thorough. The possibility of chest infection/Lower Respiratory Tract Infection (LRTI) was raised by the first doctor seeing the patient and implied by the medical registrar in his Chest X-Ray findings.
- Mrs K was already on IV antibiotics for cellulitis which would have been appropriate also for the majority of community acquired LRTIs. Further information may have been provided by a sputum culture and the antibiotic spectrum broadened by adding an agent such as roxithrodrycin (Rulide) to cover 'atypical' infections.
- Fluid chart observations were lacking on Day 3. In the context of this patient's shortness of breath and underlying heart disease, her fluid status was critical to her effective management.
- Nursing staff need to be aware of and accountable for the absence of adequate observation recordings.
- End of life plans are best made early in a patient's admission, given that a patient may deteriorate and be unable to communicate their intentions later on. The emotional difficulties inherent in asking these questions may be alleviated in part by formalising the process ie an end of life plan form filled in an the time of admission.

Panel opinion after considering area health service response:

If FBCs are ordered, then they should be done properly
End of life planning - because of her deterioration the day before her death, there was opportunity to prepare a plan. This topic needs more attention.
Nursing clinical care was inadequate.

Investigation into Macarthur Health Service Incident Review

Commission Views and Comments **Incident No 14**

The Commision makes the following conclusions and comments:

1. The Commission concludes that the medical care provided to the patient was safe and adequate for the following reasons:
a. Initial assessment of the patient was thorough
b. Regular medical reviews were carried out.

2. The medical officer would be expected to monitor the patient's fluid status given her clinical presentation. This could not have occurred as the fluid balance chart was incomplete.

3. The Commission concludes that the nursing care provided to the patient was inadequate as evidenced by:
a. Documentation of fluid intake and output for 7 days is impossible to interpret
b. The fluid balance charts indicate either extremely poor documentation practices or failure to adequately hydrate and monitor the patient.

The documentation issue was not identified. It requires immediate remediation by MHS. Nursing staff must be made aware of and accountable for the absence of adequate observation recordings.

4. The level of care would have been enhanced if end of life planning had commenced earlier. Discussions with the family did not take place until the day of Mrs K's death, Day 11. In view of her advanced age and the existing medical complications, it would have been more appropriate if discussions had taken place with the family earlier. End of Life plans are best made earlier rather than later because a patient may deteriorate and in cases such as this, the patient and the family should be given adequate time to discuss and confirm their wishes.

Outcomes **Incident No 14**

The Issue	Quality and Safety Concerns
Management response to adverse events, including incident reporting	Not substantiated
Documentation of treatment and care in health care records	Substantiated
Quality of clinical care provided by visiting medical officers	Not substantiated
Patient decision making and planning for treatment, and end of life care	Partially substantiated
Quality of clinical care provided by nursing staff	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 15

Date of Incident Qtr 4, 2001

Summary of Incident **Incident No 15**

Mrs Y was a 73 year old woman who presented to Camden Hospital emergency department at 1830 hours in late 2001 with severe central chest pain. Her past history included bilateral skin grafts to legs secondary to Bowen's disease as an inpatient in Campbelltown Hospital eight days earlier. Her other relevant past history was hypertension, hyperglycaemia, NIDDM and ischaemic heart disease.

Her chest pain was severe enough to require 5 mg morphine which was administered in incremental doses between 1840 and 1844 hours. Her blood pressure was 164/95, pulse rate 120/min, oxygen saturations 98% and BSL 18.5 mmol/L. Serial cardiac enzymes and ECG were attended. Aspirin was given. ECG showed LBBB (old) rate of 150/min and non specific St-T wave changes. By 2215 it is recorded that Mrs Y had passed only a small amount of urine. Oxygen saturations between 2230 and 2335 hours were 90-92% and were corrected via administration of oxygen.

The VMO Dr D4 was contacted by telephone by the ED medical officer. It was agreed that Mrs Y would be admitted to a monitored bed. The medical officer tried unsuccessfully to secure a suitable bed in any hospital within SWSAHS. Mrs Y remained in the ED overnight.

At 0130 hours Mrs Y reported central chest pain. Anginine □ x 3 was given and two injections of 2.5 mg morphine were given. This provided moderate relief only. A second set of enzymes was collected and a third ECG was carried out. Further unsuccessful attempts were made to locate a monitored bed.Another 5mg dose of morphine was administered at a time not recorded. The time of administration appears to be before 0935 hours.

At 0800 hours on Sunday the ED CMO Dr D12 started his shift, taking over management of Mrs Y. At approximately 1000 hours he contacted the VMO Dr D4 advising him that repeat ECG and serial enzymes were normal and that he considered the most likely diagnosis was costochondritis or chest wall pain. The VMO and CMO agreed that the patient could be discharged from hospital. A letter was provided to Mrs Y for follow up by her GP.

Mrs Y was discharged home sometime after 1100 hours with a pulse rate of 108/min. Before reaching her front door Mrs Y collapsed and died. An ambulance took her back to hospital but she was pronounced dead on arrival.

Mrs Y's daughter made a complaint about the medical management of her mother by both Campbelltown and Camden Hospitals. She identified a number of issues of concern including:
• Nursing staff's failure to provide her with any information on her mother's medical situation when she telephoned Camden ED before Mrs Y's discharge.
• Failure to acknowledge her request that her mother be kept in Camden ED until she was able to come and personally collect her in the afternoon.
The failure of medical and nursing staff to recognise that Mrs Y had bandaged legs, evidence of her recent surgery.
• When she contacted the ED medical officer after her mother's death, his main focus was whether she wanted an autopsy and the fact that the GP had refused to sign the death certificate.
• A mix up in personal possessions when Mrs Y was an inpatient at Campbelltown Hospital.

In response to the complaint, management initiated an internal investigation involving three clinical staff. The findings of two of the staff substantiated the daughter's complaint and identified criticisms to the care provided to Mrs Y. This information was not relayed to the daughter. The response sent by the General Manager to the daughter failed to adequately address the daughter's concerns. It stated that a preliminary review of her mother's management was initiated and the case 'has now been referred to the critical care review committee'. The matter has never been referred to the CCRC or similar review form.

The medical director and the nurse manager who investigated the matter both recommended that a medical review would be beneficial, with the medical director offering to carry out such a review. Management did not act on this recommendation.

In July 2003 MHS advised the Commission that the following actions were taken in response to the incident:
1. The Medical Director of Health Services met with the VMO involved in this case in March 2002 to discuss the supervision, support and direction of registrar and junior medical staff, the timing of ward rounds in relation to on-call days and documentation of management plans for patients.
2. In September 2002, the VMO Dr D4 attended a fact finding interview regarding on-call support for ED and review of patients admitted under his care.
3. The VMO was included in the performance management process for VMOs that began in 2003.
4. The Director of Medicine is working closely with VMO physicians to ensure timely review of patients.
5. MHS is participating in the Institute for Clinical Excellence patient flow and safety collaborative to improve the management of medical patients.
6. The Director of Emergency Medicine identified the cause of death of Mrs Y as acute pulmonary embolus, and subsequently developed an education program on assessing and managing pulmonary embolus.

Allegations by Informants	Location 1	Location 2
Inappropriate discharge	Camden - ED	
Inadequate assessment & management	Camden - ED	

Issues Identified by HCCC	Location 1	Location 2
Notifications of deaths to the Coroner and decision making around post mortem	Campbelltown - ED	
Patient transfer to higher level units or hospitals	Camden - ED	
Documentation of treatment and care in health care records	Camden - ED	

Investigation into Macarthur Health Service Incident Review

Management response to adverse events, including incident reporting	Camden - ED
Communication with patients and families	Camden - ED
Quality of clinical care provided by visiting medical officers	Camden - ED
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Camden - ED

Clinical Review Panel Opinions **Incident No 15**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
• This patient should not have been discharged home - unsafe care. On the day of discharge the patient had received 3 doses of morphine and anginine.
• Failure to record time of (the last) dose of morphine is unacceptable practice. The administration of repeat doses of morphine indicates the chest pain was severe and that the patient should not have been sent home.
• The sudden change in diagnosis to costochondritis appears to be influenced by the lack of bed availability. No adequate explanation why a patient identified as requiring a bed, should be fit for discharge some hours later.
• The sudden change in diagnosis and patient management is evidence of the lack of continuity of care and indicates lack of adequate patient handover.
• The VMO saw the patient only once, at the time of admission despite her presence for hours in ED. In view of the patients presentation and history, the VMO should not have agreed (over the phone) to the patient's discharge without first reviewing the patient in person.
• The patient remained in the Emergency Department for hours without being seen by a consultant.
• The patient had high risk factors, a diagnosis of pulmonary embolus or infarct should have been considered. The patient required doppler ultrasound.
• The General Manager's response to the daughter's letter failed to address the concerns raised by daughter. Otherwise, the Panel was not prepared to comment on the quality or otherwise of communication with the daughter.
• Despite internal reviews of this case, no corrective action was recommended or implemented. The Panel considered this to be a lost opportunity.
• Care became particularly unsafe and unacceptable when the decision was made to discharge the patient.

Panel opinion after considering area health service response:
The diagnosis of costochondritis was clearly inappropriate
Discharge was inappropriate however ECG and cardiac enzymes were normal
Failed to look at other possible diagnoses - the pain left when she was given morphine
Unclear of time of administration of one dose
PR 108 on discharge - on a background of chest pain this is of concern. BP was 130.
This should have gone to Coroner
It is impossible to ascertain from the notes whether VMO was made aware of patient's recent surgery
Documentation is patchy and difficult to follow. What time was [3rd dose of] morphine administered?
Re inability to locate a monitored bed elsewhere - there was no back up plan, such as keeping patient in ED. She could have been transferred to Campbelltown ED.
This case strongly demonstrates systems problems.

Commission Views and Comments **Incident No 15**

The Commision makes the following conclusions and comments:

It is the view of the Commission that the care provided to Mrs Y was inadequate and unsafe for the following reasons:
1. In relation to her care in the emergency department:
• That a patient with these presenting symptoms and medical history was discharged home without review by a VMO.
• The patient did not undergo doppler studies before discharge and differential diagnoses such as DVT and pulmonary embolus were not considered.
• The final dose of morphine, a schedule 8 drug, was not time recorded in the medical records as required. Morphine could have had significant clinical repercussions in terms of masking Mrs Y's chest pain if administered in the hours before discharge.
• Agreement to discharge should have been more than on the basis of normal ECG and enzyme results, particularly in view of Mrs Y's presentation, past history and recent leg surgery. The fact that the VMO had given advice only 13 hours earlier that the patient required admission to a monitored bed increased the inappropriateness of discharge.
2. The initial decision to locate a monitored bed was appropriate and documentation indicates that efforts were made to locate one within the area. When a monitored bed could not be located, and serial cardiac enzymes were found to be normal, a diagnosis of costochondritis was given. This appears to have been an expedient diagnosis, formed in when there was no available monitored bed.
3. The death should have been referred to the Coroner because the death may have been a direct result of the recent surgery and there was no definitive cause of death.
4. The action taken by MHS in response to the event and the subsequent complaint by the family was considered lacking because:
• The response by MHS management to the daughter's letter of complaint was inappropriate and lacking sensitivity. MHS failed to adequately address the issues raised by the daughter and did not provide a reasonable account of the lack of care and lessons learned. This is inconsistent with a culture of transparency and openness which is a community expectation.
• Two of the three staff investigating the incident recommended medical review of the incident and the department director offered to conduct the review. Management did not support this recommendation.
• The failure to refer the case to the CCRC indicates a flaw in the complaints system linkage to the wider quality system.
• The advice provided to Mrs Y's daughter that the matter had been referred to the CCRC was misleading.

Investigation into Macarthur Health Service Incident Review

• The introduction of corrective actions was delayed, most notably the fact finding interview that took place 12 months after the incident.

Outcomes	Incident No 15
The Issue	**Quality and Safety Concerns**
Notifications of deaths to the Coroner and decision making around post mortem	Substantiated
Patient transfer to higher level units or hospitals	Substantiated
Documentation of treatment and care in health care records	Substantiated
Management response to adverse events, including incident reporting	Substantiated
Communication with patients and families	Substantiated
Quality of clinical care provided by visiting medical officers	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 16

Date of Incident Qtr 3, 2001

Summary of Incident **Incident No 16**

Mrs CL was a 55 year old woman who presented to Campbelltown Hospital emergency department at 1713 hours in mid 2001. Her previous history included mitral valve replacement two weeks earlier, NIDDM and hypertension.

Mrs CL was triaged at 1713 hours as category 3. At 1720 hours her blood pressure was recorded as being 69/49, her respiratory rate 30/min and her temperature 35.3 degrees C. At 1745 hours the locum medical officer Dr D43 assessed Mrs CL and diagnosed cardiac failure, predominantly right sided. An indwelling urinary catheter was inserted, ECG attended and bloods sent to pathology. At 1835 hours 80 mg of lasix was given intravenously. At no stage was the on call physician contacted by ED staff.

On the night of Mrs CL's presentation, there was no ICU medical coverage and so no new admissions to ICU were to be made. However at 1955 hours the ICU registrar Dr D34 happened to call into the hospital and agreed to assess Mrs CL. The registrar ordered the administration of 1 litre haemacel as a fluid challenge and commencement of tridal infusion. The haemacel was not given until 2 □ hours later.

After discussing the case with the registrar, the ED locum medical officer Dr D43 recorded a problem list of (1) ?sepsis, (2) metabolic acidosis, (3) pleural effusion and (4) diarrhoea. He telephoned the VMO cardiologist Dr D37 and informed him of the presenting symptoms. The CMO Dr D43, when asked by the VMO, did not know the patient's vital observations. The CMO checked these and called the VMO a second time to inform him that blood pressure was 60/30 and the patient was asymptomatic apart from dyspnoea. The VMO instructed that Mrs CL should immediately receive intravenous fluid resuscitation, inotropic support, broad-spectrum antibiotic cover and transfer to Liverpool Hospital or an equivalent facility. The ICU registrar from Liverpool Hospital stated that there were no beds available but transfer would be possible in the morning

At 2230 hours the nursing vital observation chart documented the first blood pressure recorded by the nursing staff since the patient's arrival at the hospital, five hours previously. At this time it was realised that Mrs CL was critically unwell and she was transferred to the resuscitation room.

The VMO cardiologist arrived at the hospital sometime before 2400 hours and found Mrs CL to be anuric, hypotensive with a metabolic acidosis and a WCC of 24,000. He performed an Echo which excluded tamponade and found a competent mitral valve, a small pericardial effusion and a LVEF of 50%. He commenced an inotrope infusion and colloid resuscitation.

A fluid balance chart was only commenced at this time. The patient had been anuric since admission.

At 0230 hours the patient's blood pressure was noted to be 103/51, respiratory rate of 23 and GCS of 15/15. Liverpool Hospital finally agreed to accept Mrs CL's transfer which occurred at 0400 hours via ambulance and flight nurse. She died soon after arrival at Liverpool.

The MHS critical care review committee reviewed Mrs CL's notes. Seven months after the critical incident the committee requested the Director of Emergency Medicine oversee and report back on their recommendations.

These recommendations were:
- education on the use of spacelabs when recording blood pressure
- inservice on GTN infusions and inotropes
- ensure medical staff know about interhospital transfer procedures.

In July 2003 MHS informed the Commission of the following:
- the in-service had not taken place
- information on the transfers of critically ill patients had been included in the survival kit for all new / relief medical staff
- information on transfers directs staff to contact medical retrievals who will advise where an ICU bed is available
- a MET call was not made for Mrs CL because the emergency department does not contact MET staff unless they are overwhelmed and need additional support
- a staff specialist roster started in March 2003 to ensure after hours coverage by VMOs.

In their response to our criticisms of the medical management of Mrs CL, MHS stated that the night in question was particularly busy with 102 patient presentations in the 24 hours up to midnight. Staff coverage of the evening shift was one team leader, one triage nurse and three RN, one of whom was away ill. From 2330 hours there was one senior and one junior medical officer. There was no medical coverage for ICU during that night.

Comments by the MHS nurses who responded to the Commission's criticisms included:

- Nursing staff were with the patient but documentation of vital signs was not attended.
- Hourly observations are attended on all patients as a minimum requirement with more frequent observations of unstable patients.
- MET was not called because a senior medical officer was in attendance.

Allegations by Informants	Location 1	Location 2
Lack of availability of ICU specialist	Campbelltown - ED	
Nurses failed to inform MOs of problems	Campbelltown - ED	
MET was not called	Campbelltown - ED	

Issues Identified by HCCC	Location 1	Location 2
Documentation of treatment and care in health care records	Campbelltown - ED	
Quality of clinical care provided by nursing staff	Campbelltown - ED	

Investigation into Macarthur Health Service Incident Review

Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ED
Availability of and supervision by senior medical staff	Campbelltown - ED
Management response to adverse events, including incident reporting	Campbelltown - ED
The Medical Emergency Team (MET) at Macarthur Health Service	Campbelltown - ED
Relationships and communication within and across clinical teams	Campbelltown - ED
Patient transfer to higher level units or hospitals	Campbelltown - ED
Recognition and response to critically ill patients	Campbelltown - ED
Coordination and continuity of care	Campbelltown - ED

Clinical Review Panel Opinions **Incident No 16**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- There was a failure to recognise a critically unwell patient (septic shock)
- There was a lack of critical care skills. Staff were out of their depth.
- Early intervention was crucial. The patient needed earlier assessment by senior and experienced staff. There was delay in involving the cardiologist.
- No MET call was made but is required if the systolic BP drops below 90 (see MET protocol). However, there is no point in having a MET alert if the appropriate staff are not available.
- Liverpool Hospital ICU first refused and then agreed to take the patient, by which time it was too late. Such knockbacks are likely to affect the team's future actions and requests.
- The patient should have been transferred to an ICU anywhere. ICU beds are a finite resource, however, a failsafe system exists and you ring around.
- Neither nursing nor medical care were of acceptable standard.
- There was poor knowledge and treatment of septic shock, poor teamwork and poor communication between Campbelltown and Liverpool Hospitals.
- The MHS management response was not adequate.

Panel opinion after considering area health service response:
There was nobody in ED who could resuscitate her adequately
MET inadequately funded and staffed
MET is an ad hoc arrangement which is not being co-ordinated - this was not addressed by the Area in their response. Response said MET is not called for ED unless ED not managing - but ED was not managing in this instance. MET should have been called.
Basic ED resuscitation was not done.
Not "response neutral"

System error re critical illness
No system in place to deal with saturations
delay in recognising patient who is so unwell
Wrong drug administered
No monitoring
Mitral valve replacement done at private hospital

Re MHS response - the 3 recommendations by CCRC completely "missed the point" and did not understand that she should have been found a bed somewhere else

Critical issue - failure to call the Cardiologist early - patient languished as a result
The Cardiologist is not an Intensivist - he did his best within his ability
It is acknowledged that the Cardiologist left home and attended the hospital even though he wasn't on call. His response to shock could have been better.
RMO not experienced
Nothing done for 5 hours in ED
No review
No order to monitor

Lack of ICU beds at Liverpool. Needed to be in an ICU bed.
Did not understand the nature of the illness
Nothing changes in our original opinion

Investigation into Macarthur Health Service Incident Review

Commission Views and Comments	Incident No 16

The Commision makes the following conclusions and comments:

The Commission investigated the standard of care provided to Mrs CL by MHS and made the following comments:

The care provided to Mrs CL was unsafe and inadequate for the following reasons:

1. In relation to care in the Emergency Department:
a. There was a complete failure of care by nursing staff to adequately monitor and appropriately respond to this patient's vital observations in particular at 1720 when BP was 69/49 and temperature was 35.3.
b. Medical staff failed to recognise just how critically ill this patient was and failed to adequately resuscitate her.
c. The patient should have been transferred to an ICU bed soon after her presentation yet she remained in Emergency Department for 11 hours.
d. When staff failed to locate an ICU bed at Liverpool hospital, no further attempts to locate an ICU bed were made despite critical signs. Liverpool hospital had a role in advising use of the medical retrieval system.
e. The patient did not receive inotrope support, plasma expanding fluids, adequate diureses, fluid monitoring, antibiotics or septic work up until almost 5 hours after presentation.
f. An adequate, co-ordinated care plan, responsive to the patient's condition was not evident.
g. The patient was not seen by a VMO until 6 1/2 hours after presenting to the Emergency Department.
h. Documentation failed to reflect progress of the patient's condition during the first half of the ED stay.

2. MHS has informed the Commission that Emergency Department staff do not call a Medical Emergency Team (MET) unless they are overwhelmed. This patient's systolic blood pressure was recorded as being between 60 and 88 on 5 occasions, with 3 occasions recorded as below 69. On two occasions respiratory rate exceeded the MET criteria, reaching 165 and 150/minute. These critical levels required urgent intervention. In its response, MHS advised that on the night in question staff were extremely busy and hence delays in the monitoring and management of the patient occurred. This response serves to reinforce that MET was required to adequately resuscitate the patient.

3. The MHS response to the critical incident was inadequate. It failed to explore the reasons for, and strategies to avoid the following issues:
a. Nursing staff did not closely monitor a critically ill patient.
b. Nursing staff failed to appropriately respond to critical vital observation.
c. Medical officers failed to ensure timely review by a VMO.
d. Lack of clinical expertise in ED medical officer
e. Lack of resuscitation skills of medical officers in the Emergency Department and ICU
f. Lack of 24 hours medical coverage in ICU
g. A critically ill patient remained in the emergency department for 11 hours
h. Inotrope support was not administered until the VMO attended, 6 1/2 hours after the patient presented.
i. The Acute Services Critical Care Review Committee (ASCCRC) did not review the case until 7 months after the incident.
j. MHS advised that of the 3 recommendations made by ASCCRC, 2 of these had not been implemented 2 years after the incident

4. The action taken by MHS to ensure and relief staff receive instruction on how to locate an ICU bed and the commencement in March 2003 of a staff specialist roster is important and appropriate. However, the effectiveness of these measures needs to be evaluated further. In addition to the rostering of VMOs, it is essential that contractual arrangements ensure the VMO attends to critically ill patients in person.

5. Current policy of the Emergency Department states that hourly observations are attended on all patients as a minimum requirement with more frequent observations of unstable patients. There is no evidence to indicate that the implementation of this policy is being monitored nor that staff have been educated in the determination of an unstable patient. In the case of Ms CL, dramatically low vital signs did not result in more frequent observations.

6. Review of medical records revealed the separation of nursing records from medical records. In order to facilitate chronological interpretation and to ensure information is readily available to all staff, integration of records is strongly recommended.

Outcomes	Incident No 16
The Issue	**Quality and Safety Concerns**
Documentation of treatment and care in health care records	Substantiated
Quality of clinical care provided by nursing staff	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated
Availability of and supervision by senior medical staff	Substantiated
Management response to adverse events, including incident reporting	Substantiated
The Medical Emergency Team (MET) at Macarthur Health Service	Substantiated
Relationships and communication within and across clinical teams	Substantiated
Patient transfer to higher level units or hospitals	Substantiated
Recognition and response to critically ill patients	Substantiated
Coordination and continuity of care	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 17

Date of Incident Qtr 3, 2002

Summary of Incident **Incident No 17**

Mrs O was 82 yo when she was taken to Campbelltown ED in mid 2002. The patient was confused and was unable to eat, drink or mobilise. Her family could no longer look after her. The patient had a history of dementia, diabetes, leg ulcers and hypertension. The patient was in hospital for 6 days, and was to be discharged to a nursing home due to her level of dependence. During her hospitalisation, she was seen by the social worker and the speech therapist. The social worker met on several occasions with Mrs O's family to plan nursing home placement.

On day 3 a nursing home bed was located and it was agreed that Mrs O would be transferred to the nursing home on day 5. On the morning of day 5 Mrs O was seen by the medical officer who noted BP 190/100, HR 80/min, secondary CP and SOB, WCC 17.9, afebrile chest clear, oxygen sats 99% RA. The medical officer ordered recommencement of capoten and aldactone, 4 hourly observations, and for Mrs O to be remain in hospital. The medical officer noted that Mrs O could be transferred to a nursing home on day 8 if BP was stable.

Regular observations were taken up to 1630 hours on day 5. The only recording of further observations was one entry recorded at 0500 hours on day 6. No observations appear to have been taken for 12 1/2 hours.

On day 6 at 0500 hours Mrs O's blood pressure was 170/88, respiration rate was 24, Oxygen saturation 99%. Her breathing was noisy. The registrar saw the patient at 0550 hours, and recorded BP as 170/90, HR 100, "gurgling" chest. The registrar ordered a chest x-ray to be checked by RMO, no IV fluid, start lasix. The RMO was contacted by telephone by nursing, some time before 0600 hours. The next entry is time recorded at 0800 hours, stating family was contacted. Nurse documentation time recorded at 0810 hours states "On first round at 0750 found patient unable to … no pulse nil respiration noted" The ADON was contacted and RMO again contacted.

Documentation by the intern, written retrospectively at 0815 hours, stated that death had occurred at 0750 hours.

The death certificate stated cause of death was pulmonary embolus and long term atrial fibrillation, with history of diabetes, infection of leg ulcers and hypertension.

A staff member submitted a Problem Form stating that a MET was not called. The MHS initiated an internal review to determine whether a MET should have been called. The MHS internal reviewer stated that no active intervention was commenced because Mrs O's family was aware of the fact that Mrs O was elderly and dying, that the family had been contacted due to deterioration in Mrs O's condition, and that the proposed transfer of Mrs O to a nursing home supports the view that Mrs O was not for resuscitation. The MHS internal reviewer concluded that patient privacy had been breached by the nurse who submitted this and other problem reports because s/he was not on duty at the time.

Seven months after the incident, the matter was reviewed at the Acute Services Review Committee (ASRC) in March 2003. The ASRC referred the matter to the Nurse Educator to consider mandatory in-services on Code Blue MET calls.

Allegations by Informants	Location 1	Location 2
Death certificate issued on normal rounds	Campbelltown - Med Ward	
Patient admitted with sore knee and died	Campbelltown - Med Ward	
CPR should have been initiated	Campbelltown - Med Ward	
MET should have been called	Campbelltown - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
Documentation of treatment and care in health care records	Campbelltown - Med Ward	
Availability of and supervision by senior medical staff	Campbelltown - Med Ward	
Notifications of deaths to the Coroner and decision making around post mortem	Campbelltown - Med Ward	
Management response to adverse events, including incident reporting	Campbelltown - Med Ward	
Patient decision making and planning for treatment, and end of life care	Campbelltown - Med Ward	
The Medical Emergency Team (MET) at Macarthur Health Service	Campbelltown - Med Ward	

Clinical Review Panel Opinions **Incident No 17**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

- A major issue was resuscitation. There was no reason not to resuscitate the patient. If there is no NFR order or if in doubt, resuscitation should occur. The events reflect a culture of informal NFR.
- The MET should have been called and CPR started until/unless a decision was made otherwise.
- Staff were not proactive in investigating the patient's deterioration.
- The consultant was only mentioned once in the medical notes over six days.
- The Hospital recommendations were inadequate and did not address all the issues.
- On the basis of the death certificate and the actual scenario, the death should probably have been reviewed.

Panel opinion after considering area health service response:

The Area's response is contradictory. The Commission was critical of the failure to observe and document 4 hourly observations. In response the Area stated that the patient did not have an acute illness but was 82 years old and dying. This contradicts the VMO's stated opinion that the patient was not in imminent risk of dying and it was expected that she would have been discharged to a nursing home, and

Investigation into Macarthur Health Service Incident Review

that it would have been inappropriate to discuss end of life issues with the family.
End of life plans should have been discussed with family and documented - the patient was at the end stages of life.
MET should have been called. In the absence of discussions to the contrary, patient was entitled to appropriate intervention and resuscitation.
Documentation was substandard.

Commission Views and Comments	**Incident No 17**

The Commision makes the following conclusions and comments:

The Commission did not consider the care provided to Mrs O to be unsafe, however it was inadequate in that:
1. Nursing staff failed to observe and/or document 4 hourly observations as ordered on day 5. Prior to the patient's death, there was a period of 12 1/2 hours when no observations were recorded.

The Commission concludes that the patient's death was inappropriately handled for the following reasons:
a. No documentation exists from medical staff or the social worker to indicate that end of life discussions took place with the family. In the absence of any such documentation on the family's wishes, the patient should have been given all available intervention and resuscitation.
b. A MET should have been called because the patient demonstrated a threatened airway.
c. The management of the patient would be considered appropriate if she had been identified and documented as Not For Resuscitation.

The response by MHS to the incident was inadequate for the following reasons:
a. The conclusions drawn by the MHS internal reviewer who reviewed the problem form were not supported by any documentation. In fact the documentation is at odds with the reviewer's conclusion that the family was contacted due to patient deterioration, because they were not contacted until the patient had already died.
b. The internal reviewer was not justified in criticising the nurse who submitted the problem form. If the nurse was responsible for the care of the patient, then events affecting the patient's well-being were of concern to the nurse.
c. No action was taken until the review by the Acute Services Review Committee (ASRC), 7 months after the event and the problem report. The ASRC recommended mandatory in-services about MET calls. This does not address the wider issue of failure to identify the need to discuss and document all end of life discussions with patients and family.

MHS is currently participating in the SWSAHS's Not For Resuscitation Working Party. The Commission notes that the Department of Health issued interim guidelines in 1993. The ten year delay implementing area and local policy is unsatisfactory.

Outcomes	**Incident No 17**
The Issue	**Quality and Safety Concerns**
Documentation of treatment and care in health care records	Substantiated
Availability of and supervision by senior medical staff	Not substantiated
Notifications of deaths to the Coroner and decision making around post mortem	Not substantiated
Management response to adverse events, including incident reporting	Substantiated
Patient decision making and planning for treatment, and end of life care	Substantiated
The Medical Emergency Team (MET) at Macarthur Health Service	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 18

Date of Incident Qtr 1, 2001

Summary of Incident **Incident No 18**

Mrs B was a 40 year old married mother of four children. In early 2001, six days after the birth of her fourth child, she presented to the emergency department (ED) at Campbelltown Hospital but was sent home with a diagnosis of 'flu'. Campbelltown Hospital is unable to locate the records of that ED visit, however the electronic triage system recorded 'fevers, rigors, general aches and pains. Onset of symptoms 3 days ago. Blood pressure 100/69, pulse 106 and temperature 39.4.'

The following day, (Day 2) she went to the after hours GP service at Campbelltown Hospital feeling hot and sweaty with total body pain and a swollen right arm. Her temperature was 36.8 and her BP was 70/50. The general practitioner wrote '? septic ? cause' and sent Mrs B to the emergency department at Campbelltown Hospital.

Mrs B was triaged at 21:27 and seen by a junior medical officer (JMO) at 21:50. Her temperature was 35.7 degrees, pulse rate 107 and blood pressure 91/47. She gave a history of having had a fever of 39, rigors, watery diarrhoea, right and left arm and right leg swelling and generalised pain. She was given 1 litre of normal saline immediately.

A nursing entry before medical review stated, 'patient looked unwell. Pale and diaphoretic. Patient tachycardic and hypotensive. Awaits medical review'. The JMO in the emergency department diagnosed possible myositis secondary to viral infection and ordered a broad range of tests including blood culture. Mrs B was given pethidine 25mgs and morphine 5mgs for pain while still in ED.

Over the four hours that she was in ED, her BP and pulse rate were recorded each hour for the first two hours. The VMO physician, Dr D30 - a gastroenterologist, was notified of Mrs B's admission at 20 minutes past midnight - three hours after she arrived. The medical records state, 'For admission under [Dr D30] - notified and aware'. There is no indication of any management plan and no antibiotics were ordered.

Mrs B had an unsettled night and walked unsteadily to the shower in the morning. She was reviewed by Dr D30 at 10:15 on 6 January 2001 at which time her blood pressure was unrecordable, her temperature was 34.4 and her pulse rate was 120150 b eats/minute. She was drowsy and in septic shock. Dr D30's response was to call the CMO from ICU, Dr D1, to review the patient with him. Care appears to have been handed to the registrar Dr D1. Mrs B was transferred to ICU at 13:40 after receiving haemacel on the ward. She remained profoundly shocked. An adrenalin infusion was commenced. Dr D1 had many attempts to insert an arterial line unsuccessfully. The VMO, Dr D28, contacted Liverpool Hospital Careflight to organise urgent transfer. A septic work-up was performed and antibiotics were started. There is no record of what antibiotics were administered.

Before transfer, an obstetrician/gynaecologist and a surgical registrar reviewed Mrs B. She was transferred to Liverpool Hospital by helicopter but died at 17:00.

Blood cultures and post mortem diagnosed streptococcus pyogenes septicaemia. She had died of puerperal sepsis.

The Director of the ED provided a report to the Coroner identifying the following three factors in relation to her presentation to the ED on Day 1:
- She presented with non-specific symptoms.
- The potential significance of presenting one week post partum was not appreciated.
- An obstetric and gynaecological consultation may have lead to her condition being accurately diagnosed sooner.

In relation to Mrs B's presentation on Day 2, the Director of ED identifies the following factors:
- The failure to administer antibiotics.
- Her admission to a medical ward instead of an O&G service.
- The failure to fully recognise the importance of her recent delivery.
- The failure to obtain an O&G consultation.

The Macarthur perinatal mortality and morbidity committee reviewed the case after seven weeks and recommended that:
1. The emergency department undertake educational seminars held with a staff specialist lecture, highlighting pre and post delivery complications including postnatal infection and sepsis.

2. A procedure be put in place that all patients presenting with signs of generalised illness within six weeks of delivery have a mandatory obstetric and gynaecology consultation before discharge.

These recommendations were implemented by the Director of ED.

Mrs B's husband, Mr B, made additional inquiries to MHS two months after her death. MHS responded to Mr B by organising a meeting with the medical staff who had cared for his wife. They also organised for the Area Director Medical Services for South West Sydney to assist Mr B to obtain answers to his questions.

SWSAHS provided a report to the Commission dated 22 May 2003 in which they formally requested that we undertake an investigation of the care and management of Mrs B at Campbelltown Hospital. In this report they pointed out a number of initiatives and improvements that have taken place at MHS since 2001.

Allegations by Informants	Location 1	Location 2
Nurse did not obtain a medical review at 8.30 when instructed to do so	Campbelltown - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
Recognition and response to critically ill patients	Campbelltown - Med Ward	

Investigation into Macarthur Health Service Incident Review

Nurse failed to obtain a medical review	Campbelltown - Med Ward		Quality of clinical care provided by visiting medical officers	Campbelltown - ED
No antibiotics given	Campbelltown - ED		Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ED
			Quality of clinical care provided by nursing staff	Campbelltown - Med Ward / Campbelltown - ED
			Documentation of treatment and care in health care records	Campbelltown - Med Ward / Campbelltown - ED

Clinical Review Panel Opinions **Incident No 18**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

- Emergency medicine includes the "duty to exclude". This case revealed a basic lack of knowledge and clinical suspicion.
- A systolic BP of 70 should have meant to staff a 'red flag' about dangers.
- There were no observations taken for three hours, and no documentation for a six-hour period.

Panel opinion after considering the s.43 submission from SWSAHS:

Commission Views and Comments **Incident No 18**

The Commision makes the following conclusions and comments:

The Commission found that the care provided to Mrs B was unsafe and inadequate for the following reasons:

1. In relation to her care in the emergency department:
• The ED medical officer failed to recognise signs of possible critical illness in a patient seven days post partum at the time of her second presentation on Day 2.
• The ED medical officer failed to review Mrs B in the light of her presentation to ED the previous day with fever of 39.4 degrees, rigor and tachycardia.
• There was incomplete medical admission and assessment.
• There was no management plan.
• Antibiotics should have been ordered immediately after the collection of the blood for culture.
• There was no communication with nursing staff by the ED medical officer about vital observation requirements.
• Narcotic analgesia was given on two occasions in ED without a clear diagnosis being made.
• There was no registrar/specialist review following the narcotic administration.
• No septic work-up was organised in the ED.

2. In relation to the quality of care provided by visiting medical officers (VMOs):
• There was no VMO involvement in Mrs B's management plan.
• There was no prompt review by a VMO in spite of Mrs B being seven days post partum, very unwell and having required pethidine for atypical pain.
• Failure to promptly organise the transfer of Mrs B to Liverpool Hospital when she was reviewed by him at 1015 hours on Day 3.
• There was a failure to prescribe antibiotics in a timely fashion.

3 In relation to the quality of care provided by nursing staff:
• Mrs B was inadequately monitored in ED with only three sets of vital observations documented during the four hours in ED.
• There was a lack of response to Mrs B's deteriorating medical condition on the medical ward from 0145 hours to 1015 hours on Day 3.

4. In relation to the MHS management response to this incident, we note with approval the prompt implementation of appropriate procedures by the Director of ED. However the requirement for post partum women to have an O&G consultation should be at the time of presentation not, as suggested, before discharge. In the case of Mrs B, she was admitted rather than discharged and became critically ill without being seen by an O&G.

Outcomes **Incident No 18**

The Issue	Quality and Safety Concerns
Recognition and response to critically ill patients	Substantiated
Quality of clinical care provided by visiting medical officers	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Partially substantiated
Quality of clinical care provided by nursing staff	Substantiated
Documentation of treatment and care in health care records	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 19

Date of Incident Qtr 3, 2002

Summary of Incident **Incident No 19**

Mrs G, a 77 year old women, was admitted to hospital in mid 2002. She was taken by ambulance to Cambelltown Hospital with confusion and hyponatremia. She had a history of some memory loss, transient ischaemic attack, peripheral vascular disease and anxiety. Mrs G was an inpatient for 5 weeks. During that time her blood pressure fluctuated. On 11 occasions her systolic BP dropped below 100. On two occasions it dropped below 90 systolic. On the first occasion blood pressure was recorded as 88/57. Three days later blood pressure was recorded as being 85/55. The Medical Emergency Team (MET) was not called on either occasion. The following day the patient was discharged from Hospital.

A staff member submitted a problem form stating that the criteria for calling the MET were present, but a MET was not called. An internal review was carried out by a nurse unit manager. The MHS internal reviewer concluded that the patient's normal systolic blood pressure was between 90 and 110 as she was taking medication to keep blood pressure down, and that the patient was asymptomatic. The NUM stated that the nurse submitting the problem form was not on duty at the time of the low readings, and therefore her reporting of the incidents violated patient privacy, and that she had discussed this with the nurse herself.

Seven months later the incident was tabled at Acute Services Review Committee in early 2003. The recommended action was referral to Nurse Manager - Nurse Education for inclusion in mandatory in-service program, specifically education on Code Blue, documentation and on documenting abnormal signs.

Allegations by Informants	Location 1	Location 2
Hypotension should have been investigated	Campbelltown - Med Ward	
Hypotension should have been recorded	Campbelltown - Med Ward	
MET should have been called	Campbelltown - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
Management response to adverse events, including incident reporting	Campbelltown - Med Ward	
Documentation of treatment and care in health care records	Campbelltown - Med Ward	
The Medical Emergency Team (MET) at Macarthur Health Service	Campbelltown - Med Ward	

Clinical Review Panel Opinions **Incident No 19**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- The allegation that Mrs G had not received an adequate standard of care was not substantiated.
- The patient treatment was safe and effective.
- There is evidence of systemic issues of inadequate protocols/guidelines.
- The management response to the incident was inadequate concerning culture, response to incidents, education and development and communication.
- There was confusion about the MET protocol. The protocol should be clear to staff.
- The MHS management investigated 6 incidents of no MET call. None of the investigation teams included a doctor.
- The investigation of the MET incidents is inadequate. They do not deal with the systemic issues.
- The incident indicates nurses have lost confidence/faith in management to address issues of concern. Staff need to be able to feel confident in calling a MET without fear of reprisal by colleagues or the MET members. Hence, a literal interpretation of the criteria is preferred. If they are too stringent, then a review of the criteria is required. If they are tobe guidelines only, then this needs to be made clear to all staff so that there is no moral or legal requirement perceived to call a MET when the patients is felt to be stable.
- Ambiguity regarding mandatory nature of MET calls needs to be resolved.
- MET calls for BPs in the 80's (systolic) may be inappropriate. Staff, however, require unambiguous guidelines for initiation of a MET call. There should be consideration of revising criteria eg systolic <80 instead of 90, with nursing review for systolic between 80 and 90 where the patient is otherwise stable.

Commission Views and Comments **Incident No 19**

The Commision makes the following conclusions and comments:

1. The care provided to the patient was safe and reasonable.

2. A MET call was not clinically required given the presentation of the patient. However, there was a breach of the MET protocol. The Clinical Panel reviewing this incident were divided in their opinion regarding the need for a MET call, and this division arose because MHS has not stated whether MET criteria are mandatory or discretionary.

3. The Commission concludes that the action taken by MHS in response to a problem report was lacking because:

a. The only feedback that appears to have been given to the nurse submitting the problem form was criticism for her action in submitting the form.

b. The internal reviewer stated that patient privacy was breached by the submission of the problem form. This is not technically correct if the nurse was involved in the general care of the patient.

c. The matter was not reviewed by the Acute Services Review Committee until 7 months after the incident.

4. The recommendations of the ASCR that staff education is required on the use of MET is appropriate. It seems confusion exists amongst staff regarding the need to adhere to MET criteria. Further clarification by MHS is required regarding the mandatory or non-mandatory nature of MET criteria. If the criteria are mandatory, then the current level of systolic blood pressure of 90 may need to be lowered to say 80. If they are a guideline, then this needs to be made clear to staff.

Investigation into Macarthur Health Service Incident Review

Outcomes	Incident No 19
The Issue	**Quality and Safety Concerns**
Management response to adverse events, including incident reporting	Substantiated
Documentation of treatment and care in health care records	Not substantiated
The Medical Emergency Team (MET) at Macarthur Health Service	Partially substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 21

Date of Incident Qtr 3, 2002

Summary of Incident **Incident No 21**

In mid 2002 Mrs P, an 85 year old amputee, was taken by ambulance to Campbelltown Hospital Emergency Department. Earlier that day she had been seen by her GP who performed ECG and pathology tests and diagnosed acute myocardial infarction. Mrs P was triaged at category 3 at 2022 hours. Her medical history included IDDM, hypertension and renal failure.

Mrs P had a referral from her GP which reported acute MI and chest pain. Investigations included Troponin 12.51. The assessing medical officer in ED documented "Sent in by LMO with ?acute MI ..... O/E not unwell, HR 90, SR HSD SEM BP 140/80". Nursing notes recorded at 2050 hours stated "Pt reports intermittent chest pain since Monday [4 days prior], patient vague about symptoms, states she feels nauseous when she gets chest pain, nil SOB on oxygen 6L/min. ECG attended and r/v by med reg. BSL 14.4 mmol."

The Area advised that the VMO Dr D23 saw Mrs P promptly and noted no evidence of CCF but evidence of possible UTI and renal failure possibly due to dehydration. The medical records obtained by the Commission do not have any entries by the VMO, however it is clear that the medical intervention was appropriate to UTI and not MI.

Mrs P was regularly monitored. Nursing notes between 2050 and 2300 hours document that the registrar reviewed the patient, ceased lasix and ordered admission to the medical ward, with 4 hourly observations. She was given maxalon 10 mg. Mrs P underwent limited pathology testing and chest xray. Potassium levels were 5.9 mmol/l. Resonium 30mg was administered. Mrs P reported being pain free.

At 0212 hours, 6 hours after presenting to ED, Mrs P's oxygen saturations were 94%. At 0607 hours the saturation was 95% on 3L oxygen.

The Area advised that the following morning, at 0850 hours, Mrs P was reviewed by the CMO and the Registrar. There is no evidence of this review in the medical records held by the Commission. Later that morning a MSU was carried out and the lab report stated "Results suggest a contaminated collection." At midday Mrs P was transferred to an unmonitored bed in the medical ward. The only documentation taken over the next couple of hours reports that Mrs P was tolerating food and fluid, and had no complaints.

At 1610 hours, 20 hours following her presentation to ED, Mrs P's BP was recorded at 93/42 with a HR of 80 and 100% saturations. She was positioned with raised legs and head lowered. At 1624 hours haemacel was commenced 200 ml bolus. Some time before 1700 hours BP was recorded to be 72/52, HR of 80. A MET was called and attended ECG was onducted and found possible left bundle branch block. The nursing notes document that the ICU Registrar had informed the RN that no beds were available in ICU. No specific resuscitation was conducted. Close monitoring was recommended and N/Saline 80 mls/hr was commenced.

At 1915 hours oxygen saturations were 77% on 12L via Hudson mask, BP was 83/52 and HR was 82. The MET was called again. A 300 ml bolus N/Saline was administered with an order for a further 50 ml/hr. Oxygen saturations increased to 90% on 12 L oxygen. A diagnosis of possible right ventricular infarct was made. The attending medical officer discussed the case with the Dr D23 and the patient was identified for transfer to ICU, central line CVP and if BSL increased, insulin infusion. The medical records do not indicate any active resuscitation was provided.

The patient remained in the medical ward until at least 2020 hours at which time her vital signs were BP 99/60, oxygen saturations 85% on 12 L oxygen. These is no further documentation on the patients status and so it is assumed that the patient died some time after 2020 hours. No details of time or location of death appear on the file. The death certificate records cause of death as acute myocardial infarction and cardiogenic shock of some days duration.

MHS advised that this case was not reviewed but that mechanisms now exist to ensure all MET calls and deaths are reviewed by the ASRT.

In response to the Commission's preliminary findings, the Area responded that the care provided to this patient was appropriate and that the Commission's benchmark was unrealistic.

Allegations by Informants	Location 1	Location 2
Incorrect diagnosis of UTI should have been admitted to monitored bed not the medical ward.	Campbelltown - Med Ward	
Inadequate assessment/treatment	Campbelltown - ED	Campbelltown - Med Ward
Failure to manage cardiac condition	Campbelltown - ED	Campbelltown - Med Ward

Issues Identified by HCCC	Location 1	Location 2
The Medical Emergency Team (MET) at Macarthur Health Service	Campbelltown - Med Ward	
Documentation of treatment and care in health care records	Campbelltown - ED	Campbelltown - ICU
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ED	Campbelltown - Med Ward
Communication with patients and families	Campbelltown - ED	Campbelltown - Med Ward
Patient decision making and planning for treatment, and end of life care	Campbelltown - ED	Campbelltown - Med Ward
Coordination and continuity of care	Campbelltown - ICU	Campbelltown - ED
Quality of clinical care provided by nursing staff	Campbelltown - ED	Campbelltown - Med Ward

Investigation into Macarthur Health Service Incident Review

Quality of clinical care provided by visiting medical officers	Campbelltown - ED	Campbelltown - Med Ward
Relationships and communication within and across clinical teams	Campbelltown - ED	Campbelltown - Med Ward

Clinical Review Panel Opinions **Incident No 21**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- The patient required ICU admission, not to the medical ward.
- No diagnosis of UTI was found.
- No clear management plan was evident.
- If plan was to treat MI, the patient should have been monitored.
- Regular blood tests, ECGs, agressive anti-coagulant therapy were required.
- There appears to have been an undocumented decision not to treat aggressively.
- Nursing documentation is grossly inadequate, very poor, intermittent.
- Medical documentation is patchy.
- There was a lack of involvement of VMO.

The Clinical Review Panel for ED commented:
- Diagnosis of UTI was given when the patient was transferred to the medical ward from ED. Prior to that time it was recognised that the patient had suffered MI. This indicates poor communication and continuity of care.
- Medical records appear to be missing or incomplete. Documentation is therefore lacking.
- There was no patient care plan.
- The patient was not managed as a cardiac patient ie she was not placed in a monitored bed.
- With nursing care four hourly observations were inadequate. Triage category of 3 was inappropriate.
- Positive care was the patient received anticogulant therapy and MET was called several times.
- Medical records appeared incomplete.

Panel opinion after considering area health service response:
Lack of management plan
Lack of documentation was a critical factor in this case
The conservative medical management of this patient may have been reasonable if there had been discussions with patient and significant others regarding end of life planning.
The initial decision to treat conservatively is at odds with discussions re ICU admission. However the panel acknowledge that a change in patient's circumstances can change clinical opinion

Commission Views and Comments **Incident No 21**

The Commision makes the following conclusions and comments:

1. The Commission concludes that the care provided to this patient was unsafe and inadequate for the following reasons:
a. The patient required but did not receive serial cardiac enzyme tests, strict fluid balance monitoring, cardiac monitoring, and inotrope support when she became hypotensive.
b. The drop in oxygen saturations and hypotensive readings overnight did not result in admission to ICU or a monitored bed or resuscitation treatment.
c. Lasix was ceased instead of being increased.
d. The quality and manner of medical management by the VMO and Registrar strongly suggests that a decision was made that the patient was not for active treatment or resuscitation, in the absence of any discussion with the patient or next of kin.
e. Four hourly monitoring of a critically ill patient was inadequate.

Re assessment, admission and management plan. These were not viewed by the Commission as they were not included in the medical records obtained by the Commission. It is noted that the Area's response refers to such documentation.

2. MHS failed to review and learn from an advserse event resulting in unexpected death. MHS has informed the Commission that the current quality system would automatically identify for review all MET calls and all deaths. The content of the Area's response to the Commission's preliminary findings raises concerns about the ability of MHS to appropriately identify causes of concern and identify effective systemic changes.

Outcomes **Incident No 21**

The Issue	Quality and Safety Concerns
The Medical Emergency Team (MET) at Macarthur Health Service	Substantiated
Documentation of treatment and care in health care records	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated
Communication with patients and families	Substantiated
Patient decision making and planning for treatment, and end of life care	Substantiated
Coordination and continuity of care	Substantiated
Quality of clinical care provided by nursing staff	Substantiated
Quality of clinical care provided by visiting medical officers	Substantiated
Relationships and communication within and across clinical teams	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 22

Date of Incident Qtr 2, 2001

Summary of Incident **Incident No 22**

Mr T, a 30 year old man, had a history of substance abuse and previous psychiatric admission to Hospital. In mid 2001 he was found in the street partially naked and hallucinating following consumption of hallucinogenics and large quantities of alcohol. His feet, legs and arms were lacerated. The police took him to Campbelltown Hospital Emergency Department at 1105 hours and he was triaged as category 3. 35 minutes later he was assessed by the ED medical officer. The psychiatric registrar Dr D24 was contacted and on the registrar's verbal advice the medical officer scheduled Mr T with a view to keeping him in ED overnight. The registrar informed the medical officer that there were no beds available in the psychiatric facility, Waratah House. The registrar appears to have done a bed search within SWSAHS but was unable to locate a bed elsewhere.

Over the next few hours a number of telephone calls took place between the VMO psychiatrist, psychiatry registrar, AHHM and ED staff. There was disagreement between staff regarding the psychiatric needs of this patient and the need or otherwise for psychiatric assessment. Sometime before 1700 hours (not time recorded) the psychiatric registrar attended ED and assessed Mr T. On the basis of the assessment transfer to Waratah House was ordered. At 2000 hours, 9 hours after being brought to ED, Mr T was transferred to Waratah House where he remained until discharged home 2 days later.

On the day of the incident a problem report was completed by a staff member . An internal review was initiated and within 7 days a report was prepared. The report did not make any recommendations but documented the time and order of events. 2 days later the matter was raised at the June Mental Health in Emergency Department Working Party meeting. No strategies or recommendations were documented in response to the incident despite the fact that problem reports had been submitted over the past year, identifying similar concerns. The Commission has copies of a large number of emails sent to management outlining staff concerns re the care of psychiatric patients in ED.

2 weeks after this incident another problem report was submitted. The problem form raised concerns over the failure of psychiatric staff to assess a patient in ICU - see incident 60.

MHS has informed the Commission that since May 2002 psychiatric registrar cover is available after hours. MHS also advised that it recognises the poor interface between Emergency Department and the psychiatric team and as a result since June 2002 the MHS General Manager has chaired the meetings of the Mental Health in Emergency Department Working Party. Compliance with NSW Department of Health recommendations is being measured. A service agreement between the Mental Health Service and Emergency Department was signed in March 2003, however the Commission has concerns regarding the level of consultation which occurred prior to the devising of such an agreement, and the appropriateness of the signatories to this agreement.

Allegations by Informants	Location 1	Location 2
No psych staff care	Campbelltown - ED	
Psychiatrist/Registrar reluctant to assess	Campbelltown - ED	

Issues Identified by HCCC	Location 1	Location 2
Management response to adverse events, including incident reporting	Campbelltown - ED	
Availability of and supervision by senior medical staff	Campbelltown - ED	
Relationships and communication within and across clinical teams	Campbelltown - ED	Campbelltown - Other

Clinical Review Panel Opinions **Incident No 22**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

- Scheduling over the telephone were unacceptable.
- Delay in patient assessment by the psychiatric registrar was unacceptable. After Hours Hospital manager should not have had to spend a couple of hours seeking psychiatric assessment and care.
- Systems issues and lack of ownership of the patient, poor relationship interface between ED and psychiatric team and inadequate management response.
- Management initial response in June 2001 was that the after hours Hospital manager (AHHM) visit Waratah House to increase their knowledge of mental health staffing issues. This strategy does not address the central issue of psychiatric service access standards.

Panel opinion after considering area health service response:

This case is typical of the difficulties that occur between ED and mental health in all hospitals. There is a statewide lack of psych beds. Some action has been taken by MHS to improve relations but there remains a lack of bridging between ED and mental health unit. The presence of a mental health nurse in ED would facilitate relations. Other strategies would include memoranda of understanding.
The care of the patient was poor. He required psychiatric care, but conflict between the services delayed this. It is acknowledged that a wait of 6 hours prior to psych assessment was not unreasonable.
Re the need for the psychiatry registrar to attend and review patient. It is acknowledged that at the time of the incident psychiatry registrars were not on call after hours. It is possible that the registrar may have had difficulty getting in.
The information provided to the ED medical officer was relevant. It was reasonable to schedule patient over the phone.
If the AHHM felt there were beds available at Waratah House, she could have visited to check.
The issues originally identified by the panel remain of concern. However the level of criticism is not severe.

Commission Views and Comments **Incident No 22**

The Commision makes the following conclusions and comments:

1. The Commission concludes that the care of the patient was unsafe and inadequate for the following reasons:
a. Psychiatric staff did not attend when requested resulting in a 6 hour delay for psychiatric assessment. During this time the patient did not receive any psychiatric care.

Investigation into Macarthur Health Service Incident Review

b. The patient was scheduled in Emergency Department and detained for some time before being transferred to the gazetted section of the Hospital, Waratah House. This is not in keeping with the Mental Health Act which specifies a person under a schedule must be transported with the schedule to the nearest gazetted Hospital.

2. The MHS failed to adequately and in a timely way implement the 1998 recommendations made by the Department of Health Working Group for Mental Health Care in Emergency Departments.

3. The actions taken by MHS in response to the event were inadequate for the following reasons:
a. The incident was reviewed and discussed at the appropriate venue within 10 days of the event, however no further action occurred for almost a year until MHS initiated a policy to roster psychiatric registrars after hours in May 2002.
b. Since the time of the event, some action has been taken to address the problematic interface between the two departments. A service agreement between ED and Mental health was signed in March 2003, however the inclusion of key staff including the ED mental health liaison person has not been apparent in documentation viewed by the Commission. As well the Commission has concerns regarding the appropriateness of the signatories to the service agreement.

Outcomes	**Incident No 22**
The Issue	**Quality and Safety Concerns**
Management response to adverse events, including incident reporting	Substantiated
Availability of and supervision by senior medical staff	Substantiated
Relationships and communication within and across clinical teams	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 23

Date of Incident Qtr 4, 2001

Summary of Incident **Incident No 23**

In late 2001, a 52 year old woman was taken by ambulance to Campbelltown Hospital emergency department with a recent history of three days of continuous sharp pain in the left flank. She had a history of hypertension. The previous day she had seen her general practitioner who prescribed amoxyl and voltaren. However during the night her pain increased.

On arrival at the emergency department, Mrs T was sweating and moaning. She was assessed by an ED locum medical officer who diagnosed renal colic and advised that, if pain continued, a chest x-ray should be taken. The locum medical officer outlined a management plan stating that if blood samples and urine tested normal, Mrs T could be discharged home. However if white cell count was elevated she would be admitted and treated for pyelonephritis. Haematology results showed mildly raised levels of white cells (15.8), neutrophils (12.3) and monocytes (1.3) and reduced haemoglobin (95).

Soon after arriving at the emergency department, Mrs T was administered morphine (5mg) and maxolon (10mg) and indocid (50mg). Over the next couple of hours ceftriaxone (1g) and gentamicin (240mg) were administered. Vital signs indicated hypotension and tachycardia with a pulse rate between 90 and 130. Nursing observations were taken only once in a six hour period and two apparent anomalies in blood pressure readings were not manually checked. The accompanying nursing notes were brief.

Ten hours after first presenting to the emergency department, Mrs T ate a meal. Dr D12, the medical officer who had taken over care, consulted the VMO Dr D4 by telephone and relayed that the patient was pain free, tolerating food and feeling well. On the basis of this information, the VMO agreed to discharge with follow up by the G.P. The actual time of discharge was not recorded. The discharge summary recorded a diagnosis of urinary tract infection and suggested follow up by the G.P.

Less than 16 hours later, Mrs T was brought back to the emergency department. She was confirmed dead on arrival. The matter was referred to the Coroner but the hospital did not obtain an autopsy report. We requested a copy of the Coroner's report which confirmed cause of death as 'Dissection of the thoracic aorta caused by aneurysm of left internal mammary artery, possibility of connective tissue disorder'.

In response to the critical incident, a nurse manager submitted a problem report and sent details of the incident directly to one of the senior hospital managers recommending the need for 24 hour medical registrar cover and suggesting a review of the incident by the critical care committee. The response from the senior manager was critical of the wording of the nurse's report and queried the need for medical registrar coverage.

The incident form was reviewed by an internal reviewer. Strategies identified by the reviewer included:
- the need for better documentation for nursing staff on the effects of treatment
- better monitoring of hypotensive patients
- closer observation of patients in cubicles
- ensure pathology results are reviewed before discharge.

The incident was reviewed by the critical care committee without the benefit of the Coroner's findings. As a result of the committee's review, the emergency nursing assessment form was revised and re-issued one year later. The revised form provided space for an assessment plan.

Allegations by Informants	Location 1	Location 2
Poor communication by staff		
Inadequate medical care (vital signs)	Campbelltown - ED	

Issues Identified by HCCC	Location 1	Location 2
Availability of and supervision by senior medical staff	Campbelltown - ED	
Notifications of deaths to the Coroner and decision making around post mortem	Campbelltown - ED	
Relationships and communication within and across clinical teams	Campbelltown - ED	
Management response to adverse events, including incident reporting	Campbelltown - ED	
Coordination and continuity of care	Campbelltown - ED	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ED	

Clinical Review Panel Opinions **Incident No 23**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

- The level of care was unsafe and unacceptable. The patient should not have been discharged, low BP and on morphine. There was no definitive action taken.
- Medical staff failed to act on vital signs of hypotension and tachycardia. There was poor communication between staff, and the patient file does not show any evidence of a clear handover.
- The patient should not have been discharged. Due to the administration of morphine and low BP. The patient was admitted under the Director of DEM. This is unacceptable as a Departmental Director is not able to review patients.

Investigation into Macarthur Health Service Incident Review

- Management should have reviewed this case. Indicators should have been picked up.
- Death required referral to Coroner.
- Systems Issues: poor teamwork, lack of supervision, inadequate management response.
- Positive aspects: observations were taken, however, these were not acted upon.

Panel opinion after considering area health service response:
On discharge patient remained hypotensive (BP 90) and tachycardic (PR 130).

Issues:
. She was always hypotensive and tachycardic.
. discharge not appropriate
. No VMO involvement.
. Hypotension not communicated to VMO.
. She should have been referred to Specialist Physician.
. No care plan.
. No evidence to support MHS response or their claims.
. This case was difficult to manage and to diagnose however the main point is that she should not have been discharged. She should have been kept in hospital for observation until her condition became more apparent. Keeping her in hospital may not have altered the outcome in that she may have died anyway, but the failure to admit patient is the difference between acceptable care and this care.

Panellists remain concerned over the issues previously identified.

VMO Registrar/Staff specialist availability - No evidence in notes of attendance. It does not appear from the notes that the VMO was provided with adequate feedback on the patient's status by the ED medical officers. The documentation on file is not helpful. Discharge of patients who require but do not receive VMO review is not uncommon.

Commission Views and Comments	**Incident No 23**

The Commision makes the following conclusions and comments:

The Commission found that the care provided to Mrs T was unsafe and inadequate for the following reasons:

1. The medical officers who attended Mrs T in the emergency department failed to recognise the severity of her condition:
• The admitting medical officer failed to recognise the significance of Mrs T's hypotension, despite the patient having a history of hypertension.
• The discharging medical officer failed to recognise the significance of the patient's ongoing hypotension and tachycardia.
• The medical officer should have arranged review by a senior medical officer.
• The medical officer should have kept Mrs T for observation with a view to transferring her to a tertiary facility if vital signs warranted.
• Nursing staff should have closely monitored the vital signs in the presence of hypotension and tachycardia.

The diagnosis of thoracic aortic dissection is difficult and it would not be expected that such a diagnosis could have been made in the 12 hour period following presentation. However, the patient's worrying vital signs meant that she should have been kept in hospital for further observation with a view to transfer to a tertiary facility if critical signs warranted.

2. The Commission considers the action taken by MHS in response to the event to be inadequate because:
• A full medical review of this incident was required but did not occur.
• The revision of the emergency nursing assessment form did not address the critical issues apparent in this case.
• The senior manager's informal response to the nurse who reported the incident was dismissive.
• Appropriate remedial strategies should have included those identified by the internal reviewer, but not acted upon by the CCC. Remedial strategies were required to ensure improved nursing monitoring and thorough documentation, improve communication between more junior medical officers and VMOs, including full documentation of that communication, and increase the presence of medical registrars in ED.
• The failure of MHS to adequately respond to this incident has resulted in the loss of an opportunity to improve the quality of safety.

It is understood that the Director of Medicine appointed in January 2003 is working closely with VMO physicians to ensure the timely review of patients.

Outcomes	**Incident No 23**
The Issue	**Quality and Safety Concerns**
Availability of and supervision by senior medical staff	Substantiated
Notifications of deaths to the Coroner and decision making around post mortem	Substantiated
Relationships and communication within and across clinical teams	Substantiated
Management response to adverse events, including incident reporting	Substantiated
Coordination and continuity of care	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No **24**

Date of Incident Qtr 1, 2002

Summary of Incident **Incident No 24**

Mrs J was an 84 year old woman in the Medical Ward at Camden Hospital. In early 2002 she fell next to her bed in the middle of the night. She was noted to have a decreased level of consciousness initially but no loss of consciousness.

Dr D7 who was a locum CMO working in the ED was called to review Mrs J. Two RNs including N7 allege Dr D7 recorded an examination in the patient notes when he had visited Mrs J but had not examined her.

Mrs J required a MET call the following morning. Examination and X-Ray also determined that Mrs J had a pelvic fracture.

Nurse N7 submitted a Problem Report to her NUM, N1 the same day as the incident. The following day (Day 2) N1 sent an email to the Director of Emergency Services, the Medical Director and the Director of Nursing and Acute Services Continuum. Nurse N1 had already started to investigate the incident but was told by the Nurse Manager at Camden Hospital that she should cease her investigation.

The Director of Nursing and Acute Services Continuum replied to N1's email saying that N1 should have only notified the Nurse Manager at Camden Hospital. The Director said clinical quality issues are the responsibility of the continuums.

On Day 4 the Manager of the Emergency Department interviewed Dr D7 and he admitted he did not do a thorough examination. On Day 5 N1 submitted a Problem Report to management in relation to the lack of clarity in procedures and boundaries in responding to reported incidents. On Day 16 the Director of Emergency Department sent a memo to the Medical Director of Health Services outlining the incident and requesting further action. On Day 29 the Quality Manager, Acute Services requested an interview with N1 in relation to the incident.

On Day 381 the MHS Acute Services Review Committee reviewed the incident and concluded that the patient was managed appropriately and no further action was required.

Allegations by Informants	Location 1	Location 2
MHS failed to provide guidelines for reporting concerns	Camden - Other	
MHS failed to suspend the locum	Camden - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
Management response to adverse events, including incident reporting	Camden - Med Ward	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Camden - Med Ward	

Clinical Review Panel Opinions **Incident No 24**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- The allegation against Dr D7 is a very serious allegation.
- There appears to be a sticker placed over the Dr's notes in the medical record which in itself is a serious irregularity.
- Dr D7 missed a pelvic fracture at the time he claims to have examined Mrs J.
- Management failed to conduct an adequate incident investigation in response to a serious allegation made by nurses.
- MHS management should not have allowed Dr D7 to work in the MHS again until the investigation of the incident had been completed.
- MHS management should have contacted the locum agency that provided the doctor.
- The doctor and MHS response to the incident should be assessed for further investigation.

Commission Views and Comments **Incident No 24**

The Commision makes the following conclusions and comments:

1. The Commission concludes that the care provided to Mrs J was unsafe and inadequate as she did not receive a timely medical assessment after a fall.

2. Management failed to conduct an adequate incident investigation in response to a serious allegation made by a registered nurse and her NUM.

3. The Director of Emergency discussed the incident with Dr D7 three days after the incident however no conclusions appear to have been drawn. The Commission understands Dr D7 is no longer employed at the hospital.

4. MHS management should have contacted the locum agency and notified them of the incident.
5. There was a dispute between Nurse N1 and the Nurse Manager at Camden Hospital about who should investigate the allegation. Nurse N1 did not comply with the established procedure and did not accept the authority of the Nurse Manager to allocate the responsibility for investigating the incident.

6. There was an unacceptable delay (381 days) before this incident was reviewed by the Acute Services Review Committee.

Outcomes **Incident No 24**

The Issue	**Quality and Safety Concerns**
Management response to adverse events, including incident reporting	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 26

Date of Incident Qtr 1, 2002

Summary of Incident **Incident No 26**

Mrs C, aged 84, was a patient in Camden Hospital Medical ward in early 2002. She had a slow gastro-intestinal bleed and required blood transfusions every couple of days. She required 30 units of blood at Camden hospital.

Mrs C's admitting VMO, a gastroenterologist, Dr D9 arranged two endoscopic examinations, a colonoscopy and a red blood cell scan which showed active bleeding in her proximal small bowel. Dr D9 did not arrange for a surgical review.

Mrs C became haemodynamically unstable on the 18th day of her admission. A senior nurse, N1 made a number of approaches to management requesting a transfer for Mrs C to Campbelltown Hospital.

After 30 days in Camden Hospital Mrs C was transferred to Campbelltown Hospital for 9 days where she required a further 9 units of blood. She was then transferred back to Camden Hospital for one day.

Mrs C was transferred back to Campbelltown Hospital again for surgical review of a suspected bowel obstruction. Six weeks after her admission to Camden Hospital a laparotomy and small bowel resection addressed Mrs C's gastro-intestinal bleeding. She had an enlarged liver with metastases and metastases scattered throughout the abdominal cavity and she died two weeks later.

A senior nurse at Camden Hospital expressed concerns in writing to MHS management about the appropriateness of Mrs C remaining a patient at Camden Hospital given that there was no anaesthetic or surgical cover there. She suggested that Camden Hospital required an admission policy that recognised the limited resources available there. She also suggested that senior nurses require access to a formal avenue to express urgent concerns about patient safety. MHS did not respond to the nurse's concerns.

MHS has advised the Commission that a dedicated patient transport service between Camden Hospital and Campbelltown Hospital has been implemented since this incident.

Allegations by Informants	Location 1	Location 2
Management did not address staff concerns	Camden - Med Ward	
Inappropriate delay before surgical review	Camden - Med Ward	
Failed to call MET x3	Camden - Med Ward	
No admissions policy for Camden Hospital	Camden - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
Patient decision making and planning for treatment, and end of life care	Camden - Med Ward	
Coordination and continuity of care	Campbelltown - Med Ward	Camden - Med Ward
Management response to adverse events, including incident reporting	Camden - Med Ward	
Availability of and supervision by senior medical staff	Camden - Med Ward	
The Medical Emergency Team (MET) at Macarthur Health Service	Camden - Med Ward	
Patient transfer to higher level units or hospitals	Camden - Med Ward	
Quality of clinical care provided by visiting medical officers	Camden - Med Ward	

Clinical Review Panel Opinions **Incident No 26**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- Mrs C became haemodynamically unstable on the 18th day after her admission to Camden Hospital and endoscopy had not discovered the cause of her GI bleeding. From this time on it was inappropriate for Mrs C to remain at Camden Hospital and she should have been transferred.
- It was unacceptable to transport Mrs C to Campbelltown Hospital for a surgical review. A surgical review should have been done at Camden Hospital.
- There was not a clear case plan for her management in her medical notes.
- Overall the approach to Mrs C's treatment was much too slow.
- The patient and her family put pressure on the team to keep Mrs C at Camden Hospital and not transfer her to Campbelltown.

In relation to systems/management issues, the Panel made the following comments:
- It was unacceptable for the Hospital management to interfere in clinical issues by instructing the NUM, N1 not to contact the VMO.
- This incident illustrates a pattern of communication in which the nursing staff cannot contact the VMOs but have to try to badger the RMOs to contact the VMOs.

Panel Opinion after considering SWSAHS response:
- The system depends on transport from Camden to Campbelltown being available. Transport was not available.
- Surgical review was requested before Mrs C became unstable.
- The admitting physician should have documented his efforts to obtain a surgical consult.
- A GI surgeon should have been involved much earlier at least by the 18th day of admission.

Investigation into Macarthur Health Service Incident Review

Commission Views and Comments	Incident No 26

The Commision makes the following conclusions and comments:

The Commission concludes that the care provided to Mrs C was unsafe and inadequate for the following reasons:
1. Overall the approach to Mrs C's treatment was much too slow.
2. Mrs C became haemodynamically unstable on the 18th day after her admission to Camden Hospital and endoscopy had not discovered the cause of her GI bleeding. From this time on it was inappropriate for Mrs C to remain at Camden Hospital and she should have been transferred.
3. It was unacceptable to transfer Mrs C to Campbelltown Hospital for a surgical review. The surgeon should have come to Camden Hospital to review her.
4. There was not a clear case plan for her management in her medical notes.
5. The teams at Camden and Campbelltown Hospitals should have detected Mrs C's terminal cancer at an earlier stage and offered her palliative care. There was no end-of-life care planning evident in the medical record. Given Mrs C's condition this was a considerable oversight.

In relation to the response to this incident by MHS management, we are of the view that:
1. MHS did not respond appropriately to significant concerns expressed in writing by a senior nurse at the time of the incident.
2. The provision of the necessary transport by MHS is only one aspect of the problem. The more significant aspect is accurate clinical assessment and a prompt decision to transfer the patient to an acute care facility offering surgical review and management.
3. We note that Mrs C and her family put pressure on the team to keep Mrs C at Camden Hospital and not transfer her to Campbelltown.

Outcomes	Incident No 26
The Issue	**Quality and Safety Concerns**
Patient decision making and planning for treatment, and end of life care	Substantiated
Coordination and continuity of care	Substantiated
Management response to adverse events, including incident reporting	Substantiated
Availability of and supervision by senior medical staff	Substantiated
The Medical Emergency Team (MET) at Macarthur Health Service	Substantiated
Patient transfer to higher level units or hospitals	Substantiated
Quality of clinical care provided by visiting medical officers	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 27

Date of Incident Qtr 2, 2000

Summary of Incident **Incident No 27**

This incident was identified from new information provided to the HCCC on 25 Nov 2003. Until that time it had been deleted as a duplicate of Incident #5. The details of this incident were entered onto the MHS Incident Database on 1 December 2003.

The informant alleged that management criticsed her for calling a medical emergency when it was not warranted. The informant stated that a child had been admitted to the childrens ward via ED. At about 11pm the informant noticed the mother holding the child who was white, floppy, tachycardic, tachypnoeic and febrile. HR was 190 bpm and RR was 130/min and the informant allegedly called a medical emergency.

A review of the child's medical records indicate the following:
Child presented to ED at 1859 hours and was triaged at category 3 and seen 21 mintues later. On examination the child had a temperature of 38.5, PR 112-136 and RR 40-48/min. Oxygen saturations were 92-93% on room air and 98% on 6L oxygen via a face mask. Some time before 2130 hours (time not recorded) the child was assessed by the senior registrar. Documentation indicates that the RMO could not be contacted and so the paediatrician was telephoned. The paediatrician instructed that the registrar should be called to attend.

The registrar documented RR 96-100, HR 180 bpm, intercostal recession, nasal flaring, tracheal tug, grunting, and ordered:
. intravenous antibiotics
. ventolin via a nebuliser
. transfer by NETS to the children's hospital

At 2130 hours the NETS team arrived and at 0030 hours the child was transferred out.

This case was reviewed by the Director of Paediatrics and two paediatricians, 6 months after the incident. It was determined that the child's deterioration was typical of her chronic medical condition and in no way related to any lack of care in ED.

Allegations by Informants	Location 1	Location 2
Staff criticised for calling emergency		
Medical Emergency was needed		

Clinical Review Panel Opinions **Incident No 27**

This case was not reviewed by the Clinical Review Panel. The Commission's medical adviser reviewed the medical records and made the following comments:
Child's respiratory rate following presentation to ED would fulfil MET criteria
PR increased to 180 at about 2100 hours
Intervention provided by senior registrar was appropriate with arrangements made for transfer to childrens hospital which took place 3 hours later
The child's condition deteriorated between arrival at ED and transfer to the childrens ward. Once intervention was provided by the registrar, it was prompt and appropriate
The VMO was contacted by the SRMO, the CNS and the Registrar to discuss the case
A medical emergency call was appropriate during the period between her assessment in ED and her arrival in the childrens ward

Commission Views and Comments **Incident No 27**

The Commision makes the following conclusions and comments:

The Commission was unable to identify the patient in this case until after it had completed its investigation. The MHS therefore has not had the opportunity to respond to it, and it was not reviewed by the CRP.

The Commission's view is that the care provided to the child was appropriate, and that the extreme vital signs did indeed warrant a medical emergency call.

The allegation that the nurse was inappropriately criticised for calling a medical emergency has not been investigated. No finding is able to be made in this case.

Investigation into Macarthur Health Service Incident Review

Incident No 28

Date of Incident Qtr 4, 2002

Summary of Incident **Incident No 28**

The informant alleged:
In late 2002 a patient was admitted to Camden ED, transferred to Campbelltown a significant time later, required bowel resection. On return to Camden Hospital her IV fluids were empty with no further orders. A nurse requested medical review however the CMO stated he would not review the patient in the near future because she had already been reviewed at Campbelltown Hospital. The patient deteriorated and was transferred back to Campbelltown Hospital. (A specific date was provided by the informant.)

On 23/5/03 the Commission sought further details from the informant to assist identification. No further information could be provided.

On 12/6/03 SWSAHS queried whether this was actually a replication of incident #34. SWSAHS was not able to provide a closer match of the description.

Clinical Review Panel Opinions **Incident No 28**

Commission Views and Comments **Incident No 28**

The Commision makes the following conclusions and comments:

This incident was not able to be identified and so was not investigated.

Investigation into Macarthur Health Service Incident Review

Incident No **29**

Date of Incident No Date Identiied

Summary of Incident **Incident No 29**

The following information was provided by informant.

Male aged 45-50 years. Admitted for Cholecystectomy. At around 2300 hours the patient's BP dropped and the ICU doctor attended and ordered cessation of the patient's hypertension medication. At 0200 the nurse attempted to take a BP, but it was not recordable. MET was not called.

The man's wife was worried about his condition and stayed with him all night. When she tried to wake him at around 0630 hours she was unable to do so. "He was found in full-on cardiac arrest." He could not be resuscitated.

MHS advised the Commission that there has only been one death of a male patient on Christmas Day at Campbelltown Hospital in the last four years and the details do not fit with the information provided regarding this incident. Ward G has only been a surgical ward since 2002.

On 23/5/03 the Commission asked the information to provide any further information. No further information was forthcoming.

On 12/56/03 SWSAHS advised that the identity of the patient could not be established.

Allegations by Informants	Location 1	Location 2
Failure to refer to the Coroner		
Failure to call MET		
Lack of competence of RN attending		

Clinical Review Panel Opinions **Incident No 29**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- This case is illustrative of several potential issues although the exact details are not known.
- MET call must be made if criteria are met. If inappropriate MET calls are made, then criteria should be revised rather than ignored by staff.
- On the basis of the information available, this should have been referred to the Coroner.
- If death was due to thromboebolism then the policy regarding prophylaxis needs to be examined in the light of any international/Australian data on the risks/benefits of prophylaxis in different types of surgery.

Commission Views and Comments **Incident No 29**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No 30

Date of Incident Qtr 3, 2000

Summary of Incident **Incident No 30**

Mrs KT, a 38 year old woman presented to Campbelltown Emergency Department (ED) in mid 2000 at 1944 hours with a history of chest pain radiating down her left arm for 3 days. Her GP gave her panamax for pain without effect. Her medication was captopril, cordarone, lasix, panafortelone, slow K, losec and warfarin. On admission her BP was 120/79, PR 90, RR 22. T 37.3C, SaO2 95%, and GCS 15. The triage nurse noted that Mrs KT was not aware of a cardiac condition. Mrs KT was assessed by the triage nurse as category 3, requiring that she be medically assessed within 30 minutes.

Mrs KT was assessed by the ED doctor (D41) at 2000 hours who noted her history included systemic lupus erythematosis, mitral valve stenosis, pulmonary hypertension, peripheral vascular disease and atrial fibrillation. The ED doctor's provisional diagnosis was unstable angina pectoris. He ordered anginine and aspirin and noted that the pain slightly improved after taking these. He ordered chest x-ray and pathology including serial cardiac enzymes and coagulation studies. ECG showed normal sinus rhythm and no acute signs. The ED doctors' admission notes indicate that requests were made for a monitored bed and review by a medical registrar. The medical record indicates that during the time Mrs KT was in the ED, her vital signs were taken at 1945 hours and 2020 hours. There is a notation that Mrs KT's VMO (D4) was contacted who ordered that her steroids. Mrs KT was transferred to a medical ward at 2250 hours.

There was some concern that Mrs KT should have been sent to a monitored bed. However, as the VMO later explained, in view of his knowledge of Mrs KT's progress and the results of previous investigations, there was no need for a monitored bed. In the care of Mrs KT the VMO referred to his involvement and management of Mrs KT since 1996. He described in some detail his close monitoring of Mrs KT's complex clinical condition since that time. In respect of the comment by the Commission that further investigation were indicated the VMO stated that during 3 years under his care Mrs KT had been extensively and comprehensively investigated and aggressive treatment had been employed. The VMO stated that he had discussed the management plan for Mrs KT with the registrar, and refutes any suggestion by the Commission that there was inadequate assessment, investigation, treatment plan and lack of leadership in the care of Mrs KT.

In reference to the suggestion that Mrs KT should have been referred to a tertiary hospital in view of her complex history, the VMO responded that the there was no indication in Mrs KT's presentation that she should be transferred to a tertiary hospital. He stated that warfarin had been prescribed for Mrs KT to manage her pulmonary hypertension, and that there was no reason to refer her to a haematologist as suggested by the Commission.

The medical record indicates that during her 4+ days hospitalisation Mrs KT's vital signs were taken 14 times at around 4 hourly intervals. Mrs KT was ordered warfarin on admission at around 2000 hours. However, she did not receive her first dose until the afternoon of day 2. On day 2 of her admission, the VMO diagnosed possible serositis as the cause of Mrs KT's chest pain and recommended a cardiac echo if pain did not settle. However, Mrs KT had no complaints on the ward until day 3 when she vomited at 0515 hours. At 1400, 1939 and 2230 hours on day 3 and at 0300 hours on day 4, she complained of headache but was not reviewed by a medical officer. At 0410 hours Mrs KT was found dead in bed with frothy exudate from her mouth.

The Commission was of the view that an autopsy should have been performed or the death referred to the Coroner as there had been no clear diagnosis and the death had been unexpected. However, the VMO has advised that an autopsy had been requested and when the family refused to agree, he felt ithat there was so little doubt about the cause of her death that it was inappropriate and unnecessary to add to the distress of the family by referring the case to the Coroner.

Having reviewed the medical record and response from the VMO the Commission is of the view that, under the circumstances, the care of Mrs KT was in the main adequate in respect of VMO and RMO care and clinical management. The Commission has received advice from a consultant VMO that Mrs KT could still have had a pulmonary embolism although receiving warfarin, and that given Ms KT's clinical condition transfer to a tertiary hospital was not indicated.

In respect of referring for an autopsy, the views of the medical practitioners advising the Commission are divided. The explanation given by the VMO that in the context of his knowledge of Mrs KT's, and he was reluctant to add to the distress of the family was considered by some to be reasonable. However, the Commission is of the view that there remain questions about the cause of Mrs KT's death.

Mrs KT had been admitted with a three-day history of chest pain. This pain was diagnosed as serositis and appeared to settle with high dose steroids. For two days prior to her death, her main complaint was headache of unknown origin. In view of this the Commission considers that it would have been appropriate to refer to the Coroner even though the family was not agreeable to this in order to establish the cause of death.

Allegations by Informants	Location 1	Location 2
Failed to act with c/o chest pain, Lack of obs	Campbelltown - Med Ward	
Failed to refer to Coroner	Campbelltown - Med Ward	
Failure to refer to ICU, no clinical investigations	Campbelltown - ED	Campbelltown - Med Ward
Should have been under close monitoring	Campbelltown - Med Ward	
Not seen for days by a doctor	Campbelltown - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
Management response to adverse events, including incident reporting	Campbelltown - Med Ward	
Recognition and response to critically ill patients	Campbelltown - Med Ward	
Notifications of deaths to the Coroner and decision making around post mortem	Campbelltown - Med Ward	
Coordination and continuity of care	Campbelltown - Med Ward	Campbelltown - ED
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - Med Ward	

Investigation into Macarthur Health Service Incident Review

Quality of clinical care provided by visiting medical officers	Campbelltown - Med Ward	
Quality of clinical care provided by nursing staff	Campbelltown - ED	
Availability of and supervision by senior medical staff	Campbelltown - ED	Campbelltown - Med Ward

Clinical Review Panel Opinions **Incident No 30**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- The patient should not have been admitted to Campbelltown as she had a history of cardio-vascular problems and lupus.
- There appears to have been no co-ordinated management of the patient.
- There was inadequate recognition of patient's condition and planning management
- There was concern with ED management - Inadequate planning and recognition of condition
- There was concern re VMO/Registrar coverage
- There was failure to refer to ICU
- There was inadequate assessment, investigation, treatment by VMO, lack of leadership by VMO.

The Clinical Review Panel for ED made the following comments:
- This was an inappropriate admission to Camden given the lack of ability to manage complex cases. It is noted that the medical record was not available at the time to identify Campbelltown as the Hospital.
- There was lack of assessment.
- There were inappropriate nursing observations.
- There are some concerns about the standard of the clinical assessment and managements review of the patient and the patient should have gone to a monitored bed.

The CRP in forming their opinions reviewed information provided by the informants and a chronological summary provided by MHS re Mrs KT. Medical records were not available and were reviewed by the HCCC medical advisor and Commission officers.

Panel opinion after considering area health service response:
The response from treating Rheumatologist was meticulous and reflected his long professional relationship with the patient since 1996.
In view of the information provided by the Rheumatologist, who is in the best position to know the patient, the panel has altered its previous opinion. Thorough investigations had been done previously and the decision to send the patient to the general ward was reasonable given the special confidence that the patient did not have chest disease.
The patient had been well worked-up previously. She was seen in Rheumatologist's rooms a few days prior to her death. It seems they were looking for a response to the steroids. It is likely that she had an intra-cranial accident.
She could have had cerebral lupis.
Referral to coroner would be recommended. Even though the death was ultimately caused by lupis, this should be confirmed and narrowed down.
In view of the complexity of this case, a second opinion was sought from a Consultant Rheumatologist. The consultant raised some minor concern about the failure to ensure the patient received regular warfarin, evidenced by a period of 46 hours when she did not receive it.

Commission Views and Comments **Incident No 30**

The Commision makes the following conclusions and comments:

Our findings:
- If the facility was available, Mrs KT should have had a pulmonary angiogram or spiral CT within a 24-hour period, if none were available, the investigations should have been organised and Mrs KT transferred.
- More frequent observations were required and perhaps 24-hour monitoring of SaO2 and raises questions about the quality of nursing care.
- On the basis of the information available, it would have been desirable but not essential for Mrs KT to be in a monitored bed in order to have her parameters checked 4 hours.
- As the cause of death is not known, the case should have been referred to the Coroner.

The CRP in forming their opinions reviewed information provided by the informants and a chronological summary provided by MHS re Mrs KT. However, medical records were not available to the Clinical Review Panel and only a chronology of events provided by MHS was available for review by Commission officers.

Outcomes **Incident No 30**

The Issue	Quality and Safety Concerns
Management response to adverse events, including incident reporting	Not substantiated
Recognition and response to critically ill patients	Not substantiated
Notifications of deaths to the Coroner and decision making around post mortem	Substantiated
Coordination and continuity of care	Not substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Partially substantiated
Quality of clinical care provided by visiting medical officers	Not substantiated
Quality of clinical care provided by nursing staff	Substantiated
Availability of and supervision by senior medical staff	Not substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 31

Date of Incident No Date Identiied

Summary of Incident **Incident No 31**

Information from informant.

In late 2001, transfer of deceased patient to morgue from Pallative Care while uncovered. There were visitors and young children in area while occuring. A specific date was provided by the informant.

On 12/6/03 SWSAHS advised that the identity of patient could not be established.

Allegations by Informants	Location 1	Location 2
Deceased patients moved to mortuary uncovered in presence of visitors		

Clinical Review Panel Opinions **Incident No 31**

Not reviewed by CRP

Commission Views and Comments **Incident No 31**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No 32

Date of Incident Qtr 1, 2001

Summary of Incident **Incident No 32**

Information from informant.

In early 2002, transfer of deceased patient to morgue from Pallative Care while uncovered. Visitors and young children in area while occuring. A specific date was provided by the informant.

On 12/6/03 SWSAHS advised that the identity of patient could not be established.

Allegations by Informants	Location 1	Location 2
Deceased patients moved to mortuary uncovered in presence of visitors		

Clinical Review Panel Opinions **Incident No 32**

Not reviewed by CRP

Commission Views and Comments **Incident No 32**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No 33

Date of Incident Qtr 4, 2001

Summary of Incident **Incident No 33**

Mrs V was a 70 year old woman who was brought to Camden Hospital emergency department by ambulance in late 2001. She had been found unconscious on the floor at home following a suicide attempt. She had taken an overdose of an unknown quantity of prescription medication which, according to her husband, was most likely to have been temazepam and MS Contin. Her regular medications were MS contin, temazepam, capadex, warfarin, prothiadin and provera. Her past history included spinal surgery for successful removal of aplasmacytoma in the thoracic region.

At triage she was found to be stuperose with a GCS of 8 and to have an occipital haematoma. Her blood pressure was 153/87, pulse rate 104/min and temperature 34.2 degrees.

Mrs V was assessed by a CMO Dr D42 whose admission lacks any systems examination or management plan. Oxygen was administered by Hudson mask at 6 litres per minute. At 0015 and 0035 hours she was given 0.3 mgs IVI of anexate, a benzodiazepine antagonist. She remained stuperose. Mrs V was given Narcan 0.4 mgs at 0540 hours and again at 0700 hours. At 0830 hours Mrs V was incontinent of faeces and vomited and was given IVI maxalon despite a record of allergy to this drug. Her GCS remained between 8 and 9 all morning.

At 1200 hours it was decided by an ED medical officer to send Mrs V to Liverpool Hospital for a head CT to exclude intracranial pathology. At this stage Mrs V had had no pathology taken or drug screen ordered. She had had skull and cervical spine x-rays which were normal.

At 1320 hours, 15 hours after initially presenting to ED, Mrs V was transported by ambulance with nurse escort to Liverpool Hospital for a CT scan of the brain. The patient's airway was not secured for this trip, despite an entry just before transfer which notes 'only responding to painful stimuli'. The brain scan was negative and Mrs V was transferred back to Camden Hospital ED with a GCS of 9.

At 2231 hours on day 2, when Mrs V had been in hospital for 24 hours with a GCS of 9, an ED medical officer finally ordered FBC, EUC, BSL and LFTs. The VMO was contacted about this patient for the first time. The VMO Dr D9 suggested admission to a ward and IV fluids. Despite reluctance on the part of the medical ward RNs to accept a patient whose GCS had been 8-10 for more than 24 hours, it was agreed in consultation with the VMO Dr D9 that this transfer to the ward should proceed.

At 2340 hours, just before ward transfer, Mrs V's blood pressure was 92/41, pulse rate 68 and oxygen saturation was 100%. Nursing notes recorded by medical ward staff document concern that there was no evidence of a drug screen on the file. A phone call was made to emergency department staff who verbally advised that a toxicology screen had been done in Liverpool Hospital. However a check of the computer system showed no evidence that the screen had been carried out.

On the morning of day 3 at 0930 the VMO finally assessed the patient and outlined a treatment plan.
This plan stated - NBM, IV fluid maintenance, Repeat FBC, U/E/C, LFT, BSL, Calcium today, INR clexane 60 mg BD SCI (was on warfarin 2.5 mg nocte), Continue neuro obs 4 hourly, nursing care – regular turning, care of pressure areas, strict fluid balance chart, urine for drug screen.

From the afternoon of day 3 Mrs V gradually became less drowsy. On the morning of day 4 the intravenous drip was removed. The VMO reviewed Mrs V and recorded that she was alert and orientated, bowels recently opened, denies pain. The VMO recommended early psychiatric follow up by the patient's psychiatrist and nursing arranged an appointment with the psychiatric registrar for the following day. A social work assessment was carried out (time not recorded). The catheter was removed at lunchtime and several hours later Mrs V was discharged home in the care of her family.

The NUM of the medical ward raised concerns about the management of this patient. An internal review by MHS Director of Emergency Medicine was conducted in November 2001, six weeks after the incident. The Director prepared a detailed report which was critical of the medical management of Mrs V. The report criticised the actions of the ED Medical Officer for failing to secure the airway with oral tracheal intubation before and during transportation, for failing to ensure cervical spine precautions in the presence of head injury, for failing to x-ray the cervical spine, for failing to arrange immediate drug testing, ECG, chest x-ray and CT brain scan. The Director concluded that the patient should have been transferred to an ICU immediately after assessment, and questioned the decision to transfer her back to Camden from Liverpool Hospital after the CT scan. The Director was highly critical of the administration of anexate in the setting of a mixed overdose, stating that anexate should be reserved for patients with an isolated known and confirmed benzodiazepine overdose. The Director noted that at no point was a VMO or consulting specialist involved. Nursing notes were considered adequate but lacking a proactive approach. Despite her recorded allergy to maxalon, this was administered to the patient. The Director of EM wrote in his report 'overall this patient received grossly inadequate and inappropriate care.'

The specific recommendations made by the Director were:
- thorough review of case with the relevant MO
- teaching session for nursing and medical staff at Camden Hospital addressing initial management of poisoned patients
- in-service on the use of anexate for nursing and medical staff at Camden Hospital
- review of existing mechanisms to facilitate ED staff access to patient care plans
- review by the critical care review committee (CCRC) for further action.

In March 2002 the Acute Services CCRC recommended:
- education on the use of anexate
- compulsory education on management of critically ill patients
- ascertain why appropriate facility was not located for Mrs V
- case to be presented at medical council or grand rounds.

A memorandum of mid 2002 reported that education had been provided to CMOs and nurses on the use of benzodiazepine antagonists in the setting of overdoses.

Two months later the executive committee of MHS tabled a document that proposed changes to patient flow. They proposed that all acute

Investigation into Macarthur Health Service Incident Review

medical patients should be admitted or transferred to Campbelltown Hospital from both Campbelltown and Camden EDs, and that all Campbelltown patients awaiting transfer to nursing home, rehabilitation or palliative care should be transferred to Camden Hospital. The aim was to reduce the adverse events occurring in Camden Medical Ward and to ensure better resources for acute care patients.

Since July 2002 acute patients are no longer admitted to Camden Hospital but the emergency department continues to operate.

In January 2003 a Staff Specialist, Director of Medicine was appointed by MHS. A clinical professor has also been employed on a full time basis. MHS advised that the professor is currently conducting a review of the role and function of medical services across MHS and that the findings are to be reviewed by the clinical advisory council. Timeframes for the review and actions were not identified.

In October 2003 MHS responded to criticisms by the Commission. Their response stated that the benchmarks we applied were unrealistic.

The comments by MHS included the following:
• The administration of anexate at the time of admission was not inappropriate. This was proven by the fact that the following day Mr V confirmed that his wife had in fact overdosed on benzodiazepines.
• Although the patient had an allergy to maxalon which was administered to her intravenously, maxalon allergy is extremely uncommon.
• The administration of maxalon did not result in any adverse effect in this case.
• Staff did not feel intubation was required at the time of transportation to Liverpool because airway maintenance was adequate. The patient was transported with a paramedic who would have been able to tube her if necessary.
• The ICU registrar at Liverpool Hospital did not instruct for the patient to be intubated and ventilated.
• The delay of $3^{1}/_{2}$ months between the internal clinical review and the review by the CCRC was not unreasonable given that the meetings are monthly, and Christmas fell within the $3^{1}/_{2}$ months.

MHS did not involve the Director of EM in the process of providing a response to our findings. Yet the Director of EM had been involved in the internal review at the time of the incident and had made findings similar to those of the Commission.

Allegations by Informants	Location 1	Location 2
Poor medical management	Camden - ED	
Admission to general ward inappropriate	Camden - ED	

Issues Identified by HCCC	Location 1	Location 2
Availability of and supervision by senior medical staff	Camden - ED	
Patient transfer to higher level units or hospitals	Camden - ED	
Quality of clinical care provided by visiting medical officers		
Recognition and response to critically ill patients	Camden - ED	
Quality of clinical care provided by nursing staff	Camden - ED	
Management response to adverse events, including incident reporting	Camden - ED	Camden - Med Ward
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Camden - ED	

Clinical Review Panel Opinions **Incident No 33**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
• The medical management at ED was inappropriate and it is fortunate that the patient survived.
• The airway should have been secured.
• Maxolon should not have been administered as documentation indicated she was allergic to it.
• Bloods and toxicology should have been tested.
• There was poor observations throughout by nursing.
• The patient should not have been returned to Camden Hospital following transfer to Liverpool for CT scan. The Panel questioned Liverpool's actions in relinquishing responsibility for the patient in this way.
• The patient should not have been transferred to the general medical ward at Camden Hospital.
• The systemic issue identified was lack of supervision of apparently junior staff.
• The Management response was poor and failed to recognise significant factors. There was no attempt to address the issue of poor airway management or supervision.
• Camden Hospital should not offer an Emergency Department as it is unable to manage acute patients on the ward, as evidenced by MHS policy to cease acute admissions (2002).
• A positive aspect was the patient was triaged well.

The Panel opinion after considering the area health service response:
The patient was fortunate re the outcome
Area response disregarded the Director of EM's review and report
Re Transfer: Failure to intubate. Area's response has overridden the clinical opinion of the Director EM. This is of concern.
You could not assume what she had taken.
Why give her anexate - to temporarily bring levels up.
No indication of terminal illness or palliative care patient despite MHS making much of this

Investigation into Macarthur Health Service Incident Review

Area response causes much concern. In view of Area's comments and the fact that they ignored the views of Director EM, there is concern re their ability to change the system.

Commission Views and Comments	**Incident No 33**

The Commision makes the following conclusions and comments:

The Commission found that the care provided to Mrs V was unsafe and inadequate for the following reasons:

1. In relation to the care provided by the emergency department:
• The administration of anexate and maxalon were inappropriate and could have had serious consequences.
• The patient's airway should have been secured, particularly when she was transported to Liverpool Hospital.
• The toxicology report should have been available for ward staff to view.
• The patient should have been admitted to an intensive care unit, not a general medical ward.
• No attending medical officer was contacted about this patient's admission.
• It does not appear that the VMO was contacted about this patient until 24 hours after her arrival at ED. The VMO saw her the following morning, 36 hours after her arrival.

2. In relation to the care provided by senior medical clinicians:
• Inappropriate for a stuperose and hypotensive patient with a GCS of 8-10 to be admitted to a ward, against the advice of the RNs.
• When the VMO agreed to admission to the ward, no drug screen or pathology results were available.
• The patient was not seen by a senior medical clinician until day 3.

MHS has identified problems with delays in transporting patients from Camden ED to Campbelltown Hospital and has advised this will be addressed by implementing a Level 2 patient transport service. The service will be managed by the NUM of Camden emergency department and will facilitate the transfer of patients needing admission to Campbelltown Hospital. We remain concerned that patients requiring complex assessment and treatment would receive this more quickly if they were taken directly to the appropriate facility.

3. The action taken by MHS in response to this event was considered inadequate for the following reasons:
• There was a delay of $3^{1}/_{2}$ months between the review by the Director of Emergency Medicine and formalisation of the Committee's recommendations.
• the ASCCRC recommendations failed to address a key issue identified by the internal review ie failure to secure the airway

4. The internal review by the Director of Emergency Medicine was conducted several weeks after the incident. The review was thorough, timely and recommendations were appropriate. Some of the recommendations were followed up when the case was reviewed by the acute services critical care review committee (ASCCRC) and recommendations made in March 2002. We are concerned that the formal MHS response to our preliminary report ignores the clinical advice of a senior member of their own staff and refutes the standards identified by their own internal reviewer and supported by the Commission. This raises concerns about the ability of MHS to appropriately identify causes of concern and identify effective changes in response.

5. Some attempts by MHS to address the systemic issues were appropriate, specifically:
• The decision not to admit acute patients to Camden Hospital from July 2002.
• The appointment of a Staff Specialist, Director of Medicine from January 2003.

Outcomes	**Incident No 33**
The Issue	**Quality and Safety Concerns**
Availability of and supervision by senior medical staff	Substantiated
Patient transfer to higher level units or hospitals	Substantiated
Quality of clinical care provided by visiting medical officers	Substantiated
Recognition and response to critically ill patients	Substantiated
Quality of clinical care provided by nursing staff	Not substantiated
Management response to adverse events, including incident reporting	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 34

Date of Incident Qtr 2, 2001

Summary of Incident **Incident No 34**

Mrs O, an 88 year old woman, was brought in by ambulance to the emergency department at Camden Hospital just after midnight in mid 2001. She had a referral letter from her general practitioner with a diagnosis of '? perforated peptic ulcer'. On admission she was pale, dry retching with severe abdominal pain, tenderness and guarding.

Mrs O was admitted under VMO surgeon, Dr D3. At 0200 hours she was noted to have deteriorated with a BP of 80 systolic. She was given haemaccel 500 ml over 2 hours. By 0545 hours Mrs O had not passed urine since admission. Surgical review was to take place later in the morning.

Mrs O continued to deteriorate and was managed with IV fluids and antibiotics. Between 0615 hours and 0740 hours, RMO reviewed Mrs O and discussed her management with Dr D3 who recommended transfer to Campbelltown Hospital. At 1000 hours Mrs O's BP was 90/47 having dropped from 117/51. Her respiratory rate was 44 per minute. No MET was called.

At midday she was transferred to Campbelltown Hospital. Mrs O was diagnosed as having diverticulitis and was admitted to a ward from the ED. On arrival at the ward the intern noted 'looks unwell', cold extremities, reduced air entry and bilateral crepitations. Mrs O had been given pethidine for abdominal pain just prior to her transfer to the ward.

The next entry in her medical record was not until 2020 hours when a MET call was initiated in response to an RN discovering Mrs O 'to be quite unwell' with a respiration rate of 40, BP of 98/52 and oxygen saturation of 82% - 94% in spite of oxygen 6 - 8 l/m via a Hudson mask.

Mrs O was not reviewed by a surgical registrar until this MET call was initiated and she was transferred to ICU. That night she was taken to the operating theatre where she had surgery for a perforated large duodenal ulcer. She deteriorated slowly and died six days later.

The Director of the emergency department wrote a case review of Mrs O's case in a memo to the Medical Director of Health Services. He drew attention in particular to two concerns - failure to diagnose and delays in treatment. He concluded that her death may have been preventable if she had received more urgent surgical intervention.

There were five recommendations at the end of the case review:

1. Continued and ongoing education for medical officers on the management of abdominal pain in the elderly.

2. Ongoing education in, and reinforcement of the need for careful monitoring of patients, documentation of vital signs and clinical findings and shock recognition.

3. Initiation of a more suitable transport arrangement for patients to be transferred from Camden to Campbelltown and contingency plans available when excessive delays are encountered with ambulance transport.

4. Re-establishment of 24-hour registrar coverage for surgical registrars at Campbelltown with a system of adequate support to Camden emergency department.

5. Review of a back up surgical coverage system for instances where the surgical registrar is in theatre and not available.

The MHS critical care review committee reviewed this incident three months after it occurred and identified the following concerns:

1. X-rays should have been done immediately.

2. There was a delay in transfer by ambulance to Campbelltown ED.

3. There was a lack of nursing documentation in the Campbelltown ED.

4. There was a lack of recognition that Mrs O was critically ill.

The committee recommended that the case be reviewed with the staff at Camden. A memo dated six months after the CCRC meeting requests the Manager of the ED to implement the recommendation and report back in three weeks.

In July 2003, MHS advised us that the following actions had been implemented:

1. Development by the Director of Emergency Medicine of an education program on the management of abdominal pain in the elderly.

2. Planning for a Level 2 patient transport service between Camden Hospital emergency department and Campbelltown Hospital to start in July 2003.

3. Implementation of a dedicated pager for the surgical registrar on-call for the emergency department.

Allegations by Informants	Location 1	Location 2
Delay transfering from Camden to Campbelltown	Camden - ED	
Staff did not recognise a critically ill patient	Camden - ED	Campbelltown - ED

Issues Identified by HCCC	Location 1	Location 2
Quality of clinical care provided by nursing staff	Camden - ED	
Recognition and response to critically ill patients	Campbelltown - Med Ward	

Investigation into Macarthur Health Service Incident Review

Patient misdiagnosed	Camden - ED	Campbelltown - ED	The Medical Emergency Team (MET) at Macarthur Health Service	Camden - ED	
Patient did not receive a surgical review	Camden - ED	Campbelltown - ED	Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Camden - ED	
			Documentation of treatment and care in health care records	Camden - ED	
			Patient transfer to higher level units or hospitals	Camden - ED	
			Management response to adverse events, including incident reporting	Camden - ED	Campbelltown - Med Ward
			Availability of and supervision by senior medical staff	Camden - ED	Campbelltown - Med Ward

Clinical Review Panel Opinions **Incident No 34**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- Failure to arrange surgical review. The patient should have been surgically assessed in ED and immediately scheduled for surgery.

The failure to arrange surgical review resulted in failure to diagnose the perforation, and an unacceptable delay in provision of diagnosis.
- The patient should have been directly transferred to Campbelltown Hospital. The delay was unacceptable.
- On arrival at Campbelltown Hospital the patient should not have gone to the medical ward.
- There were no nursing entries for 5 hours indicating inadequate nursing observation.
- A MET call should have been made at 1000 hours on the day of admission.
- There is no evidence of a management plan.

The Panel identified the following systems issues:
- Transfer of acute patient was delayed.
- Surgical review was delayed due to lack of available support.
- Delay in diagnosis.

A positive aspect of the care was that staff did discuss the management with the family.

In summary, the care of this patient was unsafe. The Panel supported the view of MHS that acute patients should not be admitted to Camden Hospital. The Panel also considered the existence of an Emergency Department in a hospital not equipped to manage acute patients to be problematic.

The 5 recommendations by the Director of ED were comprehensive, however, there is no evidence that the identified actions were implemented.

Panel opinion following SWSAHS response:
No change to the earlier CRP opinion.

Commission Views and Comments **Incident No 34**

The Commision makes the following conclusions and comments:

The Commission found that the care provided to Mrs O was unsafe and inadequate for the following reasons:

1. Mrs O was not reviewed by a surgeon at Camden Hospital in spite of her presentation with an acute abdomen and her being sent to the hospital by her general practitioner with a diagnosis of '? perforated peptic ulcer'.

2. The abdominal x-ray was misread in Camden ED, failing to recognise free air under the diaphragm diagnostic of hollow viscus perforation, and indicating the need for an urgent laparotomy.

3. The delay and lack of response to Mrs O's acute abdomen and subsequent deterioration represents severe mismanagement. Mrs O should have been surgically assessed in ED and immediately scheduled for surgery.

4. Mrs O should have been directly transferred to Campbelltown Hospital. The delay was unacceptable.

5. There were no nursing entries for five hours after Mrs O presented to the ED in spite of her deterioration.

6. The observations recorded at 1000 hours on the day of admission should have triggered a call for the medical emergency team (MET).

7. There was an inappropriate delay before Mrs O's acute abdomen was correctly diagnosed at Campbelltown Hospital.

8. A diagnosis and management plan should have been noted on admission at Campbelltown Hospital.

9. Mrs O should not have been sent straight to a ward at Campbelltown Hospital because of her critical status.

10. A surgical review should have been organised as a matter of urgency.

In response to this incident, MHS was slow to address the recommendations of the Director of the ED and the recommendations of the critical care review committee.

Investigation into Macarthur Health Service Incident Review

Outcomes	Incident No 34
The Issue	**Quality and Safety Concerns**
Quality of clinical care provided by nursing staff	Substantiated
Recognition and response to critically ill patients	Substantiated
The Medical Emergency Team (MET) at Macarthur Health Service	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated
Documentation of treatment and care in health care records	Substantiated
Patient transfer to higher level units or hospitals	Substantiated
Management response to adverse events, including incident reporting	Substantiated
Availability of and supervision by senior medical staff	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 35

Date of Incident Qtr 4, 2002

Summary of Incident **Incident No 35**

Mrs R was a 91 year old woman who was transferred from an aged care hostel to Camden Hospital by ambulance in late 2002 for treatment of a strangulated hernia. She was triaged in the emergency department at 1430 hours as level 3. Mrs R was left on the ambulance trolley for an hour and ten minutes in spite of having faeculent vomiting, oxygen saturations of 90% and tachycardia.

Mrs R had chest and abdominal X-rays. She was diagnosed as having an incarcerated inguinal hernia with a bowel obstruction and dehydration.

Camden Hospital does not have a surgical service on site. The surgical registrar at Campbelltown Hospital was in theatre and could not be contacted. Mrs R was left in the Camden Hospital ED for more than seven and a half hours until she was transferred by ambulance to Campbelltown Hospital some time after 2200 hours

At Campbelltown Hospital, Mrs R was reviewed by a surgical registrar at 0030hours and taken to the operating theatre at 0100 hours where a bowel resection was carried out. Nine days later Mrs R was discharged back to her hostel accommodation.

The care and treatment of Mrs R was not reported as an incident of concern to MHS management at the time. In their response to the Commission, MHS identified the problem in this case as being the availability of transport. The use of a NSW Ambulance Service transfer quite often led to prolonged delays. MHS has now established its own transport service to provide patient transfers between Camden and Campbelltown Hospitals.

We noted in Mrs R's medical records that the ambulance transfer from Camden Hospital ED to Campbelltown Hospital was only booked at 2200 hours.

Allegations by Informants	Location 1	Location 2
Delayed hospital transfer	Camden - ED	

Issues Identified by HCCC	Location 1	Location 2
Patient transfer to higher level units or hospitals	Camden - ED	
Relationships and communication within and across clinical teams	Camden - ED	
Availability of and supervision by senior medical staff	Camden - ED	

Clinical Review Panel Opinions **Incident No 35**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- There were no problems with the care given in this matter. The care was safe and acceptable.
- There was a transfer delay on the first admission (12 hours).

Panel opinion after considering area health service response:
What is level 2 transport, is this satisfactory for "acute" care transfers

Where observations done at triage to recognise acuity, therefore is this appropraite triage? There are no notes of calls to CDA. Did the surgical registrar return call re plan of care or trasnsfer. Unacceptable delay of ambulance noted as a problem.
Why are any patients attending Camden Hospital via peripheral services if it is well known about availability or surgical service and transferring of patients to "surgical" hospital has extended delays?

Whether transport vehicle appropriate for transfer of "acute" patients" may still need ambulances for the skills of drivers and the need of nurse/medical escorts.

Poor team communication between surgical registrar and Camden Hospital, if on call. Need for a resident. Issues of communication of "dead" living patient discharged back to nursing home.

Commission Views and Comments **Incident No 35**

The Commision makes the following conclusions and comments:

1. The Commission found that the care provided to Mrs R was unsafe and inadequate for the following reasons:

a. Mrs R had an urgent surgical problem that needed prompt surgical intervention. Prompt surgery may have avoided the need for resection of the length of bowel trapped in the hernia and reduced the potential mortality and morbidity of the procedure.

b. Mrs R was inappropriately delayed in the Camden Hospital ED.

c. The medical staff at Camden Hospital appear not to have recognised the urgency of Mrs R's clinical situation.

The Commission acknowledges that the care and treatment of Mrs R was not reported to MHS management as an incident of concern at the time it happened. However the MHS response to the complaint about this incident is not adequate because the actions taken would not necessarily prevent the same failures occurring again nor did the response address the failure to make a timely request for an ambulance.

Investigation into Macarthur Health Service Incident Review

Outcomes	Incident No 35
The Issue	**Quality and Safety Concerns**
Patient transfer to higher level units or hospitals	Substantiated
Relationships and communication within and across clinical teams	Insufficient Information
Availability of and supervision by senior medical staff	Not substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 36

Date of Incident Qtr 1, 2003

Summary of Incident **Incident No 36**

Mrs H, a 71 year old woman presented to the Emergency Department of Campbelltown Hospital at 2015 hours in early 2003 with abdominal pain and vomiting. She was having regular peritoneal dialysis for renal failure. She was reviewed by the surgical registrar at 2310 hours and diagnosed as having a small bowel obstruction secondary to an incisional hernia.

At 2340 hours the registrar discussed Mrs H's treatment plan with the VMO, Dr D15 who ordered a trial reduction by muscle relaxation. Dr D15 said he/she would call back regarding the time of the operation.

At 0015 hours Mrs H was transferred to the Operating Theatre. Mrs H's treatment plan was discussed with an anaesthetist, Dr D16. Dr D16 cancelled the surgery planned in the Campbelltown Hospital OT that night because of concern that Mrs H may be difficult to extubate and recommended that she should be transferred to Liverpool Hospital.

At 0150 hours Mrs H was transferred back to the ED ready for urgent transfer to Liverpool Hospital ICU. At 0235 hours Mrs H was transferred from the ED by ambulance.

The care and treatment of Mrs H was not reported to MHS management as an incident of concern at the time it happened.

Allegations by Informants	Location 1	Location 2
Inappropriate delay in the ED	Campbelltown - ED	
Inappropriate treatment in the ED	Campbelltown - ED	

Issues Identified by HCCC	Location 1	Location 2
Quality of clinical care provided by visiting medical officers	Campbelltown - ED	
Documentation of treatment and care in health care records	Campbelltown - ED	
Patient transfer to higher level units or hospitals	Campbelltown - ED	

Clinical Review Panel Opinions **Incident No 36**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

- There was uncertainty about transferring the patient, but it did not have a major impact on care.
- There was a delay in giving analgesia and IV fluids. However, there is a justified reluctance to give fluids to renal patients.
- There was a lack of documentation about observations.
- Some times were not entered on the medical chart. Documentation of times is crucial.
- The overall picture is of acceptable and effective care.

Commission Views and Comments **Incident No 36**

The Commision makes the following conclusions and comments:

1. Overall the treatment was acceptable however:
a. There was a lack of documentation about observations.
b. Some times were not entered on the medical chart. Documentation of times is crucial.

Outcomes **Incident No 36**

The Issue	Quality and Safety Concerns
Quality of clinical care provided by visiting medical officers	Not substantiated
Documentation of treatment and care in health care records	Substantiated
Patient transfer to higher level units or hospitals	Not substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 37

Date of Incident Qtr 1, 2003

Summary of Incident **Incident No 37**

In early 2003 Mr P was brought by ambulance from a nursing home to Camden Hospital Emergency Department, having been found collapsed on the toilet, cold and clammy, with an unrecordable BP. On arrival at ED his BP was 90 systolic, PR 56/min and temp 35 degrees. The nursing entry states that he had passed "coffee ground stool". His medications were aspirin, persantin, adalat and deptran.

The ED registrar admitted Mr P and diagnosed ?blood loss ?perforated bowel ?vasovagal. He had generalised abodminal tenderness and brown stoool on PR. The ED registrar ordered pathology, abdo x-ray and chest x-ray. At 2100 hours the VMO was contacted. Transfer for surgical review at Campbelltown Hospital was advised.

Abdominal x-ray suggested faecal impaction. It also queried gas under the right haemodiaphragm but this was subsequently excluded on lateral decubitus and erect views.

At 2200 hours Campbelltown Hospital advised that no surgical bed was available as Campbelltown Hospital was "Code Red". Mr P remained at Camden ED and Campbelltown Hospital remained "Code Red" all night.

At 0820 hours on day 2 the patient was still awaiting transfer to Campbelltown Hospital despite a phone call from the surgical registrar at Campbelltown Hospital at 0730 hours asking where the patient was. The registrar was told that they were still waiting for a bed to become available. At 1030 hours the day surgeon at Camden, Dr D17 was asked to assess Mr P but refused. The General Manager was contacted in lieu of the ADON, and agreement was reached to transfer Mr P to Campbelltown Emergency Department. Pathology was repeated at 1030 hours. Haemoglobin levels had dropped from 150 the previous day, to 80. The attending VMO Physician was informed of this result. He recommended abdominal CT scan and transfusion with 2 litres of cross-matched blood. There was no recommendation re the need for colonoscopy.

Meanwhile Campbelltown Hospital remained on "Code Red".

After several hours Campbelltown Hospital advised that a CT scan could be done. Mr P was to be prepped at Camden Hospital and at 1250 hours he was transported to Campbelltown hospital. The CT scan showed massively dilated rectum and sigmoid colon with faecal impaction. In spite of the 6 gm haemoglobin drop over a 24 hour period and Mr P's recent history of hypotension and collapse the previous day, he was diagnosed with constipation.

On the afternoon of day 2 Mr P was transferred back to Camden and briefly admitted to Ward G. He was given microlax and a stool softener.

From the medical records it is difficult to tell when Mr P was transferred back to Campbelltown Hospital, however at some time during the morning of day 3 he was reviewed by the medical team at Campbelltown Hospital. The medical team ordered surgical consult and repeat pathology. The registrar was unable to take blood as the patient refused to allow it.

During the afternoon of day 3 the VMO Dr D30 saw Mr P. Dr D30 recommended discharge to the nursing home with follow up blood tests by the GP. Mr P was transported to the nursing home that afternoon.

This details of this case were not reviewed by MHS, however the issue of transportation remained one of ongoing concern. A Level 2 Patient Transport Service was established (in July 2003, for the purpose of transporting patients between Camden and Campbelltown Hospitals.

Allegations by Informants	Location 1	Location 2
Delayed hospital transfer	Camden - ED	

Issues Identified by HCCC	Location 1	Location 2
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars		
Patient decision making and planning for treatment, and end of life care		
Quality of clinical care provided by visiting medical officers	campbelltown - surgical Ward	
Documentation of treatment and care in health care records	Camden - ED	
Patient transfer to higher level units or hospitals	Camden - ED	

Clinical Review Panel Opinions **Incident No 37**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

- The patient was originally admitted under a physician.
- No surgical registrar or surgeon saw the patient for at least 24 hours.
- There were poor medical records.
- It was difficult to obtain a surgical opinion.
- The patient received safe care in Emergency Department with a final diagnosis of constipation.
- There was a delay in transfer to Campbelltown Hospital.
- There was timely and thorough assessment on arrival at Campbelltown Hospital.

Investigation into Macarthur Health Service Incident Review

Further opinion was sought from 2 physicians following response by MHS. Opinion was requested to consider results of pathology. The following comments were made:
Opinion 1.
Sent inappropriately to Camden Hospital with an acute surgical condition. Patients with acute surgical conditions should not go to Camden ED.
Patient really needed a differential diagnosis of GI bleeding therefore investigation of choice would be colonoscopy
There needs to be positive clinical decision making not inactive approach by default
Nowhere is there comment on the aetiology of haemaglobin drop from 150 to 80,
Patient collapsed on toilet, was hypotensive, clammy and cold and with 6 gm drop in haemaglobin over 24 hrs. Acute GI bleeding was most likely cause
To get a surgical opinion at Campbelltown Hospital, had to wait 2 days
Didn't do main investigation
Waited 2/7 for indifferent surgical opinion
Didn't treat the gross faecal impaction
Team seem to have decided that patient didn't warrant active treatment yet didn't document or discuss with relatives.

Opinion 2.
Patient had collapsed on toilet and dropped haemaglobin from 150 to 80 - he should have had a colonoscopy.
He needed colonoscopy before an abdo CT
To perform a colonoscopy is not that difficult to do. This patient should have had that colonoscopy and if necessary been put on Losec.
He was on aspirin and persantin and they can cause acute GI bleeding.
Objectively there was no reason given for his haemaglobin to drop from 150 to 80. It seems like they did everyything but scope him. The patient had a belly full of blood causing distension and ileus
Patient was sent back to nursing home without appropriate investigation or treatment

Commission Views and Comments	**Incident No**	**37**

The Commision makes the following conclusions and comments:

1. The care provided by Camden and Campbelltown Hospitals was unsafe and inadequate because:
a. The patient was not seen by a VMO until almost 48 hours post presentation
b. The patient was not seen by a surgeon
c. The patient remained at Camden Hospital for 18 hours. Urgent transfer to a hospital able to provide acute services was required
d. A differential diagnosis of GI bleed should have been considered in view of the rapid reduction in haemoglobin, marked hypotension and collapse. The most appropriate test for this clinical presentation was a colonoscopy. This does not appear to have been considered.
e. The documentation was poor and difficult to follow. A number of entries gave no indication of the time or location.

2. MHS did not review this incident as part of their quality process therefore it is not appropriate to comment on the MHS response to incident.

3. MHS has long recognised the delays in transportation between Camden and Campbelltown Hospitals. As a result a Level 2 Patient Transport Service was established, commencing July 2003. The service, to be managed by the Nursing Unit Manager of Camden ED, will be dedicated to Camden/Campbelltown transfers. The Commission acknowledges this action, however it should be noted that the issues of concern identified by the Commission are broader than those of transportation.

Outcomes	**Incident No 37**
The Issue	**Quality and Safety Concerns**
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Partially substantiated
Patient decision making and planning for treatment, and end of life care	Substantiated
Quality of clinical care provided by visiting medical officers	Substantiated
Documentation of treatment and care in health care records	Substantiated
Patient transfer to higher level units or hospitals	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 38

Date of Incident Qtr 1, 2003

Summary of Incident **Incident No 38**

Mr AD, 70 years of age, presented at Camden emergency department (ED) at 2235 hours in early 2003 with severe abdominal pain, abdominal distension, and increased colostomy output for the preceding 3 hours. His past history included a colostomy secondary to bowel resection for cancer of the rectum in 1998, and mild chronic airway limitation (CAL).

Mr AD was triaged as category 4 requiring him to be medically reviewed in 60 minutes. The triage nurse N13 noted Mr AD 'was not in any obvious distress' at 2235 hours. However, he was given buscopan and maxalon followed by morphine for severe pain at 2320 hours, and the triage category was not changed. There is no record of the time Mr AD was seen by the ED locum - it may have been around 2320 hours. The differential diagnoses for the abdominal pain were obstruction, ischaemia and gastritis. Both bowel obstruction and bowel ischaemia warrant prompt surgical review.

The ED locum ordered chest and abdominal x-rays, IV fluids and routine pathology tests. A surgical review was noted for the morning. No contact was made with a surgeon or VMO (D11) that evening. At 2245 hours the patient's BP was 155/100, O2 saturation was 100% on 3L O2. His temperature was 35.7C and PR 76 bpm. Because of the severity of Mr AD's abdominal pain he required morphine on 3 occasions - at 2355 hours, 0102 hours, and 0445 hours. No instructions were given to nursing staff about monitoring Mr AD's condition.

Although nursing staff were aware that Mr AD was experiencing extreme pain, there is no indication that they were responding to provisional diagnoses of bowel ischaemia or bowel obstruction. No vital observations were recorded by nursing staff between 0200 hours and 0600 hours. At 0200 hours the O2 saturation had dropped to 98% on 6L of O2, his PR had increased from 76 to 95 bpm, and his BP was 123/68mm. A nursing note at 0500 hours states that Mr AD was awake most of the night. He was complaining of pain and given morphine.

For the next seven hours there was no further PR recorded in the vital observation chart in ED. There was no record of any medical examination of Mr AD from his admission at 2200 hours until 1130 the following morning. Sometime after 0600 hours the ED locum on duty the following morning (D 12) noted that the abdominal x-ray showed 2 dilated loops of bowel and faecal loading. Mr AD's WCC was 14,800 with neutrophilia of 10,900.

At 0835 hours, having noted the abdominal x-ray results, the ED locum attempted to transfer Mr AD to Campbelltown Hospital.

The transfer was not implemented when the ED locum was made aware that the surgeon was at Camden hospital in the day surgery theatre. The surgeon was contacted at around 0900 hours was informed of Mr AD's admission.

The record notes that the surgeon would review Mr AD later that morning. The surgeon has stated he was told that Mr AD's condition was stable. At 1030 hours a nurse's record states that Mr AD 'suddenly began to lose consciousness'. Mr AD's BP at 1044 hours was 55/30. No pulse, respiration, or O2 saturation rates were recorded at this time. At 1110 hours his O2 saturation level was 88% on room air and his BP was 71/49.

The first entry in the medical record after this deterioration was at 1130 hours when it was recorded that Mr AD was cyanosed and had no BP. Haemaccel 500ml was given IV as well as 0.5mg of adrenalin. The surgeon attended ED from the day surgery theatre at around 1130 hours. Although he did not write in the notes himself, it is noted that he made a provisional diagnosis of ischaemic bowel and started IV ceftriaxone, gentamycin, and flagyl.

The surgeon went back to the day surgery unit and returned to see Mr AD at 1200 hours when he requested Mr AD be transferred to Campbelltown ICU for surgery. Mr AD was started on an adrenalin infusion, O2, ventolin, and atrovent. Blood cultures were sent to pathology.

At 1237 hours, a nursing entry states that the paramedics were booked 'asap'. Careflight arrived at around 1330 hours and found Mr AD in septic shock and under-resuscitated. Mr AD was intubated by them and stabilised. He was transferred to Campbelltown Hospital where it was clear that the patient required tertiary hospital facilities and care. Mr AD was then transferred to Liverpool Hospital at 2100 hours where he later died.

MHS management was aware of this incident when it occurred. The focus of their interest appears to have been on the mode of transport used to transport Mr AD between hospitals and bed availability with a reference to his management in that context. However, there is a reference to Mr AD's condition deteriorating after Careflight arrived necessitating intubation being "extremely unfortunate, but - we took appropriate steps to ensure that ICU were still happy to accept him." When reviewed again as a response to the s.43 report MHS identified some aspects of team communication, quality of nursing care, and VMO quality of care as being inadequate. MHS agreed with the Commission's findings in respect of coordinated care - plan and delivery, response to physical deterioration/critically ill patient, hospital transfer, and RMO/CMO quality of care. MHS did not agree that there was a problem with documentation of the care of Mr AD.

In response to the s.43 report, the Department of Surgery reviewed the case in March 2003 at its monthly Morbidity and Mortality meeting at Campbelltown Hospital. The surgeons referred to:
1. The VMO surgeon was not notified of the admission of Mr AD
2. Admissions to an ED without an acute surgical service (Operating theatre, VMO, surgical registrar)
3. Reliance of a relatively inexperienced CMO for after hours emergency cover in ED
4. The failure of the VMO to document his attendance at ED.

Allegations by Informants	Location 1	Location 2
Delay in assessment by VMO	Camden - ED	
Inadequate assessment	Camden - ED	

Issues Identified by HCCC	Location 1	Location 2
Coordination and continuity of care	Camden - ED	

Investigation into Macarthur Health Service Incident Review

Delay in transfer of patient from ED to ICU	Camden - ED	Relationships and communication within and across clinical teams	Camden - ED
		Quality of clinical care provided by nursing staff	Camden - ED Camden - ICU
		Documentation of treatment and care in health care records	Camden - ED
		Recognition and response to critically ill patients	Camden - ED
		Quality of clinical care provided by visiting medical officers	Camden - ED
		Patient transfer to higher level units or hospitals	Camden - ED
		Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Camden - ED Camden - ICU

Clinical Review Panel Opinions **Incident No 38**

An independent Clinical Review Panel reivewed the documents obtained and made the following comments:
- There was a lack of surgical review
- The patient was given Morphine 4 times. As soon as a patient is given morphine they should be medically assessed at least by a senior registrar.

Panel opinion following SWSAHS response:
The panel found that management only looked at the transfer issue, not the ischaemic bowel management.
All issues initially identified by the panel were considered to remain substantiated. In respect of some aspects of care the panel made additional comments:
There was an unacceptable delay in a surgical review. There was no surgical input despite the catastrophic situation.

The clinical assessment and treatment by a senior medical clinician and surgeon were inappropriately delayed and if no VMO was contacted this is a systems issue.

Documentation is poor.

Commission Views and Comments **Incident No 38**

The Commision makes the following conclusions and comments:

The Commission found that the care provided to Mr AD was unsafe and inadequate for the following reasons:
1.There was a lack of prompt surgical review on admission in view of Mr AD's abdominal pain.
2. In the ED staff
- Failed to notify the VMO after Mr AD presented at ED.
- Failed to appropriately review and monitor Mr AD's condition from the time of his admission to ED.
- Inappropriately administered 4 doses of narcotic analgesia without a clear diagnosis.
- Failed to give clear instructions to nurses about Mr AD's monitoring requirements.

3. There was a failure to
- Promptly transfer Mr AD to an appropriate facility given his clear surgical signs and symptoms.
- Develop and implement a clear management plan.
- Appropriately review Mr AD's condition.

4. Nursing staff failed to take vital observations of Mr AD over 4 hours, between 0200 hours and 0600 hours, despite the provisional diagnosis of ischaemic bowel and bowel obstruction and despite Mr AD needing three doses of morphine.
- Nursing notes are not in chronological order. Between 0200 hours and 1110 hours, no PR is recorded. There are only two temperatures recorded in over 12 hours, and the respiratory rate was only appropriately taken after Mr AD's condition deteriorated.

5. There was a lack of coordinated care and a plan for the care of Mr AD given his provisional diagnosis.
6. There was poor communication between the treating team as indicated by a lack of directions.
7. Given the clinical presentation of Mr AD, arrangements to transfer him to an appropriate tertiary hospital were critically delayed.

It does not appear that management was made aware of any concerns about the clinical care given to Mr AD in early 2003. However, in response to this complaint, MHS reviewed his case in June 2003. It did not identify or accept the significant and serious problems in the care of Mr AD. Management found that the main issue concerned the appropriateness of initial transfer to Campbelltown Hospital (from Camden Hospital). Management advised that transfer guidelines do exist and the Review Team has taken steps to ensure that these guidelines are readily available and understood by staff in Camden Emergency Department. When the case was later reviewed by the Department of Surgery, clinical issues were noted and issues relating to system or causal factors identified. Corrective measures were proposed which are aligned with those suggested by the Commission's Clinical Review Panel advisors.

Outcomes **Incident No 38**

The Issue	Quality and Safety Concerns
Coordination and continuity of care	Substantiated
Relationships and communication within and across clinical teams	Substantiated
Quality of clinical care provided by nursing staff	Substantiated

Investigation into Macarthur Health Service Incident Review

Documentation of treatment and care in health care records	Substantiated
Recognition and response to critically ill patients	Substantiated
Quality of clinical care provided by visiting medical officers	Substantiated
Patient transfer to higher level units or hospitals	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 39

Date of Incident Qtr 1, 2003

Summary of Incident **Incident No 39**

Mrs X, a 61 year old woman, was admitted to Campbelltown Hospital in early 2003 for a laparoscopic cholecystectomy (removal of her gall bladder by 'key hole' surgery). Mrs X had been on the waiting list for her surgery for eight months.

The operation started at 2015 hours on the 'emergency' operating list. The procedure was more difficult than expected because Mrs X's gall bladder had adhered to her duodenum and her liver. It contained multiple gallstones and pus. The laparoscopic procedure lasted for three hours and was not converted to an open surgical procedure. The pathology report described the removed gallbladder as 'ragged and partially opened'.

The following morning (Day 2) Mrs X was pale, sweaty, hypotensive 80/50, tachycardic 110 bpm and had not passed urine. The only remedial action taken was blood pressure monitoring and commencement on intravenous therapy. Blood pathology tests were taken at 1020 hours and showed a WCC 35,600 and creatinine of 166. Oxygen saturation at 1300 hours was 91% falling to 88% at 2100 hours. The surgeon saw Mrs X and recommended free fluids and chest physiotherapy.

On the afternoon of Day 2, Mrs X complained of severe abdominal pain which required morphine 10 mg.

The following day (Day 3) a MET was called at 0915 hours in response to a pulse rate of 136 bpm. Basal lung collapse and pulmonary embolism were suspected. A chest X-ray and Clexane were ordered. The surgeon reviewed Mrs X at 1020 hours and ordered removal of the drain, free fluids and medical review. Her tachycardia persisted throughout the day and was 150 at 1550 hours. The cardiology team saw Mrs X at 1715 hours and noted her persistent tachycardia but did not think that it was due to a heart problem.

A little later, an RMO examined Mrs X because she was short of breath and continued to complain of upper abdominal pain. Her heart rate was 132 and her oxygen saturation was 93% - 95% on 50% oxygen at 8 l/m by mask. The white cell count from blood taken at 0810 hours was 28.3. Arterial blood taken at 1655 hours showed a pH of 7.31 with a base excess of –5. The RMO discussed Mrs X with the surgical registrar and concluded that she had a likely pulmonary embolism. There was no VQ scan or contrast CT angiogram to confirm or exclude this diagnosis. There was no differential diagnosis of intra abdominal sepsis.

Another MET was called at 2100 hours because Mrs X had a heart rate of 150 – 160, cold periphery, right sided abdominal tenderness and rebound. Mrs X was transferred to ICU at 2220 hours. She was reviewed some time later by the surgical registrar who wrote 'feels better. Tachicardia 144. Transfuse 2 units. Repeat Hb tomorrow'.

Mrs X continued to be short of breath and to complain of abdominal pain. She was given 10 mg of morphine at 0030 hours on Day 4. Arterial blood gasses at 0618 hours showed a pH of 7.24 with a base excess of -6. Her urine output remained poor and her heart rate stayed elevated.

At 0530 hours on Day 4, Mrs X continued to desaturate to 91% on room air. Her pulse rate was 150 and her urinary output had reduced. At 0545 hours she was noted to be drowsy, sweaty and complaining of abdominal pain. At 0620 hours Mrs X's blood gasses showed her to be markedly acidotic.

She was reviewed by the surgical team before 0830 hours. She was tachycardic140 bpm. For the first time abdominal CT was suggested.

At 0830 hours on Day 4, the ICU registrar for the first time mentioned sepsis and Mrs X was sent for an urgent CT scan of her abdomen. The surgeon who had performed Mrs X's surgery saw her at 1700 hours and noted that the CT showed free fluid in the pelvis and under the liver. Gentamycin was administered. There was no suggestion of the need for a laparotomy at this review.

On the morning of Day 5, Mrs X was noted to be 'unwell'. Her blood pressure was 90/-, her heart rate was 130 and her oxygen saturation was 93% on oxygen by mask. She was peripherally shut down and sweaty. Mrs X was seen again by the surgeon and the possibility of sepsis and intra-abdominal collection was raised. It was planned to resuscitate her and take her to the operating theatre for exploratory laparotomy. At about 0900 hours Mrs X appeared to be about to arrest.

A retrieval team from Careflight arrived at about 1115 hours. They planned to intubate Mrs X before transport. However during the intubation she vomited and aspirated into her lungs. Her lungs were sucked out and she was put on a ventilator. Noradrenaline was started and intravenous fluid resuscitation was given. At 1400 hours Mrs X was transferred to Liverpool Hospital.

Mrs X died that same day. Her husband, Mr X, was told that she had died of aspiration pneumonia. The death of Mrs X was not referred to the Coroner.

The case was initially referred to the acute services review team for review. They started an investigation but, after discussion between the General Manager, Medical Director of Health Services, Area Patient Safety Officer and Director of Nursing & Acute Services, it was decided to establish a team to undertake a root cause analysis, with involvement of the Director of Liverpool ICU.

The root cause analysis conducted by MHS came to the following conclusions about the systemic failures in the care of Mrs X.

1. The operating theatre was scheduled late. The scheduling decision made by theatre staff led to the operation being postponed over 48 hours until late on a weekend evening. This contributed to the immediate post-op period coinciding with a time of minimal staffing levels.

2. A significant deterioration in the patient's clinical condition was not recognised.
- A Carepath was not used and therefore variances were not recognised.
- The immediate post-op period occurred during the middle of the night.
- No criteria exist for sending patients to ICU post-op following unexpected, extended abdominal surgery after hours.
- The failure to recognise a critically ill patient was due to the increased workload on the surgical registrar as the patient became unwell on a Sunday when there is only one surgical registrar on duty. The patient was unwell on change-over day, that is the one day of the year when combined change-over occurs.

Investigation into Macarthur Health Service Incident Review

• A surgical focus masked medically based problems.

3. Criteria for transfer of deteriorating patients
• There were no formal criteria for transfer of patients to a tertiary hospital at that time.

Mrs X's husband, Mr X, complained to MHS about her care. The management of MHS wrote back to Mr X and senior staff from MHS met with Mr X on two occasions to provide feedback on the issues he had raised and to give feedback on the outcome of the root cause analysis.

In February 2001 a surgical audit was started in MHS that reviews all general surgical cases at Campbelltown Hospital.

In March 2003 an intensivist at Liverpool Hospital reported the death of Mrs X to the Coroner.

Allegations by Informants	Location 1	Location 2
Transfer to Liverpool was delayed	Campbelltown - ICU	
Post op treatment was inadequate	Campbelltown - Surgical Ward	Campbelltown - ICU
Post op monitoring was inadequate	Campbelltown - Surgical Ward	Campbelltown - ICU
Performance of the surgery was inadequate	Campbelltown - OT	
Delay on the waiting list	Campbelltown - Other	

Issues Identified by HCCC	Location 1	Location 2
Notifications of deaths to the Coroner and decision making around post mortem	Campbelltown - ICU	
Management response to adverse events, including incident reporting	Campbelltown - Other	
Quality of clinical care provided by visiting medical officers	Campbelltown - Surgical Ward	Campbelltown - ICU
Availability of and supervision by senior medical staff	Campbelltown - Surgical Ward	Campbelltown - ICU
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - Surgical Ward	Campbelltown - ICU
Communication with patients and families	Campbelltown - Surgical Ward	Campbelltown - ICU
Relationships and communication within and across clinical teams	Campbelltown - Surgical Ward	Campbelltown - ICU
Patient transfer to higher level units or hospitals	Campbelltown - ICU	
Recognition and response to critically ill patients	Campbelltown - Surgical Ward	Campbelltown - ICU

Clinical Review Panel Opinions **Incident No 39**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

• This incident was a very serious failure to diagnose a postoperative intra abdominal sepsis when there were clear signs.
• Consequently there was an excessive delay before a laparotomy.
• Mrs X became unwell on changeover day thus there was no continuity of care. There was a different surgeon doing the post-operative care.
• The operating surgeon should have been called.
• There was no follow through on the mistaken diagnosis of pulmonary embolism.
• There should have been a post mortem or referral to the Coroner.
• Mrs X was not put on a 'Care Pathway'.
• The post-operative monitoring and observations on Mrs X were adequate, but no one interpreted them correctly until too late.
• The surgical care should be assessed for further investigation.

In relation to management/systems issues:
• It is likely that the poor outcome of Mrs X's surgery was significantly affected by her 11 month wait on the waiting list.
• The Root Cause Analysis conducted by the MHS missed the root causes.
• There appears to be a failure in the MHS system to review post-operative deaths.
• The letter from the General Manager to Mr X following the death of his wife was considered to be bureaucratic, cold and insensitive.

The Clinical Review Panel for operating theatre made the following comments:
• The Panel noted that the pre-operative assessment in this instance was inadequate commenting that it had been done at the wrong time by the wrong person.
• The Panel was critical of the fact that this relatively healthy patient who had waited 8 months for a straight forward elective procedure, underwent that surgery on a Saturday night as an emergency procedure. The Panel stated that this dramatically increases the risk as it is well recognised that delivery of quality of care is less satisfactory in after hours emergencies than that delivered in business hours as elective procedures. The Panel was of the view that only life saving surgery should be done as emergency procedures.
• In respect of the surgery the Panel noted that the procedure took 3 hours which was felt to be excessively lengthy and stated that the decision to persist over such a long period with a laparoscopic rather than an open procedure was inappropriate.
• The Panel noted that it was apparent from the patient's clinical picture the next day that this patient was very sick and expressed the view that while the MET call was appropriate there was a delay in recognising how ill the patient was early enough.
• The Panel opined that there appeared to be a lack of follow up senior medical clinicians, particularly in view of the fact that the surgery was lengthy and difficult.

Investigation into Macarthur Health Service Incident Review

- The Panel was critical of the failure to perform a post mortem in this patient as a way of determining the cause of death.
- The Panel further noted that there appeared to be a lack of process as to what constitutes emergency surgery.

Commission Views and Comments	**Incident No 39**

The Commision makes the following conclusions and comments:

The Commission found that the care provided to Mrs X was unsafe and inadequate for the following reasons:

1. The facts strongly suggest that Mrs X died from a major intra-abdominal complication of her laparoscopic cholecystectomy.

2. Mrs X was a relatively healthy patient who had waited eight months for a straightforward elective procedure. It was not appropriate for her to undergo surgery on a Saturday night as an emergency procedure. Only life saving surgery should be done as an emergency procedure.

3. There appears to be a lack of appropriate process for identifying cases that will be done as emergency surgery.

4. The decision to persist with a laparoscopic procedure for three hours rather than an open procedure was inappropriate.

5. It was apparent from Mrs X's clinical picture on the first day post-op that she was very sick. The MET call was appropriate but there was a delay in recognising how ill the patient was and proactively investigating the cause.

6. There was a failure to recognise the serious nature of Mrs X's post-operative state and to intervene appropriately.

7. Investigations were not done to confirm the diagnosis of possible pulmonary embolism.

8. The responsible staff in ICU failed to diagnose post-operative intra-abdominal sepsis of which there were clear signs.

9. The intensive care unit at Campbelltown Hospital is not adequately staffed. It does not have a director or permanent staff. It operates, particularly at holiday time, with locums and part time staff. The ICU staff lack emergency medicine or anaesthetic training and are therefore not equipped to adequately diagnose and resuscitate the critically ill patient.

10. As the death occurred at Liverpool, Campbelltown had no obligation to report the death.

In relation to the response to this incident by MHS management at the time it happened:

1. We note with approval that MHS initiated their own root cause analysis investigation of this case. MHS has given us a timetable of actions to be implemented in 2003 to rectify the systemic problems identified. MHS has developed updated instructions on Peri operative Services for their Work Instruction Manual. In particular Section 1D.3 updated in September 2003 establishes discharge criteria for patients being transferred from the recovery room. However we note that the MHS response does not adequately address critical care skills in a way that would necessarily prevent the same failure to recognise clinical deterioration in another patient.

2. Mr X objected to the letter from the General Manager of MHS following the death of his wife. This highlights the difficulty for hospital management responding to consumer expectations. We note with approval that in recognition of the need to improve the complaints management system (including the quality of written responses) the MHS has begun a process whereby members of the Macarthur Health Community Council review complaints.

Outcomes	**Incident No 39**
The Issue	**Quality and Safety Concerns**
Notifications of deaths to the Coroner and decision making around post mortem	Not substantiated
Management response to adverse events, including incident reporting	Substantiated
Quality of clinical care provided by visiting medical officers	Substantiated
Availability of and supervision by senior medical staff	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated
Communication with patients and families	Substantiated
Relationships and communication within and across clinical teams	Substantiated
Patient transfer to higher level units or hospitals	Substantiated
Recognition and response to critically ill patients	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No **40**

Date of Incident Qtr 4, 2002

Summary of Incident **Incident No 40**

In November 2002 Mrs Z, was 83 years old when she presented to her GP with abdominal pain of 3 days duration. She was taken from the medical centre directly to Campbelltown Hospital ED at 1415 hours. She was diagnosed with likely bowel obstruction. At 1530 hours Mrs Z underwent abdominal CT and was given medication and fluid intravenously. She was kept overnight. At 0400 hours she had repeat x-rays and blood tests. At 1640 hours that afternoon she underwent emergency surgery for hemicolectomy and colostomy. No ICU beds were available at Campbelltown and so she was transferred to ICU at another hospital.

This case was not reviewed by MHS.

On 30/3/03 MHS management informed the Commission that this woman was transferred from Campbelltown operating theatre to the Intensive Care Unit at another hospital because there were no ICU beds available at Campbelltown Hospital. Management confirmed that this woman recovered, and has been treated as a patient by the ambulatory care team on 2 occasions since her admission last year.

Allegations by Informants	Location 1	Location 2
delays results in patient's death		
20 hour delay in transfer to campbelltown hosp		
patient received minimal treatment on presentation	Campbelltown - ED	

Issues Identified by HCCC	Location 1	Location 2
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ED	
Coordination and continuity of care	Campbelltown - ED	
Patient transfer to higher level units or hospitals	Campbelltown - ED	

Clinical Review Panel Opinions **Incident No 40**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

- The Panel was not critical of the medical management of Mrs Z. Her care was safe, acceptable and timely although some communication difficulty was evident between the RMO and the surgeon.
- Mrs Z received prompt attention on arrival by ambulance. Within 1 hour of arrival she had been seen by emergency and surgical officers. Appropriate investigations and initial management were ordered.
- The patient had a metabolic acidosis in the context of acute abdominal pain and changes on abdominal x-ray. She also had signs of early cardiovascular decompensation and was appropriately admitted to ICU. The early morning review on Day 2 may have resulted in a few hours delay before surgery, due to communication problems between the ED officer and the surgeon. However, this possible delay is very unlikely to have altered the poor outcome given the poor prognosis of bowel infarction in an elderly woman with multiple chronic illnesses.
- It is of note that the surgeon comments on diverticular disease being seen on CT whereas other officers gave a report of no diverticular disease.
- The official radiologist report of this investigation could not be seen, however the discrepancy in the doctors' opinions may reflect a communication problem. The whereabouts of the films was in question, but could have been be avoided if films had remained with the patient or in radiology.

Commission Views and Comments **Incident No 40**

The Commision makes the following conclusions and comments:

1. The Commission concludes that the care provided to this patient was safe and adequate for the following reasons:
a. She received prompt attention on arrival by ambulance.
b. Within 1 hour of arrival the patient had been seen by the emergency and surgical officers.
c. Appropriate investigations and initial management were ordered.
d. She was appropriately transferred to ICU following surgery.

2. The Commission concludes that there were no factors apparent in this case that would prompt an internal review.

Outcomes **Incident No 40**

The Issue	Quality and Safety Concerns
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Not substantiated
Coordination and continuity of care	Not substantiated
Patient transfer to higher level units or hospitals	Not substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 41

Date of Incident Qtr 2, 2002

Summary of Incident **Incident No 41**

Mr NE, a war veteran, was taken by ambulance to the ED at Campbelltown Hospital in mid 2002 with a history of retrosternal chest pain and shortness of breath. He was pale and diaphoretic when leaving his home and suffered a respiratory arrest when being placed into the ambulance. He had a history of cardiac ischaemia.

On arrival at the ED, Mr NE was triaged as level 1. He was seen promptly, resuscitation was commenced and he was transferred to the ICU. The provisional diagnosis was ischaemic chest pain, pulmonary oedema, AF, (R) lung aspiration pneumonia, respiratory acidosis. On arrival at ICU he was intubated and bagged.

Mr NE's progress and care in ICU is well documented. He was assessed and attended by a number of VMO and ancillary staff specialists. He was ventilated with a CPAP positive pressure machine for 2 □ days before this was ceased. However he experienced respiratory distress and was re-intubated for a further two days. He was transferred to the medical ward on his 8th day after admission. Two days after transfer onto the ward, he experienced respiratory distress and wanted to use the CPAP machine. The EN (N3) responsible for his care, wanted to call a MET and claims this request was refused by the registered nurse on duty, R3. The nurse did however contact an ICU registered nurse, who came to the ward and assessed Mr NE. The ICU nurse advised the nurse that a MET was not required and that the CPAP machine could not be brought out of ICU to the ward. It is claimed the ICU nurse then advised Mr NE to calm down and left. The ICU nurse was in fact part of the MET that is made up of staff from ICU. At the time, the CMO on duty in ICU was attending a clinical emergency.

According to the medical record, Mr NE remained acutely distressed and continued to request to be reconnected to the CPAP machine. The nurse claimed that she consulted a registered nurse on the same ward about the management of Mr NE. In view of Mr NE's respiratory distress, the nurse allowed him to have assisted breathing through a hand held resuscitation bag. She reported that after about 15 breaths Mr NE became more settled. Mr NE was stable when the ICU doctor attended around one hour later.

According to the informant management was aware of this incident at the time, and that the enrolled nurse was called to a disciplinary meeting in regard to her bagging the patient as it was outside her role. In July 2003 MHS confirmed that the enrolled nurse had been called to a fact finding/disciplinary interview where her bagging of the patient was discussed. At that time, MHS advised that concerns about the nurse's care of Mr NE were raised by 'staff', and that failure to call a MET was not part of the fact finding/disciplinary process. No documents were provided in relation to the interview or the incident reported by staff.

In its response to the Commission's s.43 report, MHS agreed with the findings of the Commission in respect of the quality of the nursing care and failure to call a MET. Management agreed with some aspects of concern expressed by the Commission about managements' response to an adverse event, and disagreed that there was an issue regarding coordinated care.

Allegations by Informants	Location 1	Location 2
Management practices	Campbelltown - Other	
Failure of RNs to call MET	Campbelltown - Med Ward	
Dr from ICU (MET) unavailable to attend		
Delay in medical assessment of acute respiratory distress	Campbelltown - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
Coordination and continuity of care	Campbelltown - Med Ward	
The Medical Emergency Team (MET) at Macarthur Health Service	Campbelltown - Med Ward	
Quality of clinical care provided by nursing staff	Campbelltown - Med Ward	
Management response to adverse events, including incident reporting	Campbelltown - Med Ward	

Clinical Review Panel Opinions **Incident No 41**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

- It was not appropriate care to bag the patient.
- MET criteria were met.
- An RN should have managed the patient's respiratory distress
- Management response to the incident was excessively critical.
- There was underresourcing of the MET team.
- There was a delay in medical assessment.
- There was a failure to call MET.
- There was a concern over VMO/Registrar coverage and concern over management's response to critical incident.
- The care of the patient was unsafe and unacceptable as there was no doctor available.

The Clinical Review Panel view after consideration of the AHS response:

Although management denies giving first and final warning to N3 in relation to this case, to discipline for this incident alone is heavy handed given the lack of leadership from RNs.

While it has been suggested that a person may suffer anxeity of withdrawal after cessation of CPAP, there is no such syndrome. However, there appears to be a lack of experience or skill demonstrated in the management of acute respiratory distress.

The EN should have been more appropriately supported.

A MET should have been called by the EN. However, it is acknowledged that the ICU nurse who attended is part of the MET.

Investigation into Macarthur Health Service Incident Review

Commission Views and Comments	Incident No 41

The Commision makes the following conclusions and comments:

The Commission found that the care provided to Mr NE was unsafe and inadequate for the following reasons:

1. The MET was not called when Mr NE's clinical signs indicated the need to call the MET in accordance with hospital policy and procedure.

2. Two registered nurses failed to take appropriate clinical action to relieve the acute respiratory distress of Mr NE.

3. In view of Mr NE's medical history and recent transfer from the ICU, there was no coordinated care plan for managing a recurrence of his acute respiratory distress.

4. In relation to the MHS response to this incident at the time it remains unclear if the nurse received a first and final warning for bagging Mr NE. It is our view that such a warning would be excessive. If the nurse did not receive such a warning then it was unnecessarily confusing to raise the incident together with episodes warranting disciplinary action.

Outcomes	Incident No 41
The Issue	**Quality and Safety Concerns**
Coordination and continuity of care	Substantiated
The Medical Emergency Team (MET) at Macarthur Health Service	Substantiated
Quality of clinical care provided by nursing staff	Substantiated
Management response to adverse events, including incident reporting	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 42

Date of Incident Qtr 2, 2002

Summary of Incident **Incident No 42**

In mid 2002 Mrs KC a 72 year old woman had her left femur pinned and plated at Liverpool Hospital following a fall at home in which she sustained a fractured left neck of femur. Mrs KC was admitted to the medical ward at Campbelltown Hospital pre and post surgery. Mrs KC had a history of non insulin dependant diabetes and hypertension.

Mrs KC was transferred to a private hospital 2 weeks post surgery for rehabilitation. Six days later she was transferred back to Campbelltown Hospital because of wound dehiscence and likely infection of the surgical site. In a two week period from her initial admission after her fall she had endured, along with her surgery, 4 hospital transfers. It is her final admission to Campbelltown that has been examined by the Commission.

Mrs KC was re-admitted (under the orthopaedic VMO) to Campbelltown Hospital via the Emergency Department where she was triaged priority code 3 at 2115 hours and she was seen at 2225 hours where it was established that she was 16 days post hip surgery. Mrs KC's dressing and clips had been removed 2 days earlier and persistent and increasing bloody ooze had been noted from the distal end of her surgical wound. It is noted that her LFT's were abnormal at this time and no INR had been done in spite of persistent bleeding from the wound. Mrs KC was admitted to medical Ward A.

Mrs KC's managment was discussed per phone with the VMO who ordered wound washouts, IV antibiotics and anaesthetic review with a view to surgery the following day. IV flucloxicillin was commenced. Mrs KC went to theatre on Day 3 and had the wound cleaned and resutured, and returned to the ward at 1900 hours. A wound drain had been placed insitu with small drainage. A wound swab result revealed staph aureus.

Mrs KC was seen by the orthopaedic team the following morning (Day 4) who continued current management and suggested psychiatry review for depressive features. Swab culture revealed , staph aureus, coliform and skin flora sensitive to flucloxicillin and erythromycin.

Mrs KC was seen by the psychiatry registrar that day who noted at length her fear of further surgery as 'she may not live through them.' Mrs KC acknowledged that she had been angry at staff having felt hopeless and frightened about operating theatre. She also expressed fears re pain and her future. She was stated by the psychiatry registrar to be in a depressed mood and felt her pain killers were contributing to her confusion particularly at night.

On Day 6 Mrs KC was seen again by the surgical team who noted that she was slightly febrile. Her antibiotics were changed and a central line was inserted. Daily UEC's were requested. Nursing staff consistently described Mrs KC as demanding. A skin break was noted on Mrs KC's sacrum and an air mattress was suggested.

In the early hours of Day 9 Mrs KC's serum potassium dropped to 2.1. She was seen by an intern in the afternoon, who increased her oral KCl and supplemented 30mmol of KCl in her IV fluids. In spite of this her Potassium dropped further to 1.8 requiring consult with a medical registrar who ordered a further 60 mmol of IV KCl. There was no involvement of the VMO at this point. The nursing notes also record a large malaena stool at around midday. In spite of the ongoing bloody ooze from her left hip wound and her abnormal LFT's there was no investigation of this bleeding (eg. INR).

On the same day at 1830 hours the MET was called when Mrs KC was found unresponsive by nursing staff. Whilst Mrs KC appeared to recover quickly her electrolyte derangement was again noted (low serum magnesium, and low serum potassium. She was also noted to have a low haemoglobin and persistent fresh blood oozing from her wound. There was still no active management of investigation of her bleeding. In spite of this episode, there was no VMO involvement that evening. She was managed by an Intern, who appeared to consult a surgical registrar over the phone.

On Day 10, Mrs KC was seen by the orthpaedic team and the team does not comment on her recent MET event or her electrolyte imbalance and persistent bleeding. Mrs KC was also seen by a dietician regarding her poor oral intake. The dietician suggested enteral feeding may need to be considered.

On Day 11, the nurses were noting a deterioration in Mrs KC's condition in the patient records. Her urine output was poor. Blood was now oozing from her subcutaneous anti coagulation injection site, her surgical wound and her nostrils. She also had further malaena. Mrs KC was again seen by an intern who did an INR (2 days after the initial malaena) which was found to be very elevated at 12.1. Her LFT's were also elevated. She was treated with Vitamin K, FFP and and her anti coagulant was ceased.In spite of these events and a worsening in Mrs KC's condition, there was still no VMO involvement by either the physicians or the orthopaedic consultant. On the evening of Day 11, Mrs KC was transferred from Ward A to ICU for a transfusion. It appears from the records that Mrs KC's management was handed over to a VMO physician, but that the physician was again not involved in management decisions in spite of Mrs KC's worsening condition. The nursing notes also record Mrs KC's distress at the transfer to ICU.

On Day 12, Mrs KC was seen by a VMO physician who stated that she could be transferred back to the ward. Other than following up microbiology, there was no overall management plan proposed at this point. Mrs KC was again reviewed by the psychiatry registrar who noted Mrs KC's withdrawal, anger and depressed mood. That same day, Mrs KC's family were seen by a social worker who expressed increasing concern and anxiety over their mother's worsening condition and her apparent depressed state. There is no evidence in the records that these concerns were addressed by any senior medical staff involved in Mrs KC's care, nor is there evidence that the family was advised of Mrs KC's deteriorating health. Mrs KC was transferred out of ICU in the afternoon of Day 12 and did not go back to Ward A, but instead was admitted to Ward C, making continuity of care by nursing (and medical) staff more difficult. Mrs KC's compliance with taking medications and refusing to eat was becoming increasingly problematic. The VMO physician appeared to be contacted but again did not see the patient or formulate a management plan in co-ordination with the other teams involved in her care in spite of further decline in Mrs KC's health and well being including increasing depression, worsening skin integrity. On the evening of Day 12, Mrs KC was seen by the admitting VMO (orthopaedics). At this point, the VMO effectively continued current management, making no mention of Mrs KC's declining state, or the need to address this issue with family members. He notes that a VMO physician is away and to be covered by a colleague, indicating a lack of decisiveness as to who is co-ordinating Mrs KC's care.

Investigation into Macarthur Health Service Incident Review

On day 13, Mrs KC was seen by the consultant microbiologist who decreased her antibiotics due to her abnormal LFT's. Mrs KC was again seen by a dietician who noted Mrs KC's failure to meet her nutritional requirements. Mrs KC was seen by a VMO physician, covering for the VMO who was away, who noted her electrolyte problems and suggested upper abdominal CT to check the distal bile duct, but otherwise appeared to be 'holding the fort' until the return of the primary physician, and again no management plan was formulated. Nursing staff were continuing to record Mrs KC's increasing withdrawal, anger and refusal to comply with attempted episodes of nursing care, taking medications and eating solids.

On Day 16, the NUM of Ward C noted that the patient had not been reviewed by any medical team since Day 9. The NUM's record in the notes indicates a lack of clarity as to who is co-ordinating care and the involvement of a number of teams. On this same day, Mrs KC was again transferred, this time to Ward B.

On day 17, Mrs KC was seen by the orthopaedic registrar who noted her serum potassium had again dropped to 1.7. He stated that he had notified the nursing staff that they needed to 'find out the maximum dose of potassium that can be delivered on the ward.' He also requested a repeat wound swab. There appeared to be no urgency attached to this request. Later that same day the same registrar noted that he had discussed Mrs KC with a VMO physician who was 'happy for shared care.' There is no evidence that the primary VMO physician was informed of this arrangement and he did not see the patient himself that day. Again there was no clarity as to who was ultimately responsible for co-ordinating decisions around her care which is further evidenced by the lack of communication with the family.

On Day 18, now in Ward B, Mrs KC was seen by the orthopaedic team who requested removal of her sutures, continue potassium replacement and described Mrs KC's condition as stable. This is in spite of nursing documentation and clinical evidence to the contrary. There was still no active management of Mrs KC's significant medical problem- electrolyte derangement. Later that day she was seen by the VMO physician, who had consented to shared care, who continued to note Mrs KC's electrolyte disturbance but other than proposing an abdo CT does not actively manage it. In the evening she was seen by the orthopaedic VMO who said nothing at all about the patient's decline and wrote 'need physicians help to correct electrolytes'. There is at this point no communication evident between the teams in spite of the electrolyte disturbance being noted by all the teams, and there is still no active management of the problem or leadership and active planning by a physician in charge of overall care.

On Day 19, Mrs KC had an abdo CT, the result was not followed up by a VMO physician until Day 21 and the only reference to it was that the result was noted (the CT report could not be located in the records provided). There is also no evidence that the result was discussed with any family members. In addition to an order to continue to observe the LFT's. There was an ongoing failure to actively manage the problem. The nursing report that same day reported on the increasing drowsiness of Mrs KC.

On Day 20, nursing staff again noted Mrs KC's drowsiness. The nursing staff requested medical review when they became concerned that Mrs KC was virtually anuric. The RMO ordered Hartmann's solution and IV Lasix. Her urine output remained poor although her creatinine was normal. Again there was no VMO input.

On Day 21 at 0900 she was again seen by a medical registrar who noted her decreased urine output, queried left ventricular failure, continued management and suggested further review. He also suggested a Chest x-ray. There was no senior clinical involvement in decision making again in spite of further signs of deterioration in Mrs KC's condition, and no evidence of an approach to the family to involve them in any decisions about Mrs KC's future management. At 1600 hours she was seen again by the same medical registrar who noted her urine output was still poor and that the x-ray was still pending. He ordered Lasix and NG feeds as per the dietician's recommendation of earlier that same day. There was again no discussion with a VMO at this point re management.

On Day 22, early in the morning, Mrs KC was seen by the orhtopaedic team, six days after they last saw her. The team described Mrs KC as alert and stable, medical review is noted with thanks. A bilateral pleural effusion is noted. Although Mrs KC was admitted under the orthopaedic team, it appeared there had almost no input by this team into her ongoing care and problems other than review of her wound, and that medical management was handed over without anyone co-ordinating the many teams involved (including dietician's, psychiatry and microbiologists). Later that morning, Mrs KC was seen again by the medical registrar who noted her saturations had dropped to 92% and that she was in pulmonary oedema. IV fluids were ceased, Lasix was increased and a GTN patch was ordered. This attempt to resurrect Mrs KC's clinical situation appears to have been left very late given the clinical signs of deterioration had been present for many days and yet again there was no VMO involvement and no co-ordination of her care.

On Day 23 at 0500, nursing notes described Mrs KC as initially having an unsettled night but that she was settled at the time of report. However, 5 minutes later, when that same nurse went to attend Mrs KC's pressure area care, she noted and documented that the patient's respirations had ceased and that an RMO had been contacted. At 0510 hours the family was contacted and notified that Mrs KC had died. There is no evidence that the nurse checked Mrs KC's pulse rate or attempted any resuscitation measures, or made a MET call, which given that there was no 'not for resuscitation'order in the notes and that there had been no end of life decision making or discussions held with the patient or her family, would have been appropriate.

The medical certificate states the cause of death was:
a. Cardiac arrest (minutes)
b. Low potassium/congestive cardiac failure (1 or 2 weeks)
c. Infected hip wound (month)
d. Other: Hypertension, non-insulin dependent (years) diabetes.

Within a few days of admission it was clear that Mrs KC's condition was deteriorating. She was increasingly depressed and non-compliant. Her electrolyte disturbance was ongoing and worsening. Mrs KC's oral and nutritional intake was poor and her skin integrity was worsening.

Her family which was frequently at her bedside for lengthy periods were seen by the social worker 9 days into her admission and were clearly anxious about Mrs KC's condition and her behaviour. The family were expressing concerns about being unable to talk to a doctor who was in charge of their mother and not being told what was happening. It was clear from the records that she was under the care of a number of teams and physicians, but it was unclear as to who was leading the multidisciplinary teams in terms of her clinical decisions. None of the teams appeared to take responsibility for liasing and communicating with the family re her deteriorating condition and her complex problems.

Investigation into Macarthur Health Service Incident Review

In the meeting between the family and the Commission they described the experience as completely alienating. They felt that no one was taking their concerns on board and that in the last week of their mother's life her management seemed even more disorganised. The family states that their mother waited days to see a doctor responsible for their mother's care. The description of their experience was that it was like trying to find your way to somewhere, when your life depends upon it, without a map in a foreign country where you don't speak the language. They felt that the system lacked compassion and didn't seem to appreciate the vulnerability of the elderly.

The case was not reviewed by the Critical Care Review Committee or any other quality committee.

Allegations by Informants	Location 1	Location 2
Quality of care	Campbelltown - Med Ward	
Failure to call MET	Campbelltown - Med Ward	
Lack of follow-up of patient and condition	Campbelltown - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
Documentation of treatment and care in health care records	Campbelltown - Med Ward	
Patient decision making and planning for treatment, and end of life care	Campbelltown - Med Ward	
Notifications of deaths to the Coroner and decision making around post mortem	Campbelltown - Med Ward	
Communication with patients and families	Campbelltown - Med Ward	
Quality of clinical care provided by nursing staff	Campbelltown - Med Ward	
Quality of clinical care provided by visiting medical officers	Campbelltown - Med Ward	
Coordination and continuity of care	Campbelltown - Med Ward	
Availability of and supervision by senior medical staff	Campbelltown - Med Ward	

Clinical Review Panel Opinions **Incident No 42**

An indepdendent Clinical Review Panel reviewed the documents obtained and made the following comments:
- INR should have been done earlier and when done on the 10th day it was grossly elevated.
- There was no care plan.
- The attending Doctor was not present.
- In calling MET, it is not clear if the patient showed signs of having been deceased for some time, or whether she appeared to have just arrested when it was discovered she was not breathing. In the latter, a MET call is warranted, in the former, it is not.
- The following factors should have been considered: the patient was non-compliant after transfer to Campbelltown and she was depressed. These psychological factors may have interfered with the ability of staff to deliver the standard of care they may have wished.
- Aspects of care were below minimum acceptable standards.
- The patient allegedly remained unseen by a doctor "for days". There appear to be no medical entries for the 2 consecutive days. Patients should be reviewed by a medical officer at least once a day while in Hospital.

Panel opinion after considering area health service response:
Geriatricians should manage to co-ordinate care
Leadership deficient evidenced by ICU being under the charge of a CMO
Complications of surgery
Re wound dehiscience - she clearly had infection
Matter should have been reported to coroner
Inadequate care and availability of VMO

Commission Views and Comments **Incident No 42**

The Commision makes the following conclusions and comments:

The care provided to Mrs KC was considered unsafe and inadequate for the following reasons:

1. There was a lack of VMO supervision and no comprehensive management plan.

2. There were days when Mrs KC was not reviewed by the orthopaedic team even though her condition was clearly deteriorating.

3. Reviews conducted were by the intern and medical registrar, not the VMO.

4. There was no review by the orthopaedic team for 6 days despite copious wound discharge from the left hip at the suture line site.

5. It does not appear that any VMO was asked to review Mrs KC regarding her drowsiness, low urine output and abnormal electrolytes.

Outcomes **Incident No 42**

The Issue	Quality and Safety Concerns
Documentation of treatment and care in health care records	Partially substantiated
Patient decision making and planning for treatment, and end of life care	Substantiated

Investigation into Macarthur Health Service Incident Review

Notifications of deaths to the Coroner and decision making around post mortem	Substantiated
Communication with patients and families	Substantiated
Quality of clinical care provided by nursing staff	Substantiated
Quality of clinical care provided by visiting medical officers	Substantiated
Coordination and continuity of care	Substantiated
Availability of and supervision by senior medical staff	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 43

Date of Incident Qtr 2, 2002

Summary of Incident **Incident No 43**

In April 2002, Ms BJ, a 21 year old woman was a patient in the Campbelltown OT for a caesarian section. The informant, an experienced theatre nurse, N4 alleged that the anaesthetic CMO Dr D1 made repeated unsuccessful attempts to administer a spinal anaesthetic. Dr D1 changed the procedure to a general anaesthetic. Dr D1 requested a nurse to fetch a laryngeal mask. N4 considered laryngeal mask not safe for caesarean anaesthetic due to possibility of vomiting.

N4 alleges that when she went to inflate the cuff of the endotracheal tube Dr D1 slapped her hands repeatedly.

N4 submitted a detailed incident report to the NUM of the operating theatre the same day as the incident.
N4 referred to the incident 5 months later in an exit interview. She alleges that the incident was not properly investigated.

The medical records document "failed attempts" at spinal anaesthesia and Ms BJ's complaints of pain "down toward the vagina" prior to abandonment of the attempts. Subsequent general anaesthesia with endo-tracheal intubation was undertaken, with no mention of any intention to use a laryngeal mask.

There is no record of any response by MHS management to the nurse N4's incident report or exit interview.

Allegations by Informants	Location 1	Location 2
Inappropriate request for laryngeal mask		
Multiple unsuccessful epidurals	Campbelltown - OT	
A CMO slapped a registered nurse	Campbelltown - OT	

Issues Identified by HCCC	Location 1	Location 2
Relationships and communication within and across clinical teams	Campbelltown - OT	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - OT	
Management response to adverse events, including incident reporting	Campbelltown - OT	

Clinical Review Panel Opinions **Incident No 43**

An independent anaesthetist reviewed this matter and made the following comments:
. Shooting pains as described by Ms BJ are not uncommon.
. It is not uncommon for women having a caesarian section to be very nervous. It is the role of the anaesthetist and nursing staff to reassure the patient.
. Shooting pains and movement were not the fault of the patient.
. It appears that the CMO did not establish a rapport with Mrs BJ and was not sympathetic to her anxious state
. If the spinal block was proving difficult to perform and paresthesia without CSF had been encountered on 2-3 occasions despite redirecting the needle, further attempts at spinal should have been abandoned, particularly as there seems to have been no contraindication to general anaesthetic for Mrs BJ.
. The standard of care was less than one would expect from a person qualified to adminster anaesthetic services to obstetric patients.
. It was appropriate for the CMO to request a laryngeal mask and to request that the covering be removed.
. Rational communication between the CMO and the nurse broke down in such a way that patient safety may have been compromised.
. The head of the Anaesthetic Dept should have interviewed the CMO.
. The patient should have been interviewed to obtain her version of events
. Some direct supervision of the CMO may have been warranted
. A resolution of the dispute between the CMO and the nurse should have been sought.
. The CMO should have listened to the nurses concerns about Mrs BJ.
. MHS management should have asked the anaesthetic department head to assure them of the competence of the CMO
. MHS management should have ensured that adequate protocols were in place and competency standard were met.
. MHS management should have had a system to audit staff performance.
. MHS management shold have investigated the competency of staff performing anaesthetics
. MHS management should ensure that there is a quality improvement program in place.

Commission Views and Comments **Incident No 43**

The Commision makes the following conclusions and comments:

1. The medical records support the allegations of failed attempts by the anaesthetic CMO to insert the spinal block.
2. The incident report submitted by N1 supports the allegation of inappropriate behaviour and poor team communication that could have adversely affected the safety of the patient.
3. The record of N1's exit interview supports the failure of MHS management to properly investigate the incident
4. The incident report should have resulted in some performance management measures by MHS management in relation to Dr D1.
5. MHS management should have provided some feedback to N1 in response to her incident report
6. The CMO failed to communicate adequately with Mrs BJ to reassure her
7. The CMO did not provide an adequate standard of anaesthetic care to Mrs BJ
8. The MHS management response to this incident was not adequate in that:
. Some direct supervision of the CMO was warranted as a result of this incident
. A resolution of the dispute between the CMO and the nurse should have been sought.
. MHS management should have ensured some clinical review and or performance review in relation to Ms BJ's clinical management.
. MHS management should have ensured that adequate protocols were in place.
. MHS management should have had a routine system to audit staff performance management.
. MHS management should ensure that there is a quality improvement program in place.

Investigation into Macarthur Health Service Incident Review

Outcomes	Incident No 43
The Issue	**Quality and Safety Concerns**
Relationships and communication within and across clinical teams	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated
Management response to adverse events, including incident reporting	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 44

Date of Incident Qtr 2, 1999

Summary of Incident **Incident No 44**

In June 1999, Ms LG arrived at Campbelltown delivery suite suffering respiratory distress. She had a history of asthma and was at 35 weeks gestation. Within 15 minutes of her arrival she was seen by the O&G registrar, Dr D38, at 1505 hours. Dr D38 telephoned the VMO obstetrician, Dr D39, to advise of Ms LG's arrival and the fact that she had shortness of breath. She had been taking the antibiotic Keflex for about a week and two days previously she had been offered hospital admission due to the chest infection.

Ms LG's blood pressure was 80/30 and oxygen saturations were recorded to be 89-96% on room air. At 1650 hours she was seen by the anaesthetic CMO Dr D1 and transferred to ICU due to respiratory distress. Ms LG was given ventolin but she remained critical ñ tachypnoeic with oxygen saturation of 98%. A Hudson mask was applied.

At 1715 hours her blood pressure was recorded to be 80/66. The patient was tachycardic at 136 bpm and foetal heart rate was175 bpm. Haemacel was commenced immediately but by 1745 hours her condition worsened with blood pressure at 71/33. According to the obstetrician, he contacted the registrar at approximately 1730 hours and was informed that Ms LG seemed a little improved.

Sometime after 1730 hours the registrar contacted the VMO respiratory physician, Dr D45, who arrived approximately 30 minutes later. The physician recognised the serious condition of Ms LG, recommended important management changes (IV antibiotics, IV fluids for elevation of blood pressure and inotrope support if unsuccessful) and Careflight transfer to a larger unit.

At 1815 hours Ms LG continued to deteriorate, with oxygen saturations of 91% on 6 litres of oxygen. The respiratory physician contacted the VMO obstetrician Dr D39 who attended at 1920 hours. The obstetrician considered it unsafe to perform a caesarean delivery until the mother's condition was stable. He informed us that he recommended helicopter transfer to Liverpool Hospital where intensivist services were available.

At 2025 hours diminishing consciousness and increasing respiratory distress with low saturation resulted in intubation and Bennetts ventilator being used. After this oxygen saturation could not be kept above 85%, so 'hand bagging' with 15 litres of oxygen per minute was commenced.

The patient's medical records indicate that sometime around 2030 hours the O&G registrar ordered road ambulance transport. The registered nurse subsequently contacted Careflight requesting urgent transfer. The patient was taken to Liverpool Hospital by road ambulance with a Careflight anaesthetist in attendance. Ms LG arrived at Liverpool Hospital at approximately 2200 hours. It is understood that both mother and baby survived but we have been unable to confirm this.

The following month this case was presented at the perinatal mortality and morbidity meeting. It was agreed that the registrar had failed to recognise the severity of the patient's illness. It was recommended that communication between departments and between registrars and VMOs should be improved and that registrars should ring obstetric VMOs any time they have concerns. There is no evidence that these recommendations were relayed to the acute care review committee or that any changes to hospital protocol were implemented. In June 2003 MHS confirmed that the case had not been reviewed by acute services or maternal and child health.

Allegations by Informants	Location 1	Location 2
O&G registrar failed to call Careflight transfer	Campbelltown - ICU	
Registrar failed to recognise critical condition	Campbelltown - ICU	

Issues Identified by HCCC	Location 1	Location 2
Quality of clinical care provided by visiting medical officers	Campbelltown - ED	Campbelltown - ICU
The Medical Emergency Team (MET) at Macarthur Health Service	Campbelltown - ED	Campbelltown - ICU
Management response to adverse events, including incident reporting	Campbelltown - ICU	
Availability of and supervision by senior medical staff	Campbelltown - ED	Campbelltown - ICU

Clinical Review Panel Opinions **Incident No 44**

The Clinical Review Panel did not review this incident. This was because the patient was not identified until later. In the absence of a Panel opinion, a clinical adviser from the Commission reviewed the medical records and formed an opinion on the care provided to the patient.

The following is a summary of the clinical adviser's report:
- The medical record is of an acceptable standard albeit somewhat disjointed.
- The O&G registrar saw the patient at 1505 hours in ED and ordered some investigation and apparently notified the VMO obstetrician under whose name the patient appears to have been admitted. Consult with respiratory physician was arranged.
- It seems the obstetrician opined the patient "would not tolerate OT" ie was not fit for caesarean section.
- The respiratory physician saw the patient at an unstated time after 1730 hours and recognised that she was "very unwell", recommended IV fluids to elevate blood pressure and inotropic support if fluids did not do so, intravenous antibiotics and transfer to a "larger unit".
- There was a serious systemic problem. The obstetrician probably confined his attention to the obstetric problems.
- There were delays in the institution of initial measures as follows:

a. treatment of hypotension.
b. treatment of severe hypoxia not reversed by simple oxygen therapy.
c. treatment of serious pulmonary infection.
d. transfer to ICU some 2 hours after ED presentation.

Investigation into Macarthur Health Service Incident Review

• The systemic problems were at least in part due to:
a. Ms LG being under the primary care of an obstetrician when her illness was medical.
b. No one medical officer took overall responsibility for her care.
c. There was no intensivist on site to assess and treat her. The doctor who assessed her prior to transfer to ICU was apparently a CMO.
d. Absence of communication between the obstetrician and physician about management.
e. Under the circumstances, it is expected that management would have been aware of the concerns raised by staff.

Panel opinion after considering area health service response:
1. The clinical management of this patient was poor specifically:
a. Intervention was too slow
i. There was a 2 hour delay from presentation until CMO ICU was involved
ii. The trouble began when the O&G Registrar saw her and did not act the VMO should have been brought in earlier
iii. She should have been transferred to a tertiary hospital earlier
iv. She was kept at Campbelltown Hospital for several hours despite it being the middle of the working day when support services were readily available. She was not transferred until late at night
b. Lack of recognition of the seriousness of the patient's condition
i. The VMO Obstetrician's response to telephone contact by O&G Registrar was prademetic. Attendance by a senior medical clinician was clearly warranted immediately.
ii. Pneumonia in the presence of gestation is a serious indicator.
iii. It should have been recognised she was very ill and required immediate intervention
iv. This patient was probably one of the most seriously ill patients in the hospital

2. Systemic issues contributing to the poor management of this patient
a. There was no senior person in charge, and no consultant anaesthetist or intensivist
b. ICU is unable to provide ICU services. This case indicates ICU is used as a holding bay.

3. A MET was not called when MET criteria were met. The calling of a MET may have sped things up.

4. Other comments:
The patient's respiratory distress would have been less severe after the birth.
This case is an example of poor response to critically ill patients, and of poor quality of care by the VMO (Obstetrician).

Commission Views and Comments	**Incident No 44**

The Commision makes the following conclusions and comments:

The Commission found that the care provided to Ms LG was unsafe and inadequate for the following reasons:
1. The O&G registrar and the VMO obstetrician failed to recognise the severity of the patient's condition:
• When the O&G registrar contacted the VMO obstetrician for the purposes of admission, the VMO obstetrician should have asked the patient's vital signs. This would have alerted him to the need for his immediate attendance at the hospital.
• When the VMO obstetrician telephoned the O&G registrar at 1730 hours, the registrar misled the VMO by stating that the patient was somewhat improved. This was despite the presence of hypotension, tachycardia and a foetal heart rate of 175 bpm.
• The CMO and at least one of the VMOs recommended urgent transfer by Careflight to Liverpool Hospital. Despite this recommendation, the O&G registrar booked ordinary road ambulance transport. It was only because of the intervention of the registered nurse that a Careflight anaesthetist attended the patient during transfer.

2. The response by MHS to the critical incident was inadequate because:
• The case was presented at the perinatal mortality and morbidity meeting where it was recognised that there were problems with team communication and supervision. The quality committee (acute care committee) did not review the case and no changes to hospital protocol were formalised.

• There is no evidence that any action was taken by MHS to prevent a similar occurrence.

Outcomes	**Incident No 44**
The Issue	**Quality and Safety Concerns**
Quality of clinical care provided by visiting medical officers	Substantiated
The Medical Emergency Team (MET) at Macarthur Health Service	Substantiated
Management response to adverse events, including incident reporting	Substantiated
Availability of and supervision by senior medical staff	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 45

Date of Incident Qtr 2, 2002

Summary of Incident **Incident No 45**

Mr Y, 56 years, was admitted to Campbelltown Hospital emergency department (ED) in early 2002 at 0242 hours. The triage nurse, R 2, attended him at 0314 hours, 32 minutes after his arrival and assessed him as triage category 3, requiring him to be seen within 30 minutes. The triage nurse noted Mr Y had a history of a strange feeling at around 0230 hours, was feeling unwell, clammy to touch, nausea, epigastric pain, and had jaw pain. Mr Y's blood pressure was 166/104, his PR was 87, his RR was not recorded, his temperature was 36.3C, and his O2 saturation was 99%.

The ED CMO (D12) examined Mr Y 22 minutes after he was triaged at 0342 hours. Dr D12's detailed history states that Mr Y had chest pain radiating to the jaw and arms at around 0200 hours earlier that night. The provisional diagnoses were acute transmural myocardial infarction and hyper-cholesterolaemia. The ED CMO prescribed metalyse, IV fluids were commenced followed by heparin infusion and oral aspirin. An ECG, chest x-ray and blood tests were ordered. The ED CMO noted that the ECG showed inferior myocardial infarction. There is no record that a VMO was consulted.

ICU was contacted at 0430 hours, around 1 hour and 26 min after the patient was triaged. Mr Y was given morphine and maxalon for pain. His BP was 165/115. As Mr Y was being transferred to ICU at 0618 hours he suffered a cardiac arrest. He was successfully defibrillated on the third attempt. After defibrillation Mr Y denied chest pain, but was observed to be pale and diaphoretic. On arrival in ICU his BP was 98/60, PR 44 60 in slow AF. Arrangements were made for urgent Careflight transfer of Mr Y to Liverpool Hospital at 0800 hours where he died. Mr Y's family were in attendance at Campbelltown Hospital and there is a record that Mr Y's management plan was explained to the family.

Management was not aware of this case at the time of Mr Y's admission in April 2002. A report dated 14 April 2003 shows that the case was reviewed by the Acute Services Review Committee and referred to the Physicians QA meeting for advice. The Physicians discussed the case on 17 February 2003 and commented that treatment, such as aggrostat should be considered in the future management (of myocardial infarctions), in consultation with a cardiologist. Further, if one of the MHS 2 cardiologists is unavailable, the on-call cardiologist at Liverpool Hospital should be contacted.

In response to the Commission's s.43 report, MHS agreed that there were issues relating to the quality of the nursing care of Mr Y. but did not specify the aspect of care this was. There was no information provided in relation to the implementation of the recommendations of the physicians in February 2003 and any evaluation if any, of the protocols introduced.
Having reviewed documents relating to this case the Commission found that, while a number of aspects relating to the care and management of Mr Y were just within limits of what would be considered adequate care and the timeframe considered reasonable for the care, some aspects of the clinical management of Mr Y were of an appropriate standard. Those aspects considered to be unsafe and inadequate were:
1. Mr Y should have been transferred to a tertiary hospital rather than transfer him from ED to ICU given that he required urgent angiography, stenting or bypass surgery, and this was not available at Campbelltown Hospital.
2. There was a failure to illicit information about Mr Y's symptoms and inappropriately categorised Mr Y at Level 3 when he should have been Level 2 due to his clinical presentation and history.

Allegations by Informants	Location 1	Location 2
Failure to provide constructive feedback to staff	Campbelltown - ED	
Campbelltown "swept the incident under the carpet"	Campbelltown - ED	
Delay in treatment recognising cardiogenic shock	Campbelltown - ED	

Issues Identified by HCCC	Location 1	Location 2
Patient transfer to higher level units or hospitals	Campbelltown - ICU	
Quality of clinical care provided by nursing staff	Campbelltown - ED	
Management response to adverse events, including incident reporting	Campbelltown - ED	

Clinical Review Panel Opinions **Incident No 45**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- The triage nurse inappropriately categorised Mr Y at Level 3 when he should have been Level 2 due to the infarct.
- The nurse failed to elicit information from Mr K about his symptoms. He was under-triaged.
- The Health Department benchmark for "door to needle" time is one hour, and according to the medical record, he was treated just within that time.
- The patient's progress through the ED was delayed, but not unacceptably.
- The management may be considered just safe and the care acceptable.

Commission Views and Comments **Incident No 45**

The Commision makes the following conclusions and comments:

Having reviewed documents relating to this case the Commission found that, while a number of aspects relating to the care and management of Mr Y were just within limits of what would be considered adequate care and the timeframe considered reasonable for the care, some aspects of the clinical management of Mr Y were of an appropriate standard. Those aspects considered to be unsafe and inadequate were:

1. Mr Y should have been transferred to a tertiary hospital rather than transferring him from ED to ICU given that he required urgent angiography, stenting or bypass surgery, and this was not available at Campbelltown Hospital.

2. There was a failure to illicit information about Mr Y's symptoms and inappropriately categorised Mr Y at Level 3 when he should have been Level 2 due to his clinical presentation and history.

Investigation into Macarthur Health Service Incident Review

Outcomes	Incident No 45
The Issue	**Quality and Safety Concerns**
Patient transfer to higher level units or hospitals	Substantiated
Quality of clinical care provided by nursing staff	Substantiated
Management response to adverse events, including incident reporting	Not substantiated

Investigation into Macarthur Health Service Incident Review

Incident No **46**

Date of Incident Qtr 1, 2001

Summary of Incident **Incident No 46**

Ms P, a 26 year old woman presented early one morning in mid 2001 with acute asthma to Campbelltown Hospital Emergency Department. She gave a story of upper respiratory tract infection over the previous day and had a history of numerous presentations to hospital with acute asthma, but had never been intubated or admitted to ICU. She was able on arrival at ED, to speak in long sentences, had prominent wheezing, adequate air entry, and her asthma was judged to be of moderate severity.

Despite appropriate initial therapy, she remained acidotic (PH 7.32) 2 hours after admission and was transferred to ICU, where she complained of tiredness. After one hour of further intensive appropriate treatments in ICU her Arterial Blood Gases were worse, with pH 7.25 and retained Carbon Dioxide of 49.

A respiratory physician was then rung, and he advised that the patient should be ventilated forthwith. The anaesthetic CMO on duty, Dr D1 had the necessary equipment for intubation brought to the bedside but delayed intubation because Ms P was able to talk and had an oxygen saturation of 99% and because intubation and ventilation in acute asthma can be difficult. Dr D1 gave Ms P small dose of less than 1 mg of Midazolam, as she thought that might improve Ms P's anxiety and respiratory reserve. Ms P became calmer, but her respiratory rate and levels of consciousness decreased and she was immediately intubated. She was easy to ventilate, but oxygen saturation dropped from 90% to 50% and she became bradycardic. She then developed electro-magnetic dissociation then VT on her ECG before reverting to EMD. Urgent chest X-ray showed only a small insignificant pneumothorax, and despite intensive resuscitation for next 40 minutes, she died 2-1/2 hours after admission to ICU, about 4 hours after admission to ED.

The care and treatment of Ms P was not reported to MHS management as an incident of concern at the time it happened. Her death was not reported to the Coroner.

Allegations by Informants	Location 1	Location 2
Failed to refer the death to the Coroner	Campbelltown - ICU	
Clinical review meeting confirmed wrong diagnosis	Campbelltown - Other	
An incorrect 'cause of death' entered on the death certificate	Campbelltown - ICU	
Test results were inconsistent with the diagnosis	Campbelltown - ED	Campbelltown - ICU
An important cause of death was missed	Campbelltown - ED	Campbelltown - ICU

Issues Identified by HCCC	Location 1	Location 2
Recognition and response to critically ill patients	Campbelltown - ED	
Documentation of treatment and care in health care records	Campbelltown - ED	
Communication with patients and families	Campbelltown - ICU	
Availability of and supervision by senior medical staff	Campbelltown - ICU	
Quality of clinical care provided by nursing staff	Campbelltown - ED	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ED	Campbelltown - ICU
Notifications of deaths to the Coroner and decision making around post mortem	Campbelltown - ICU	

Clinical Review Panel Opinions **Incident No 46**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- The doctors failed to recognise the severity of Mrs P's condition, and the fact that she was dying.
- It is very difficult to treat severe asthma as the approaches are diverse and highly specialised.
- The manoeuvres provided to her were acceptable, and the doctors tried everything, however, there was a lack of practitioner experience.
- When an asthma attack is severe enough to warrant intubation, the morbidity rate is high.
- The most likely cause of death is asthma. The allegation that the patient did not die of asthma cannot be substantiated.
- No-one notified the relatives of this woman's transfer to ICU. This should have occurred.
- Ms P was given 1 mg Midazolam for agitation just prior to arrest. Midazolam should only be used if the practitioner is about to intubate as it can have a depressant effect.
- There was a lack of specialist input. The consultant should have been called to see the patient once it was decided to postpone intubation.
- The VMO was notified at 0720 hours and the patient arrested at 1100 hours.
- There was inadequate medical coverage. A specialist intensivist is needed in ICU.
- Nursing records indicate inadequate observations and monitoring in ED, no peak flow, no ECG, infrequent observation.
- If a fallback staff specialist is not available, the facility should not be looking after such patients.
- An intern should never be in ICU.

Panel opinion after consideration of the s.43 submission from SWSAHS:
- The panel did not support the view that the death of Ms P should have been reported to the Coroner. The cause of death was clear.
- The delay in intubation was reasonable. The procedure should not be done too early. They had the equipment ready.
- The administration of Midazolam was injudicious but does not warrant criticism in the circumstances
- This was a very complex clinical case and required a senior intensivist
- Concern about the standard of care by the ICU CMO is only partially substantiated due to the lack of specialist supervision.

The main issue in this incident is the lack of an intensivist on site. In order to provide and adequate standard of care in the Campelltown Hospital ICU. The MHS state that they have been trying to recruit one for 7 years is not an adequate response.

Investigation into Macarthur Health Service Incident Review

Commission Views and Comments	Incident No 46

The Commision makes the following conclusions and comments:

The Commission concludes that the care provided to Mrs P was unsafe and inadequate for the following reasons:
a. There was a lack of practitioner experience and a lack of specialist input. The consultant should have been called to see the patient once it was decided to postpone intubation.
b. A specialist intensivist was needed in the ICU.
c. Nursing records indicate inadequate observations and monitoring in the Emergency Department, no peak flow, no ECG and infrequent observations.

In relation to hospital systems issues, the Commission acknowledges that care and treatment of Ms P was not reported to MHS management as an incident of concern at the time it happened. However the main systems issue in this incident is the lack of an intensivist on site. The Commission is of the view that MHS should have obtained the services intensivists in order to provide and adequate standard of care in the Campelltown Hospital ICU. The MHS response that they have been trying to recruit one for 7 years is not an adequate response.

Outcomes	Incident No 46
The Issue	**Quality and Safety Concerns**
Recognition and response to critically ill patients	Partially substantiated
Documentation of treatment and care in health care records	Substantiated
Communication with patients and families	Not substantiated
Availability of and supervision by senior medical staff	Substantiated
Quality of clinical care provided by nursing staff	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Partially substantiated
Notifications of deaths to the Coroner and decision making around post mortem	Not substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 47

Date of Incident No Date Identiied

Summary of Incident **Incident No 47**

The following information was provided by the informant.

42 year old male diabetic. Regular insulin had not been ordered as the doctor on duty was a locum and reluctant to order his regular insulin.High blood sugar levels - exceeded 30 mmols. A nurse contacted the doctor who ordered 8 units of actrapid which was considered by the EN to be insufficient. FBC was phoned through from Liverpool reported that the BSL was 42 mmol.

On 23/5/03 the Commission requested further information from the informant, however no further information could be provided.

Clinical Review Panel Opinions **Incident No 47**

Commission Views and Comments **Incident No 47**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No 48

Date of Incident No Date Identiied

Summary of Incident **Incident No 48**

The following information was provided by informant.

22 year old man in ICU. Post appendectomy. Septic, pulmonary oedema. Delay in review by medical officer. Doctor was seated in the tea room and had to be asked repeatedly to examine the patient. Incident occurred around april 2001.

On 23/5/03 the Commission requested the informant provide further information to assist identification. No further information could be provided by the informant.

Clinical Review Panel Opinions **Incident No 48**

Commission Views and Comments **Incident No 48**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No 49

Date of Incident No Date Identiied

Summary of Incident **Incident No 49**

The following information was provided by informant.

19 year old man in ICU with chicken pox. A nurse reported she left instructions for him to remain on CPAP and bed rest. Another nurse walked him to the shower and he subsequently required intubation. Occurred early 2002.

On 23/5/03 the Commission requested the information provide further information to assist identification of the patient. No further information was forthcoming.

Clinical Review Panel Opinions **Incident No 49**

Commission Views and Comments **Incident No 49**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No **50**

Date of Incident No Date Identiied

Summary of Incident **Incident No 50**

The following information was provided by informant.

Female patient with acute abdomen in ICU at Camden Hospital died of sepsis in 2001. Case was presented by Director of EM on 21/9/01. Patient was pale, stable, at 6 o'clock became diaphoretic, BP of 70 to 80. Reviewed again by doctor - tachypnoeic and marked "Distress". Despite appearing ill, no action was taken. She was transferred to Campbelltown Hospital where no action was taken. Her doctor stated she had distended abdomen, no bowel sounds, looks grossly unwell. She was sent to the ward. She had a letter from her local doctor with a diagnosis. 24 hours after presentation, MET was called and she was transferred to ICU to be stabilised to go to theatre. She died from overwhelming sepsis due to 24 hour delay in action.

On 21/5/03 a description was provided to SWSAHS requesting identification.

Further information was sought from the informant on 23/5/03, however no further information could be provided as the informant was not familiar with incidents occurring at Camden Hospital.

On 29/5/03 MHS informed that the patient could not be identified.

Clinical Review Panel Opinions **Incident No 50**

Commission Views and Comments **Incident No 50**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No 51

Date of Incident No Date Identiied

Summary of Incident **Incident No 51**

The following information was provided by informant.

Male patient, post vascular surgery. The surgeon was contacted by a nurse post operation. He returned to the hospital at 0400 hours. Patient was transferred about 0900 but died on the way to Liverpool Hospital.

On 21/5/03 the Commission requested SWSAHS identify the patient involved.

On 23/5/03 the Commission sought further information from the informant, however no further information was forthcoming.

On 29/5/03 MHS advised the Commission that the patient could not be identified.

Clinical Review Panel Opinions **Incident No 51**

Commission Views and Comments **Incident No 51**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No **52**

Date of Incident No Date Identiied

Summary of Incident	**Incident No**	**52**

The following information was provided by informant.

Young male patient in ICU with pneumonia who was deteriorating for weeks. He died with undiagnosed pulmonary embolus. Poor blood gases went unnoticed. Case referred to critical care committee. The case was presented at the Mobidity and Mortality meeting by Dr D37 in mid 2001.

On 29/5/03 MHS advised that the patient could not be identified.

On 4/6/03 further information was provided to SWSAHS regarding this incident.

On 10 June 2003 SWSAHS confirmed that the identity of the patient could not be established, and that Dr D37 did not recall presenting this case at a meeting in mid 2001. The minutes of the meetings for 2001 did not include any cases that matched the details of this incident.

The minutes of the meeting of 24/7/00 provided to the Commission refer to the case of an 82 year old man with pneumonia suffering pulmonary oedema and cardiac arrest. This did not match the informant's description.

Clinical Review Panel Opinions	**Incident No**	**52**

Commission Views and Comments	**Incident No**	**52**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No 53

Date of Incident No Date Identiied

Summary of Incident **Incident No 53**

The following information was provided by informant.

Patient was hypoxic - nurse unable to work the ventilator.
Patient not hand-bagged in the meantime.

On 24/4/03 further information was sought from the informant. The informant informed the Commission that this incident did not related to one particular patient, but had occurred several times.

Because of the lack of identifying features, this case was not investigated.

Clinical Review Panel Opinions **Incident No 53**

Commission Views and Comments **Incident No 53**

The Commision makes the following conclusions and comments:

This incident could not be investigated due to lack of identifying information.

Investigation into Macarthur Health Service Incident Review

Incident No **54**

Date of Incident No Date Identiied

Summary of Incident **Incident No 54**

The following information was provided by informant.

Psychiatric patient in ICU - picked up a fire extinguisher. Had to be talked down.
(No date provided.)

On 23/5/03 the information was asked to provide further information to assist the identification of the patient. No further information was provided to the Commission.

This incident was not investigated due to lack of information.

Clinical Review Panel Opinions **Incident No 54**

Commission Views and Comments **Incident No 54**

The Commision makes the following conclusions and comments:

This incident could not be investigated due to the lack of identifying information.

Investigation into Macarthur Health Service Incident Review

Incident No **55**

Date of Incident No Date Identiied

Summary of Incident **Incident No 55**

The following information was provided by informant.

Pyromanic patient in ICU. Lit fires on two consecutive nights in the new ICU unit.
(No date provided.)

On 23/5/03 the Commission sought further information from the informant, however no further information could be obtained.

This incident was not investigated due to the lack of information.

Clinical Review Panel Opinions **Incident No 55**

Commission Views and Comments **Incident No 55**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No 56

Date of Incident No Date Identiied

Summary of Incident **Incident No 56**

The following information was provided by informant.

Female patient with embolism in leg undetected by nurse. Required ambulance transfer and emergency surgery.

On 23/5/03 the Commission sought further information from the informant, however no further information was forthcoming.

This incident was not investigated due to the lack of identifying information.

Clinical Review Panel Opinions **Incident No 56**

Commission Views and Comments **Incident No 56**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No **57**

Date of Incident No Date Identiied

Summary of Incident **Incident No 57**

The following information was provided by informant.

No graft of correct size available for patient undergoing triple A bypass. Patient had aorta clamped for 2 hours - 1 hour is the longest safe time for clamping.

On 23/5/03 the Commission sought further information from the informant, however no further information was forthcoming.

This incident was not investigated due to lack of identifying information.

Allegations by Informants	Location 1	Location 2
Surgeon - poor practices and poor outcomes		

Clinical Review Panel Opinions **Incident No 57**

Not reviewed by CRP

Commission Views and Comments **Incident No 57**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No **58**

Date of Incident No Date Identiied

Summary of Incident **Incident No 58**

The following information was provided by informant.

52 year old female with chest pain. Patient presented unconscious -reportedly had no care, no BSL, no routine drug screen done, no ECG despite having VEBs and written overdose. Died at home following discharge from ED.
(No date provided. Some conflicting information regarding the allegations.)

On 23/5/03 the Commission sought clarification from the informant. NO further information was provided.

Clinical Review Panel Opinions **Incident No 58**

Commission Views and Comments **Incident No 58**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No 59

Date of Incident Qtr 2, 2001

Summary of Incident **Incident No 59**

In mid 2001, Mr C was admitted to the emergency department at Campbelltown Hospital after taking a number of Valium and Cipramil pills with a quantity of alcohol. Prior to admission, the ambulance officers recorded that Mr C had a BP of 150/100, a Glasgow Coma Scale (GCS) of 15 out of 15 and his pupils were normal and equal. On arrival at 0243 hours, Mr C was conscious and had a BP of 140/80, one set of observations were unsafe and no neurological observations were recorded on his medical file. On arrival Mr C was spoken to by the ED registrar who recorded that Mr C was depressed.

Mr C's wife was contacted and she refused to attend to take charge of Mr C. At 0400hrs Mr C was located in the ED smoking and attempting to hang himself in the bathroom of the ED with a towel. Mr C was described as being ìnon responsive but cooperative. There was no supervision of the patient although hospital security was aware of his presence.

At 0530 hours the psychiatric registrar was contacted by CMO and an arrangement was made to assess Mr C at 0700 hours. By 0830hrs no assessment had been made by the psychiatric registrar. Contact was made with Waratah House (Psychiatric Unit). The psychiatric registrar was not in the unit and nursing staff were watching another patient.

At 0835 hours Mr C was scheduled by two registrars in ED. Security was then contacted but they refused to watch the patient as he was not actively running away. At 0850 hours the psychiatric registrar assessed Mr C, found him to be ìdepressedî but ìnot detainableî under the Mental Health Act and discharged him with follow up advice.

In the year preceding this incident, a number of problem forms had been submitted to management. One had been submitted a matter of days before this incident (refer to incident 22).

It is apparent that MHS knew about this incident at the time as the Director Emergency Medicine, called a forum to discuss ongoing problems impacting on Mental Health and ED functioning. As well a problem form was submitted, identifying deficits in the care of psychiatric patients who presented to the hospital for medical treatment. In May 2002, one year after this incident, MHS initiated the rostering of psychiatry registrars after hours. In March 2003 a service agreement between the Mental Health Service and the Emergency Department was signed however the Commission has concerns regarding the level of consultation which took place prior to the devising of such an agreement, and the appropriateness of signatories to the agreement.

Improved access to acute beds for mental health patients remains an issue.

Allegations by Informants	Location 1	Location 2
Patient tried to suicide in ED not placed on observation	Campbelltown - ED	
Care of psych patients brought to ED	Campbelltown - ED	

Issues Identified by HCCC	Location 1	Location 2
Quality of clinical care provided by nursing staff	Campbelltown - ED	
Quality of clinical care provided by visiting medical officers	Campbelltown - ED	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ED	
Relationships and communication within and across clinical teams	Campbelltown - ED	
Management response to adverse events, including incident reporting	Campbelltown - ED	
Availability of and supervision by senior medical staff	Campbelltown - ED	

Clinical Review Panel Opinions **Incident No 59**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- One set of nursing observations as recorded in the patient notes is unsafe. No neurological observations were done on this patient.
- The psychiatric registrar saw the patient after several hours. The psychiatric registrar was notified at 0530 hours and agreed to attend at 0700 hours. The patient was scheduled at 0835 hours. The registrar assessed the patient at 0900 hours.
- There was an inadequate observation regime for someone who was unconscious.
- There is an issue about security refusing to watch the patient. This is a global problem relating to availability of resources for psychiatric patients to ensure patient safety.
- The patient was quiet and intoxicated.
- The patient should have been scheduled immediately after the suicide attempt.
- Based on the file, there is no indication of a management action plan.
- The care was suboptimal as there was no supervised observation.

There has been a review of security arrangement, and ED/Mental Health relations which both appear relevant to addressing some of the issues highlighted

There is a clear picture of the arrangements that stood at the time, for contact and review by the psychiatric team, and this issue has now been addressed. There appears to have been improvements made, and efforts to address the situation. There are continuing problems, this is endemic for patients with mental health problems in ED's

Investigation into Macarthur Health Service Incident Review

There is an opinion that the patient did not require a schedule following an attempted hanging. This is refuted. This is a critical incident, and it is evident that the patient was eliciting behaviour, which displayed an intention for self harm. The staff required the patient to be placed under close observation, hence they must have had some (well-founded) doubts that the patient may attempt further self harm. Thus, it can not be assumed that the danger was resolved. The psychiatrist later reports that the schedule was probably written after consultation with the psych team, thus they must have thought it justified on the patient history.

The nursing notes report that the patient had been unconscious prior to arrival. If a nurse believes this to be so, the patient should be commenced on neurological observations. If intoxicated, an alcohol withdrawl scale is also recommended.

Commission Views and Comments	**Incident No**	**59**

The Commision makes the following conclusions and comments:

1. The Commission concludes that the care of the patient was unsafe and inadequate for the following reasons:
a. Psychiatric staff did not attend when requested resulting in a delay to psychiatric assessment, this was despite the fact that the patient had attempted self harm in the ED. During this time the patient did not receive any psychiatric care.
b. The patient was scheduled in the Emergency Department and detained for some time before being seen by the psychiatric registrar and discharged home. The decision to discharge a patient who had made 2 suicide attempts in the previous 24 hours and who had a flat, unresponsive affect, was unsafe and inappropriate.
c. There was an absence of appropriate medical assessment and investigation of this patient's possible drug overdose.
d. Supervision of this patient was required.

2. Consideration should be given to the immediate transfer of acute psychiatric patients to the mental health unit at Waratah House where they would have access to appropriate treatment and supervision. This should occur only after excluding serious medical problems. If a bed is available that belongs to a psychiatric patient on gate pass, that bed should be used for acute psychiatric patients awaiting urgent admission to Waratah House.

MHS has failed to adequately and in a timely way implement 1998 recommendations made by the Department of Health Working Group for Mental Health Care in Emergency Departments.

3. The response to this incident by MHS was inadequate for the following reasons:
a. There was an 11 month delay before after hours coverage was initiated. This is despite the fact that management had been alerted to similar problems since mid 2000.
b. Guidelines should have been set down to clearly define the responsibilities for non clinical staff in relation to the supervision of patients while they are in ED.
c. The appropriateness of the signatories to the service agreement, signed in March 2003, is of concern.
d. Despite the submission of a number of problem forms reporting concerns to management about the care of mental health patients, after hours rostering of psychiatry registrars did not occur until 11 months after this incident.

4. The Director of Emergency Medicine, MHS convened a forum to discuss on-going problems impacting on mental health and ED functioning. This action was appropriate.

Outcomes	**Incident No**	**59**
The Issue		**Quality and Safety Concerns**
Quality of clinical care provided by nursing staff		Substantiated
Quality of clinical care provided by visiting medical officers		Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars		Substantiated
Relationships and communication within and across clinical teams		Not substantiated
Management response to adverse events, including incident reporting		Substantiated
Availability of and supervision by senior medical staff		Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 60

Date of Incident Qtr 2, 2001

Summary of Incident **Incident No 60**

In June 2001, Mr V was transported to the emergency department at Campbelltown Hospital by ambulance after an overdose of an unknown quantity of duromine 30 mgs. On arrival at 0140 hours, Mr V had a Glasgow Coma Scale (GCS) of 3 out of 15, no response to verbal or painful stimuli, and was fitting and peripherally shut down. Mr V was intubated and ventilated and transferred to ICU. The patient's condition improved during the day and he was extubated in the late afternoon. The ICU registrar requested 24 hours monitoring and psychiatric review before discharge.

The following day, a Sunday, the ICU registrar discussed Mr V with a psychiatry registrar who refused to consult face to face as she had been at Waratah House at 0900 hours and was not prepared to return. The ICU registrar suggested a phone assessment but the psychiatry registrar refused, stating that she would prefer the ICU registrar to make the assessment himself or for the patient to remain in hospital overnight for review by the psychiatric team the next morning.

The ICU registrar was of the opinion that Mr V needed a formal psychiatric consult before discharge because of the seriousness of his presentation. As there was an on-call psychiatry registrar who had the expertise to perform an appropriate psychiatric assessment, it was felt that he should review Mr V.

The psychiatry registrar remained resistant to requests to assess the patient for possible discharge. Mr V was in ICU and the bed he was occupying was urgently required for an ED patient. The psychiatry registrar finally informed the ICU registrar that, after telephone consultation with the psychiatrist on call, it was decided that Mr V could be discharged home without formal review. Mr V was reluctant to be discharged as he would be at home alone. He was therefore transferred to a ward bed and a psychiatric review finally took place at 1335 hours the following day.

Dr David Hugelmeyer, director Emergency Medicine, MAHS called a forum to discuss on going problems impacting on Mental Health and ED functioning

MHS appears to have known about this incident because this incident appears to have been reviewed at the After Hours Hospital Managers meeting on 14/1/02. At this meeting it was decided that if a psychiatric patient needed review by a psychiatric registrar before being transferred to a facility out of area, the review could be completed by telephone.

The Mental Health Services review of this incident included the following comments:

1. The Macarthur Mental Health Service had inadequate resources to meet this type of service need.
2. The inadequacy of services has been acknowledged in various reviews of the service.
3. The patient was not under the Mental Health Act.
4. All medical practitioners should be able to conduct a basic psychiatric assessment.
5. Psychiatrists have requested on duty registrar services for the after hours shifts over several years.
6. After hours on duty registrar cover started from May 2002 following action by ASMOF.
7. Provision of a psychiatric consultation requires the active participation of a patient's medical team. The mental health team is concerned that information was not conveyed by the medical team to the allocated VMO.

A response from the VMO physician under whom this patient was admitted indicates that at no time was he informed of this patient's admission.

Allegations by Informants	Location 1	Location 2
Inadequate psychiatric support	Campbelltown - Other	Campbelltown - ICU

Issues Identified by HCCC	Location 1	Location 2
Quality of clinical care provided by visiting medical officers		
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - Other	
Management response to adverse events, including incident reporting	Campbelltown - ICU	Campbelltown - ED
Availability of and supervision by senior medical staff	Campbelltown - Other	

Clinical Review Panel Opinions **Incident No 60**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:
- The psychiatry registrar should have visited the patient at ICU once he was stabilised.
- In relation to the issue of coverage by the psychiatry registrar. After-hours psychiatry registrar coverage was commenced in May 2002.
- MHS action implementing after-hours coverage was appropriate.
- Positive aspects of care included good triage and initial medical care given to the patient.

Panel opinion after considering area health service response:
Evaluation was necessary as still not acceptable that psych registrar was unwilling to attend despite the fact that she was on call/covering and that is her role.

On call duties are to respond and or attend to assess situation if required or necessary to do so. More importantly this was discharge dependent. This delayed patient either going home or receiving a more appropriate bed allocation rather than occupying an ICU bed, NOT client based care . It was not appropriate for the ICU registrar to give a psych consult. The ICU registrar had valid concerns re this request.

Investigation into Macarthur Health Service Incident Review

Psych consult may be needed to be pre-arranged, change in mental state not necessary for psych consult patient unable to be consulted as intubated. What mental state? In an overdose not enough to warrant a psych review?

CRP is fully aware of factors contributing to admission delays as we are climatised to these, but on call registrar still attends if necessary. If the decision to delay review is reasonable, patient needed appropriate placement until this was done ICU bed was not appropriate.

Discharge was not a priority client centred care and appropriate placement according to greatest need.

Initial care was good
Lack of mental health beds (Universal)
Unwillingness of psych registrar to attend/assess despite being on call
Initiatives regarding mental health issues forum by ED - Mental Health Team not aware. It is hard to solve problems when uninformed - need to evaluate and implement
Inappropriate bed usage as psych unwilling to attend
A basic psych evaluation as suggested by mental health team inappropriate for ICU doctor to do re the circumstances of severity of overdose. Needed a specialist psych review.

Commission Views and Comments	**Incident No**	**60**

The Commision makes the following conclusions and comments:

The Commission makes the following conclusions and comments:
1. The Commission concludes that the care of the patient was inadequate for the following reasons:
a. There is no documentation in the medical records that the attending VMO was notified of this patient's admission.
b. A call psychiatry registrar should have been available to attend Mr V on the Sunday when requested by the ICU registrar.
c. This patient had made a serious overdose attempt and it was unreasonable to expect the ICU registrar to conduct a psychiatric assessment on a high risk patient before discharge. Such an assessment does not constitute a basic psychiatric assessment.
d. Mr V did not receive any psychiatric care whilst in the ICU.

2. Guidelines should be set down which clearly define the responsibilities for RMO's who are not psychiatry registrars doing psychiatric assessments on patients away from a MH Unit.

3. The response to the incident by MHS was inadequate:
a. At the time of the incident there was inadequate after hours psychiatric coverage at Campbelltown Hospital. This was one of three such incidents to occur in the same month. Each incident involved a mentally unwell patient who failed to receive timely psychiatric input. Each incident was reported to management however after hours coverage was not implemented for almost one year.
b. The Commission has concerns about the appropriateness of the signatories to the ED Mental Health service agreement, signed in March 2003.

4. Consideration should be given to the immediate transfer of psychiatric patients to the Mental Health Unit (Waratah House) when they are not in need of other medical attention and vacant beds exist.

5. It was appropriate that the Director of Emergency Medicine, MHS called a forum to discuss on-going problems impacting on Mental Health and ED functioning.

Outcomes	**Incident No**	**60**
The Issue		**Quality and Safety Concerns**
Quality of clinical care provided by visiting medical officers		Not substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars		Substantiated
Management response to adverse events, including incident reporting		Substantiated
Availability of and supervision by senior medical staff		Not substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 61

Date of Incident Qtr 2, 2002

Summary of Incident **Incident No 61**

Mrs R. was an obese 69 year old woman in biventricular failure with atrial fibrillation who was treated as both an in-patient and outpatient over 7 months prior to her death in Mid 2002.

Mrs R was on a number of medications for her heart condition. In late 2001 she was admitted to Campbelltown Hospital with digoxin toxicity. Digoxin was ceased but recommended on a subsequent admission in late 2001. In early 2002, she had worsening of her biventricular failure leading to her admission in early 2002 when aldactone was increased to 125 mgs per day in an effort to reduce her fluid retention.

Mrs R was discharged on clexane in the care of her husband who was required to inject the clexane. Warfarin was instituted by ambulatory care under the direction of Dr D47. Mrs R suffered a nose bleed at around this time which was considered to be secondary to trauma from her nasal prongs. INR was within therapeutic range.

Mrs R was readmitted to Campbelltown Hospital in mid 2002 and hyponatraemia was diagnosed. It was considered that the medication may have contributed to her low sodium and worsened renal function.

Mr R, her husband was distressed at being required to administer clexane injection and redress his wife's cellulitic legs without adequate training and explanation.

Mrs R died in mid 2002.

It does not appear that MHS knew about this incident at the time.

Allegations by Informants	Location 1	Location 2
Management of cardiac condition	Campbelltown - Other	
Inappropriate doses of medication	Campbelltown - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
Patient decision making and planning for treatment, and end of life care	Campbelltown - Med Ward	
Communication with patients and families	Campbelltown - Med Ward	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - Other	
Coordination and continuity of care	Campbelltown - Other	

Clinical Review Panel Opinions **Incident No 61**

This incident was not reviewed by the Clinical Review Panel. It was reviewed by a Commission Medical Adviser who made the following comments:

The prescribing of Digoxin was appropriate as it increases the contractibility of the heart in heart failure. The actions of the registrar in placing Mrs R back onto aldactone when admitted on 27/2/02 were appropriate in that the aldactone helps the body excrete excess fluids decreasing the load on the heart.

The expectations of the Hospital for Mr R to inject Mrs R with clexane was only appropriate if Mr R was willing to administer the injection, and on the basis of that he had been shown how to administer this injection. Mr R was anxious about doing it and he was not shown how.

The anticoagulation protocol of warfarin with the clexane is not unreasonable with the 7mg dosage of warfarin being appropriate for a woman of the patient's size and weight with normal renal function.

Mrs R weighed in excess of 90kgs and the dosage of clexane given, 80mgs, was a low normal dosage at the rate of 1mg/1kg of body weight twice per day. In spite of her nosebleed, which was light but persistent, the patient's INR level was 1.5, which is below the required level of 2 required for effective coagulation. Mr R's suggestion that if he had given Mrs R the 100mg of clexane she would have bled to death is not supported.

Mr R should have been provided with clear written care instructions, being a non-medical carer, regarding the administration of clexane.

The treatment provided to the patient was not questionable and the medication changes at the time were not a deviation from acceptable practice.

Mrs R was admitted with marked hyponatraemia, hyperkalaemia with intravascular dehydration.The Hospital staff's care of her was not inappropriate. However, the patient's medical management was extremely difficult because of the severity of her cardiac failure. Her chest X-rays demonstrated gross cardio megaly with fluid in the lung fields. The prescribing of large doses of lasix and aldactone was an attempt to fluid deplete her and reduce intra-vascular load on the heart, however, she became dehydrated which compromised her renal function.

Investigation into Macarthur Health Service Incident Review

Commission Views and Comments	Incident No 61

The Commision makes the following conclusions and comments:

1. The prescribing of the medication was appropriate.

2. Mrs R's husband was understandably concerned about the burden placed on him to care for his wife when he was not trained to do so.

Outcomes	Incident No 61
The Issue	**Quality and Safety Concerns**
Patient decision making and planning for treatment, and end of life care	Not substantiated
Communication with patients and families	Partially substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Not substantiated
Coordination and continuity of care	Not substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 62

Date of Incident Qtr 3, 2002

Summary of Incident **Incident No 62**

Mrs L, 81 years of age, was taken to Campbelltown Hospital in mid 2002 by her relatives. Mrs L has a long history of severe kyphosis, severe chronic airways limitation (CAL) for which she used O2 at home, chronic airway disease, congestive cardiac failure, gout, hypothyroidism, osteoporosis, and fracture of the neck of a femur. The diagnosis on her admission in mid 2002 was infective exacerbation of her CAL.

The record notes that at 1644 hours the triage nurse (N8) assessed Mrs L as category 3 requiring that she be medically assessed within 30 minutes. The triage nurse noted that Mrs L presented with right-sided chest pain that had been present for about 2 weeks, Mrs L used O2 at home for emphysema, and had been unable to cough up phlegm. A nursing note for 1700 hours states that Mrs L presented with right side chest pain, her colour was grey, she was not responding to questions and her eyes deviated to the right. Mrs L suffered a respiratory arrest. Her O2 saturation level was 43% and respirations 48 (recorded as at 1655 hours). Mrs L's resuscitation was commenced with an immediate positive response to BiPAP with corresponding improvement in her O2 saturation and respiration rate.

The ED medical officer's (D46) examination of Mrs L notes a history of increased shortness of breath over two hours, and a cough, wheeze, and shortness of breath for two weeks that became worse and precipitated presentation at the hospital. This history differs from that of the triage nurse. Given the latter history, and Mrs L's clinical symptoms on presentation, which deteriorated into a respiratory arrest within minutes of being triaged, it is indicated that Mrs L was under-triaged. Although Mrs L was in fact treated as triage category 2 because of her arrest, questions are raised about the standard of nursing clinical assessment and history taking in relation to triage in this case.

Following assessment by the ED medical officer, the VMO (D9) and ICU registrar were contacted and a decision was made to transfer Mrs L to ICU. At 2000 hours Mrs L was transferred to ICU where she remained for 8 days before being transferred to a medical ward. During the admission Mrs L was assessed for placement in a nursing home.

Sixteen days after admission, at 1000 hours and again at 1600 hours, Mrs L's BP dropped to around 88/58mm and around 85/60mm respectively. One criterion for calling the MET is a systolic BP below 90mm. At 1000 hours, the BP reading is not mentioned in the nursing notes. Mrs L was observed to be sleeping intermittently while continuing O2 at 3L. At around 1600 hours the nursing notes record that Mrs L had some respiratory distress when a nurse removed the O2 from Mrs L that settled after the O2 was returned to her.

In a response to the Commission from MHS in June 2003, management noted that Mrs L had been asymptomatic throughout her stay and that her BP ranged from 90 ñ 100 systolic, that this was relatively normal for her, and therefore did not need a MET call. In a report dated September 2003, a manager stated that the criteria for MET are guidelines for staff to observe and detect any deterioration in patients. In addition, the manager advised that if there is a medical officer available who can review the patient quickly a MET does not have to be called unless the doctor required additional assistance.

The management response in September 2002 to the (then not provided) problem report focussed on whether the person who had completed the form was on duty at the time of the incident. Although details of the incident were accurately reported to management, it appears management's response was to discredit the information and the person who had made the report about Mrs L (and other patients).

In response to issues raised by the Commission, MHS Acute Services Review Committee (ASRC) reviewed documents relating to the incident again in March and April 2003. Following these reviews, management identified only ìinsufficient documentation in the notes about the incidentî, ìdocumentation should have reflected why MET was not calledî and referred the matter to the Nurse Manager and Nurse Educator for unspecified action.

In the absence of a doctor being present and in the absence of any decision about end of life management the MET should have been called. It is noted that on her 2nd day after admission, the VMO's assessment of Mrs L was ìPoor prognosis, intubation ventilation not recommended. These issues need to be discussed with the daughter.î However, there is no evidence that the issue of end of life planning was resolved.

On the 19th day Mrs L was transferred to a nursing home where she is reported to have died within a few days of admission.

Allegations by Informants	Location 1	Location 2
Alleged breach of MET protocol	Campbelltown - Med Ward	

Issues Identified by HCCC	Location 1	Location 2
The Medical Emergency Team (MET) at Macarthur Health Service	Campbelltown - Med Ward	

Clinical Review Panel Opinions **Incident No 62**

An independent Clinical Review Panel reviewed the documents obtained and made the following comment:

- The MET should have been called.

Clinical care review of SWSAHS response

Strictly adhering to criteria a MET should have been called. If not, as the response notes the patient was clinically well) a reason must be stated whcy the MET was not called. This must be addressed at a local level by review of the MET policy.

There is inadequate triage documentation to determine an appropriate triage category for this patient. There is no documentation of the patient's level of respiratory effort of distress on arrival. The initial nursing record (which documents a respiratory rate of 48) would suggest the patient had sever respiratory distress. Thus according to triage guidelines provided would recommend category 2.

Investigation into Macarthur Health Service Incident Review

Commission Views and Comments	Incident No 62

The Commision makes the following conclusions and comments:

After examining the medical record of the care provided to Mrs L, the Commission found aspects that were unsafe and inadequate for the following reasons:
1. Mrs L was under triaged on admission as category 3 despite her history and clinical symptoms on admission of acutely increasing SOB over the preceding 1 – 2 hours on a background of chronic CAL.

2. Although Mrs L's systolic BP was below 90 at 1000 hours and 1600 hours on her 16th day of admission, and was one of the criteria for calling the MET, its significance does not appear to have been recognised by nursing staff.

3. In the absence of the presence of a doctor or an end of life plan, when Mrs L's systolic BP dropped below 90, in accordance with hospital policy and procedure, a MET should have been called.

The confusion among clinical staff about whether calling a MET when the criterion is met is a feature of a number of incidents investigated by the Commission.

Outcomes	Incident No 62
The Issue	**Quality and Safety Concerns**
The Medical Emergency Team (MET) at Macarthur Health Service	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 63

Date of Incident Qtr 3, 1999

Summary of Incident **Incident No 63**

Ms J was admitted in mid 1999 at 2240 to Campbelltown Hospital ED with contused lung, pneumonia and mild respiratory distress. Her temperature was 38.9 degrees Celsius, BP 105/55 pulse 155 respiration 18. She had had a fall while snowboarding 5 days prior to admission. She suffered a blunt impact to the right side of her chest.

At 2320 hours, Ms J was transferred to the observation ward with a BP 108/55, pulse 115, respiration 20 with no obvious respiratory distress. She was assessed as requiring a transfer to ICU, but there was no bed available.

On Day 2 at 0200 hours, Ms J was transferred to ICU, temperature was 36.5 degrees C, BP 100/56, pulse 89, respiration 18, condition stable.

Treatment in ICU included antibiotics, analgesia and physiotherapy. Ms J had a cough productive of purulent blood stained sputum.

From Day 2 to Day 4, there was no improvement in her condition. On Day 4, she had increasing fatigue, thick brown sputum. At 1830 hours, the patient deteriorated to the point of requiring Retrieval Team transfer to Concord Hospital. At 1930 hours she was intubated and sedated.

Ms J was transferred to Concord Hospital at 2200 hours where she recovered.

It is apparent that MHS was aware of the incident after the event as the VMO physician was not notified that Ms J was admitted under his care, and he had no knowledge of the patient and no possibility of seeing the patient. This clearly is unacceptable and has been addressed by the Department of Medicine on numerous occasions since that time. The Department of Emergency Medicine now has a policy that all patients, after the decision has been made to admit them, must have their notes stamped that the VMO has been notified before they are transferred out of DEM.

Allegations by Informants	Location 1	Location 2
Patient transferred to another hospital when almost too late	Campbelltown - ICU	

Issues Identified by HCCC	Location 1	Location 2
Documentation of treatment and care in health care records	Campbelltown - ICU	
Availability of and supervision by senior medical staff	Campbelltown - ICU	
Patient transfer to higher level units or hospitals	Campbelltown - ICU	

Clinical Review Panel Opinions **Incident No 63**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

- There was reasonable initial management although there was a delay in notification of the VMO.
- When transferred to ICU after 3 hours vital observations on arrival in ICU were alright.
- Ms J became unwell. She was intubated - reason not documented. There was poor documentation overall.
- The patient was not seen by a VMO.
- Ms J being transferred was appropriate.

Commission Views and Comments **Incident No 63**

The Commision makes the following conclusions and comments:

1. The care provided to the patient was inadequate for the following reasons:
a. Ms J was admitted under a VMO and yet it would appear that the VMO was not contacted about this patient and did not attend this patient in Hospital
b. Ms J's transfer to another Hospital was delayed.
c. Documentation was inadequate

Outcomes **Incident No 63**

The Issue	Quality and Safety Concerns
Documentation of treatment and care in health care records	Substantiated
Availability of and supervision by senior medical staff	Not substantiated
Patient transfer to higher level units or hospitals	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No **64**

Date of Incident No Date Identiied

Summary of Incident	**Incident No**	**64**

The following information was provided by informant.

Man admitted for TUR (Trans Urethral Resection), developed pulmonary embolus and was symptomatic. He was ignored. Had a bleed and then fell out of bed. Suffered a fracture and nobody got any help for him. His daughter, a nurse, noticed his foot was shortened and rotated. X-rays confirmed fractures. The matter went to the Critical Care Committee however no action was taken. (No date or timeframes provided.)

On 213/5/03 the Commission requested further information from the informant, however no information was provided.

This incident was not investigated due to lack of identifying information.

Clinical Review Panel Opinions	**Incident No**	**64**

Commission Views and Comments	**Incident No**	**64**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.

Investigation into Macarthur Health Service Incident Review

Incident No **65**

Date of Incident Qtr 2, 2001

Summary of Incident **Incident No 65**

Miss C, a 26 year old woman, was admitted to the Emergency Department of Campbelltown Hospital in May 2001. She had taken an overdose of intravenous 'speed'. She was complaining of chest pain, diarrhoea and abdominal pain. She brought her 2 year old child with her. She was seen promptly at 0630 hours and triaged priority 2. She was given Valium, Maxolon and Buscopan and Oxygen therapy. She was noted to be hypotensive with a BP of 69/25 at 0700 hours.

An IV cannula was inserted through which was administered a fluid challenge, a litre of normal saline commenced at 0650 hours, and a further litre commenced at 0900 hours. Her blood pressure was unresponsive to this treatment and a litre of Haemaccel was commenced at 1030 hours.

At 1115 hours her BP was noted to be 59/44. Miss C was given 3 bolus doses of IV Aramine in an attempt to elevate the blood pressure also without benefit.

Colloid and crystalloid fluid resuscitation continued throughout the day to a total of over 5 litres of fluid but her blood pressure which was well monitored by the nursing staff in ED remained unresponsive. Although the medical records do note a lack of urine output, no indwelling urinary catheter was inserted to closely monitor urine output until 1400 hours. The possibility of septicaemia was mentioned in the records (the patient having injected) but no antibiotic therapy was given.

Miss C was transferred to ICU 10 hours after admission at 1620 hours, where a central line was inserted at 1920 hours and an inotrope infusion of Noradrenaline commenced. From 1420 hours until commencement of a Noradrenaline infusion at 1920 in ICU Miss C's systolic BP remained less than 80. At 2200 hours although still hypotensive her blood pressure had begun to improve and antibiotics were commenced. She remained on the infusion for 2 days until it was weaned and ceased. Miss C was discharged home from ICU 3 days after admission. It does not appear that the VMO was contacted at the time of Miss C's admission. A VMO reviewed the patient for the first time on day 3 just prior to her discharge.

The case was reviewed by the Critical Care Review Committee. The recommendations outlined in a memo 10 months after the incident were:
1. Need to improve documentation of nursing and medical staff (ED & ICU), via education, staff meeting and ongoing reviews. Consideration should be given to integrated notes in ED for medical and nursing staff. A standard format should be developed for both medical and nursing.
2. Need to ensure medical staff clearly document plan of care and evaluation of strategies implemented.
3. Development of an education program including case presentations.
4. Development of policy regarding IV Aramine.

Allegations by Informants	Location 1	Location 2
medical management was poor	Campbelltown - ED	

Issues Identified by HCCC	Location 1	Location 2
Management response to adverse events, including incident reporting	Campbelltown - ICU	Campbelltown - ED
Relationships and communication within and across clinical teams	Campbelltown - ICU	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ICU	Campbelltown - ED
Quality of clinical care provided by visiting medical officers	Campbelltown - ICU	
Availability of and supervision by senior medical staff	Campbelltown - ED	Campbelltown - ICU
The Medical Emergency Team (MET) at Macarthur Health Service	Campbelltown - ICU	
Documentation of treatment and care in health care records	Campbelltown - ED	Campbelltown - ICU

Clinical Review Panel Opinions **Incident No 65**

An independent Clinical Review Panel Emergency Department reviewed the documents obtained and made the following comments:

- Medical management was inappropriate in that the use of IV aramine was an inappropriate choice in the circumstances.
- Nursing management and monitoring was adequate.
- Documentation was found to be lacking and therefore inadequate.
- The panel felt unable to comment on the issue of communcation.

The Intensive Care CRP made the following comments:

- A diagnosis was not made.
- Miss C was in ED a long time (9 hours), the reason for this was not explained in the progress notes.
- Incorrect treatment was given for hypotension.
- There was a delay in putting in a central line.

Investigation into Macarthur Health Service Incident Review

- Names and designation of persons making entries in the medical record were missing.
- Documentation in ED was poor.
- There was absence of VMO involvement.
- No senior clinician was overseeing the management of the patient.
- Resuscitation was not aggressive.
- There was no observation chart in the medical records provided by MHS.
- No MET call was made.

The positive care was that the ICU Doctor recorded a good history and made a treatment plan.

The CRP reviewed the matter again in the light of the MHS response and made the following comments:

The clinical management was inadequate in that Ms C remained significantly hypotensive for the duration of her stay in the ED and it was not until her admission to ICU that the appropriate management (CVL and inotrope infusion) was commenced.

Bolus doses of Aramine was an inappropriate choice in the circumstanmces and in any event was ineffective.

The fluid resuscitation in ED was acknowledged as occurring but was noted to be ineffective as her blood pressure was unresponsive.

An effective management plan would have dealt more efficiently with this lack of response to treatment.

While the MHS states that there was a management plan it was mainifestly inadequate in that she was not responding to treatment and the insertion of a central line should have occurred much sooner than it did to remedy this. Furthermore sepsis did not appear to be be considered (the patient having injected speed) and antibiotic therapy was not instituted.

Documentation was found to be seriously lacking.

In respect of MET process, the panel stated that clarification was required where the criteria is met for an extended period as was the case here.

Management's response was found to be inadequate. The Panel notes that the MHS did not contest the HCCC view as regards management.

The explanation re the VMO's availability was unsatisfactory.

Commission Views and Comments	**Incident No**	**65**

The Commision makes the following conclusions and comments:

1. The Commission concludes that the care provided to the patient was unsafe and inadequate for the following reasons:
a. There was a failure of the VMO to be available to the clinical staff managing the patient and to attend in a timely manner to provide the appropriate clinical support.
b. There was a failure to instigate the appropriate medical treatment in the circumstances in that the patient was markedly under-resuscitated for a prolonged period in ED. In addition Aramine was an inappropriate choice of inotrope and the insertion of a central line for inotropic support should have occurred much earlier. The prolonged low blood pressure could have resulted in renal impairment for this patient.
c. There was a failure of medical staff attending the patient in the emergency department to adequately document management.
d. VMO input and therefore senior clinical support in this case did not occur due to an apparent failure of the clinical staff in ED to notify the VMO of the admission.

The Commission also found:
e. That the medical records in this case were extremely difficult to follow as the nursing and medical notes were not integrated.
f. That the Critical Care Review Committee did not identify all of the causal factors and its plans were not adequate.
g. The Commission notes the response of the MHS in relation to this incident but is still of the view that the medical management and lack of supervision and VMO support in clinical decision making were less than adequate.
h. That the MHS provide no evidence of the implemetation or evaluation of the recommendations. The Commission concludes that no action was taken to prevent a reoccurence.

3. The Commssion acknowledges the MHS response on the issue of MET in this instance but still of the view that if MET criteria are present and a decision is taken not to call MET, the reason for this decision should be fully documented in the patient medical records.

Outcomes	**Incident No**	**65**
The Issue		**Quality and Safety Concerns**
Management response to adverse events, including incident reporting		Substantiated
Relationships and communication within and across clinical teams		Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars		Substantiated
Quality of clinical care provided by visiting medical officers		Substantiated
Availability of and supervision by senior medical staff		Substantiated
The Medical Emergency Team (MET) at Macarthur Health Service		Substantiated
Documentation of treatment and care in health care records		Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 66

Date of Incident Qtr 3, 2001

Summary of Incident **Incident No 66**

In mid 2001, Mrs R, a 32 year old woman presented to Campbelltown Hospital Emergency Department. She 16 weeks pregnant and was displaying symptoms of pre-eclampsia. She had extremely high blood pressure, was short of breath, had peripheral oedema and proteinuria.

She was triaged priority 2. She was seen by a registrar who diagnosed pre-eclampsia, a medical emergency and proposed that she be reviewed by an obstretric physician. She remained in ED for approximately 4 hours and was then admitted to the delivery suite where she remained for a further 2 hours. The patient was reviewed by an O&G CMO 3 hours after presentation and an hour later was seen by an O&G VMO. During this time her blood pressure was only taken twice by nursing staff in the Emergency Department despite being critically elevated. Furthermore an anti-hypertensive medication, Catapres was ordered (at a time not known) but never given. No ultrasound was performed. Nursing documentation relating to the 2 hours she spent in delivery suite could not be located by the Hospital.

There was no active management of this patient's hypertension and she was not reviewed by an obstetric VMO until 4 hours after admission. This VMO on reviewing the patient ordered urgent transfer to Liverpool Hospital, however this did not occur for another 2 hours. Ultimately after spending 6 hours at the Hospital she was transferred to Liverpool Hospital.

The case was reviewed by the Critical Care Review Committee. The Committee's recommendations outlined in a memo dated March 2002 (6 months after the incident) were:

1. Patients identified as pregnancy induced hypertension to have urgent O&G review.

2. Inservice of nursing staff re importance of frequent observations and checking of charts.
Attached to these recommendations was a file not dated a year later which noted that 'These recommendations were sent to varying departments. However, no reply was obtained as requested and ultimately no action was taken.'

Allegations by Informants	Location 1	Location 2
No allegations by informant/s		

Issues Identified by HCCC	Location 1	Location 2
Documentation of treatment and care in health care records	Campbelltown - ED	
Recognition and response to critically ill patients	Campbelltown - ED	
Management response to adverse events, including incident reporting	Campbelltown - ED	
Quality of clinical care provided by nursing staff	Campbelltown - ED	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ED	
Availability of and supervision by senior medical staff	Campbelltown - ED	

Clinical Review Panel Opinions **Incident No 66**

An independent Clinical Review Panel reviewed the documentation obtained and made the following comments:

- Nursing observations and documentation were found to be inadequate
- There was no evidence of implementation of CCRC recommendations
- Delay re O&G review is difficult to comment on as it is unclear from the medical records provided whether and when she was seen by an O&G registrar.
- Mrs R was not managed as a critical patient.
- There was a delay in acting on doctors' orders.
- There was no treatment of BP.

The CRP reviewed the incident again in the light of the MHS response and made the following comments:
. The feature of this incident was the overall failure to recognise the potential seriousness of the patient's condition.
. There was no active management of the hypertension instituted
. BP monitoring was inadequate.

The panel also noted the apparent mix up as to who to admit the patient under.
The Panel changed its opinion on the issue of VMO availability noting that when contacted he ordered appropriate treatment which unfortunately wasn't given and on seeing the patient 4 hours later he appropriately arranged transfer to Liverpool.

Commission Views and Comments **Incident No 66**

The Commision makes the following conclusions and comments:

1. The care provided to the patient was unsafe and inadequate for the following reasons:
a. There was a failure to recognise the seriousness of the patient's presenting condition and the need for urgent transfer.
b. There was a failure to refer the patient to the appropriate specialist physician (an O&G VMO) for treatment of the primary presenting

Investigation into Macarthur Health Service Incident Review

problem in a timely manner, which would have resulted in a quicker referral of this patient whose presenting condition was extremely serious.
c. There was a failure to instigate treatment or intervention in a timely manner, and no effort was made to organise transfer until 4 hours after her admission.
e. There was a failure to provide adequate ongoing monitoring whilst the patient was in the Emergency Department
f. There was a failure to adequately document the management or treatment, particularly in respect of nursing documentation in the delivery suite which the MHS has been unable to locate.

The Commission also found that the response to the Critical incident by MHS was inadequate in that:

a. The recommendation that patients identified as PIH should have urgent O&G review is vague and is not accompanied by a strategy or policy for putting it into effect.
b. The MHS acknowledged that no action was being taken in respect of the CCRC recommendations. Having since advised that an action plan was being developed, no evidence of implementation or evaluation of any recommendations has been provided.
c. The incident was at that time considered sufficiently serious to warrant internal review, however, no action has been taken.

2. The response of the MHS in relation to this incident fails to adequately address the issues raised, particularly in respect of the issue of the inadequate montioring of the blood pressure.

3. The MHS has provided no evidence of the implementation of any recommendations which would prevent a reoccurrence of this incident. Furthermore, the PIH policy provided by the MHS is manifestly inadequate in that it mandates 4 hourly blood pressure monitoring in a patient typically presenting with high blood pressure which if unmonitored and uncontrolled can be life threatening to the mother and unborn baby.

4. The Commission acknowledges the CRP opinion that the O&G VMO saw the patient after 4 hours and his decision to transfer immediately was appropriate. However, the Commission is of the opinion that the patient should have been admitted under the O&G team instead of the physician and that this would have facilitated more urgent review, an more timely transfer and been safer for the patient. Furthermore this shortfall while recognised by the MHS in its internal review has not been acted upon (that is no evidence has been provided to the Commission that a policy has been formulated to facilitate admission under O&G where the presenting condition is pregnancy related such as in pregnancy induced hypertension. This inaction will not prevent a reoccurrence of this incident.

Outcomes	**Incident No 66**
The Issue	**Quality and Safety Concerns**
Documentation of treatment and care in health care records	Substantiated
Recognition and response to critically ill patients	Substantiated
Management response to adverse events, including incident reporting	Substantiated
Quality of clinical care provided by nursing staff	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated
Availability of and supervision by senior medical staff	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 67

Date of Incident Qtr 4, 2001

Summary of Incident **Incident No 67**

Mr R, was a 35 year old man admitted to the Emergency Department of Campbelltown Hospital in end 2001 at 1200 hours. He was brought in by ambulance after having been found by the family who called an ambulance obtunded, fitting and centrally cyanosed with decorticate movements. He had a GCS of 3 and was intubated and sedated and given anti convulsants and antibiotics.

A number of investigations were ordered including a CT scan of the head. No septic work-up was performed in spite of a diagnosis of possible meningitis. No neurological observations were ordered by the medical officer or performed by the nursing staff over almost 8 hours in ED. Whilst in ED Mr R self extubated and although he desaturated to SaO2 79%, (although this improved on non-rebreathing bag) and had become very acidotic the endotracheal tube was not re-inserted until admission to ICU when he was already acidotic with grunting respirations. Lumbar puncture was not performed for 10 hours and no VMO was contacted until admission to ICU around 2015 hours. He was not seen by a VMO for 3 days.

The case was reviewed by the Critical Care Review Committee. The recommendations outlined in a memo 3 months after the incident were:
1. Education to ED medical and nursing staff re management of critically ill patients
2. ED doctor asked to justify transferring a patient with these parameters
3. Staff educated in documentation eg signatures.

The CCRC decided to devlop an action plan covering the recurring themes identified in this and a batch of other cases. The MHS has not provided any evidence of the implementation of the recommendations or action plan.

Allegations by Informants	Location 1	Location 2
No allegations from informant/s		

Issues Identified by HCCC	Location 1	Location 2
Quality of clinical care provided by visiting medical officers	Campbelltown - ED	
Documentation of treatment and care in health care records	Campbelltown - ED	
Management response to adverse events, including incident reporting	Campbelltown - ED	
Quality of clinical care provided by nursing staff	Campbelltown - ED	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ED	

Clinical Review Panel Opinions **Incident No 67**

An independent Clinical Review Panel reviewed the documents. The Emergency Department Panel made the following comments:
- Medical management was inadequate in particular the decision to stop sedation and allow the patient to wake up.
- The lack of documentation by both medical and nursing staff was unacceptable.
- The MHS response does not address the broader issues of case management problems and lack of experienced staff.
- The standard of nursing observations was inadequate.

The Intensive Care Unit Panel made the following comments:
- No VMO was contacted.
- No neuro observations were made.
- No nursing observations were made.
- There was delay in transfer to ICU.
- There was no recorded reason given for remaining in ED for several hours.
- Initial assessment and resuscitation was adequate.
- The patient self-extubated and it was ill advised not to replace the tube.
- There was a delay in re-intubation of 2 hours. The patient was only re-intubated when it became obvious he was not breathing due to respiratory acidocis.
- There was an inappropriate 8 hour delay in considering lumbar puncture.
- A lumbar puncture was not done for 10 hours after admission.
- This was a young person, very ill, and was not reviewed by a VMO.
- A written ICU care plan was absent.

The clinicai review panel reviewed the matter again in the light of the MHS response and commented:
the initial management plan was good
the delay re lumbar puncture was acceptable
the decision to turn off the sedation in the circumstances was inappropriate and the failure to re-intubate electively where the patient was acidotic and hypoxaemic was inappropriate.
The lack of VMO support in the first 3 days was inadequate

The panel felt unable to comment on management response to advesre event on the available evidence
The lack of neuro obs by nursing staff in ED was inadequate

Investigation into Macarthur Health Service Incident Review

Commission Views and Comments	Incident No 67

The Commision makes the following conclusions and comments:

1. The Commission concludes that the care provided to the patient was unsafe and inadequate for the following reasons:
a. There was a failure to notify the VMO of the admission in a timely manner and once notified, the failure to attend in a timely manner and thus an opportunity for appropriate clinical support was missed.
b. There was a failure to provide adequate or ongoing monitoring of the patient whilst in the Emergency Department, particularly by nursing staff in respect of neuro obs.
c. There was a failure of the medical staff attending the patient to adequately document the management.
d. The overall medical management and lack of senior clinical support was less than adequate.
e. The MET was not called on this occasion although the patient met the relevant criteria, and the decision not to call MET whilst it may be reasonable should be fully documented in the medical records.
f. Failure to facilitate transfer of the patient out of the ICU into an appropriate care unit in a timely manner. Whilst the Commission recognises that this is a statewide issue, the delay in the transfer of the patient to an appropriate inpatient area and the utilisation of the ED as a holding ward for a patient in a critical condition was inappropriate.

The Commission notes and acknowledges the panels' view re the nursing staff but is of the view that the failure to do neurological observations on an intubated sedated patient who was admitted with a GCS of 3 and a clear neurological deficit is inadequate and therefore the Commission substantiates this issue. The reasoning of MHS that the patient was intubated and thus sedated and not requiring neuro obs raises serious concerns around competency of the nursing staff and the clinical leadership. It is the Commission's view that an intubated and sedated patient with a neurological deficit still under investigation is exactly the type of patient who requires diligent neurological observation. Furthermore, no neuro obs were done for almost 2 hours after the patient self extubated, and sedation was ceased in ED.

The Commission agrees with the Panel that the quality of care provided by the more inexperienced medical clinician should be partially substantiated based on the fact that the initial plan was good, the delay in lumber puncture in the circumstances was acceptable, and the CMO did entertain a diagniosis of meningitis. However, clinical decision making around the decision to allow the patient to wake up while still intubated in the ED was inappropriate. The Commission recognises that such clinical decisions require senior clinical support which in this instance was seriously lacking.

The Commission notes the panels' view and is of the view that the MHS response is inadequate in that:
a. it fails to address the issue of the need for senior clinical support in the circumstances
b. the lack of neuro obs was not addressed satisfactority.
The Commission notes the MHS opinion in its response that this issue of managemtn response to advserse event is substantiated.
The Commission notes with concern the comment by the MHS that neuro obs are not done on a sedated patient.
The Commission also notes the comment that the patient was intubated within 10 minutes but opines that this was 10 minutes after his arrival to ICU rather than when intubation was clinically indicated. This failure to stabilise the patients airway and to transfer him between wards with an unstable airway is inadequate.

Outcomes	Incident No 67
The Issue	**Quality and Safety Concerns**
Quality of clinical care provided by visiting medical officers	Substantiated
Documentation of treatment and care in health care records	Substantiated
Management response to adverse events, including incident reporting	Substantiated
Quality of clinical care provided by nursing staff	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Partially substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 68

Date of Incident Qtr 4, 2001

Summary of Incident **Incident No 68**

Mrs Q, an 81 year old woman was admitted to Campbelltown Hospital ED in late 2001. She had a past history of ischaemic heart disease, chronic airways limitation, non insulin dependent diabetes, atrial fibrillation and a pacemaker. Mrs Q was critically unwell having been found collapsed at home. On arrival in ED Mrs Q was triaged promptly at 1230 hours priority one. Mrs Q was conscious with a Glasgow Coma Score of 13 and central and peripheral cyanosis. Mrs Q had some right sided heart failure and an ECG showed inferolateral ischaemia. A differential diagnosis of query pulmonary embolus, query septicaemia was made by the ED medical officer.

Whilst in ED Mrs Q was noted to have no urine output and was noted to be de-saturating. An indwelling urinary catheter was placed insitu. Mrs Q was noted to have failed a fluid challenge and did not respond to Lasix. The ICU registrar was contacted at approximately 1330 hours and asked to review the patient. The registrar advised he would 'see the patient when he could' and advised that there were no beds in ICU. Mrs Q was transferred for a CT scan at approximately 1400 hours but the CT was not attended apparently as there was no creatinine level available . On return to ED, Mrs Q was moved from the resuscitation room to an observation bed. No active treatment was initiated. At 1730 hours it is documented by an ED medical officer that he discussed with Mrs Q's daughter the 'unsatisfactory condition' of Mrs Q. At 1800 hours ICU staff were contacted again about the availability of an ICU bed for Mrs Q and were told that ICU was too busy to accept Mrs Q. Also at 1800, it is documented in the medical records that end of life issues were discussed with Mrs Q's daughter, however she did not wish to make this decision without consulting the family. Therefore there was no documented 'not for resuscitation' order at this time.

At 1900 hours Mrs Q was reviewed by an ICU registrar who noted her history and examined her. He noted in the records that Mrs Q was acidotic, anuric, in deteriorating liver function and a deteriorating mental state. The registrar queried ischaemic disease, ordered pathology but there is no documented treatment or management plan. There is no evidence of VMO involvement, although the VMO was apparently notified of Mrs Q's admission while still in ED. There was no documented evidence of a Not For Resuscitation order.

At 1945 hours Mrs Q was still in ED and was again seen by the ICU registrar following a significant deterioration. Mrs Q was noted at this time to be mentally obtunded, and cyanosed with an unrecordable blood pressure but a palpable carotid artery. Mrs Q's heart rate was 50-100 and her blood ph was 6.95. The impression of the registrar was that the deterioration was due to a massive pulmonary embolus. Again there was no documented management or treatment plan and there is no evidence of VMO consultation or involvement. There was still no documented evidence of a Not For Resuscitation order. There was no evidence of active resuscitation of Mrs Q at this point.

Mrs Q was transferred to ICU at 1930 hours. A nursing progress report at 2100 hours describes the deterioration of Mrs Q and states that on arrival to ICU Mrs Q responded to Adrenaline, Bicarbonate, Glucose and Insulin but there is no documentation of these medications in the medication charts. Nor is there documentation for 2.5mgs of Morphine Mrs Q was stated to have been given when agitated.

At 2400 hours the ICU registrar documented that Mrs Q was asystolic, with fixed pupils and no pulse or respirations, Mrs Q was pronounced dead. The registrar notes that the family was aware and stated he would notify the VMO in the morning.

The case was reviewed by the MHS Critical Care Review Committee. The recommendations outlined in a memo dated 4 months after the incident were:

1. Follow policy for bed management. If no bed available after 4 hours, bed to be sought elsewhere in area.
2. ED staff education re importance of raising NFR issues.

Allegations by Informants	Location 1	Location 2
No allegations from informant/s		

Issues Identified by HCCC	Location 1	Location 2
The Medical Emergency Team (MET) at Macarthur Health Service	Campbelltown - ICU	
Patient decision making and planning for treatment, and end of life care	Campbelltown - ICU	Campbelltown - ED
Documentation of treatment and care in health care records	Campbelltown - ICU	
Quality of clinical care provided by nursing staff	Campbelltown - ICU	
Documentation of treatment and care in health care records	Campbelltown - ICU	
Quality of clinical care provided by visiting medical officers	Campbelltown - ICU	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ICU	

Clinical Review Panel Opinions **Incident No 68**

An independent Clinical Review Panel reviewed the documents obtained and made the following comments:

- In respect of bed management guidelines were not followed but this is a Statewide issue.
- There was serious concern expressed about the overall management of the patient in ICU including no management plan, inadequate assessment, no diagnosis, inadequate resuscitation, failure to address end of life issues with family members, inadequate documentation, no MET call and no consultant involvement.

Investigation into Macarthur Health Service Incident Review

The CRP reviewed this incident again in the light of the MHS response and made the following comments:

There was no active management of this patient who was inadequately assessed, inadequately resuscitated and whose end of life management was inadequately documented.

The CRP altered its opinion in respect of the nursing monitoring which they felt was reasonable.

The Panel also opined that the issue of documentation was partially substantiated in that while it was generally reasonable it was inadequate not to document NFR in this case.

Commission Views and Comments **Incident No 68**

The Commision makes the following conclusions and comments:

1. The Commission concludes that the care provided to the patient was unsafe and inadequate for the following reasons:
a. The lack of support and assistance of a senior medical clinician given the seriousness of the patient's presenting condition.
b. Failure to provide active resuscitation, assessment, investigation and treatment and to implement a plan of active management for the patient whilst in the ED awaiting transfer.
c. Failure to facilitate transfer of the patient out of the ED into an appropriate care unit in a timely manner. Whilst the Commission recognises that this is a Statewide issue, the delay in the transfer of the patient to an appropriate inpatient area and the utilisation of the ED as a holding ward for a patient in a critical condition was inappropriate.
d. Failure to consult with Mrs Q and her family about Mrs Q's wishes in relation to treatment decisions.

2. The Commission notes the response of the MHS in relation to this incident, however, it fails to adequately address the issues raised in that the Critical Care Review Committee only partially identifed the contributing factors for the poor care provided. There is no evidence that the actions identified were implemented. The management response was inadequate and would not prevent a reoccurence.

Outcomes **Incident No 68**

The Issue	Quality and Safety Concerns
The Medical Emergency Team (MET) at Macarthur Health Service	Substantiated
Patient decision making and planning for treatment, and end of life care	Substantiated
Documentation of treatment and care in health care records	Partially substantiated
Quality of clinical care provided by nursing staff	Not substantiated
Documentation of treatment and care in health care records	Partially substantiated
Quality of clinical care provided by visiting medical officers	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 69

Date of Incident Qtr 4, 2001

Summary of Incident **Incident No 69**

Mr F, 70 yrs, was transported to Campbelltown Hospital by ambulance in late 2001, arriving at the emergency department (ED) at 0429 hours unresponsive, pale, cold and clammy. During his trip to the hospital, the ambulance officer was unable to obtain a systolic BP reading. Mr F's past history included CAL, NIDDM and hypertension. He had had many admissions for recurrent LRTIs.

Mr F was seen by the triage nurse at 0430 hours and assessed at category 1. Between 0430 hours and 0550 hours the nurse in ED recorded no vital observations. Mr F was attended by the ED medical officer (MO) at an unrecorded time, and observed to be ìobtunded with pulmonary oedemaî. He had a history of having had a fever the day before.

The ED MO's ordered O2, IV lasix, glyceryl trinitrate (GTN), pathology tests and referral to ICU. The ED MO found Mr F's vital signs were: BP 130/90, Glasgow Coma Scale (GCS) 3, PR 180, and O2 saturation 78%. Arterial blood gasses (ABG) were not ordered.

The ICU night registrar attended Mr F in ED at an unrecorded time and found Mr F to be conscious and breathing spontaneously. His vital signs were: RR 36, PR 150 with a gallop rhythm, BP 110/60. Mr F's neck veins were full and he had wet crepitations. His breath sounds improved after commencement of CPAP. The ICU night registrar ordered, amiodarone, lasix, CPAP, GTN, blood tests and chest x-ray. His provisional diagnosis was also acute pulmonary oedema with ? left sided consolidation. No antibiotics were ordered in spite of likely sepsis.

Mr F arrived in ICU at 0550 hours but this was only entered in the record at 0715 hours. He was observed to be very drowsy, cold, clammy and diaphoretic. His O2 saturation could not be obtained and his BP was 60. The nurse noted that the IV GTN infusion was suspended in response to his severe hypotension. IV lasix 160mg was repeated at 0715 hours. At this time Mr F had a BP if 106/56, a PR 158 and only minimal urinary output. From the time Mr F arrived in ICU his nursing vital observations were recorded at frequent intervals. His BP was consistently low at <90 systolic, and his O2 saturation and PR fluctuated. At 0930 hours his BP was 83/30.

Mr F was seen by a VMO at an unrecorded time who ordered a dopamine infusion and dichloride. Mr F was found to be febrile (38.5C), PR 140, O2 saturation 86% on CPAP, and tachycardic. He had worsening (R) sided heart failure and poor urinary output. Chest x-ray showed cardiomegaly, with left sided consolidation/effusion. IV therapy was ordered with repeat ABGs and blood culture. IV antibiotics were ordered and given at 1000 hours. No diagnosis is recorded.

Mr F's condition rapidly deteriorated with a loss of consciousness. At 1100 hours Mr F suffered sudden apnoea and bradycardia. He was intubated and CPR was commenced. At 1122 hours Mr F was pronounced deceased.

Although Mr F had a GCS of 3, neither intubation nor transfer to ICU appears to have been considered on admission. Mr F was not intubated until he suffered a respiratory arrest just before his death. It is noted that the possibility of sepsis was not considered despite Mr F's history of multiple infective exacerbation of his chronic obstructive airway disease (COAD) and his fever the preceding day. Antibiotics were not given for 5 □ hours after Mr F's admission to ED.

In early 2002 MHS critical care review team reviewed Mr F's medical record and identified issues relating to documentation and GTN protocol. This contrasted to the significant clinical issues identified by the Commission.

Information provided to the Commission by MHS in June 2003 indicates that management was aware of this case by March 2002 when a memo indicates that the Acute Services Critical Care Review Committee (ASCCRC) had reviewed the case and recommended liaison with nurses in the ED regarding the importance of documentation and in-service for nurses about GTN protocol. In February 2003 management noted that the recommendations of the ASCCRC had not been implemented. It was suggested that the newly established Acute Services Review Team would look at the case and if recommendations required actioning, the matter was to be sent to the Director of Nursing Services. However, this does not appear to have been acted upon.

In response to the Commission's s.43 report, there are significant differences in the way MHS views the care provided to Mr F and the findings of the Commission in relation to the quality of care and management provided by nurses and doctors. However, the Commission accepts the response from MHS in respect of the need to call a MET and the need to notify the Coroner as being within acceptable limits in this instance.

Allegations by Informants	Location 1	Location 2
GTN infusion protocol - staff untrained	Campbelltown - ED	
No ED Nursing notes	Campbelltown - ED	

Issues Identified by HCCC	Location 1	Location 2
Patient decision making and planning for treatment, and end of life care	Campbelltown - ICU	
Notifications of deaths to the Coroner and decision making around post mortem	Campbelltown - ICU	
Relationships and communication within and across clinical teams	Campbelltown - ED	
Documentation of treatment and care in health care records	Campbelltown - ICU	Campbelltown - ED
Recognition and response to critically ill patients	Campbelltown - ICU	Campbelltown - ED
Management response to adverse events, including incident reporting	Campbelltown - ICU	

Investigation into Macarthur Health Service Incident Review

Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ICU	Campbelltown - ED
Quality of clinical care provided by visiting medical officers	Campbelltown - ICU	
Quality of clinical care provided by nursing staff	Campbelltown - ICU	Campbelltown - ED
The Medical Emergency Team (MET) at Macarthur Health Service	Campbelltown - ED	Campbelltown - ICU

Clinical Review Panel Opinions **Incident No 69**

An independent Clinical Review Panel received the documents obtained and made the following comments:
- The standard of care provided to Mr F was unsafe, unacceptable, not patient focussed or effective.
- The management response to the incident was unsatisfactory.
- There was no MET call.
- Mr F was hypotensive initially.
- Mr F was on GTN without GTN order.
- Management failed to adequately address staff concerns.
- There is inadequate documentation in the medical records eg. prescription of GTN, record of admission. The documentation is insufficient to follow the case.
- There was unexplained and untreated hypotension.
- Intubated and CPR occurred at the last minute. It was too little, too late.

Concerning the management/system issues the Panel commented:
- There was no VMO involvement.
- There was no VMO supervision of RMOs.
- The VMO should drive the management and standard of care.
- The clinical staff could manage manual interventions but failed to comprehensively assess and treat a critical deterioration in Mr F's condition.

Commission Views and Comments **Incident No 69**

The Commision makes the following conclusions and comments:

Mr F, 70 yrs, was transported to Campbelltown Hospital by ambulance in late 2001, arriving at the emergency department (ED) at 0429 hours unresponsive, pale, cold and clammy. During his trip to the hospital, the ambulance officer was unable to obtain a diastolic BP reading. Mr F's past history included CAL, NIDDM and hypertension. He had had many admissions for recurrent LRTIs.

After reviewing the care provided to Mr F the Commission found the care to be unsafe and inadequate for the following reasons:
1. The admission assessments and investigations were inadequate in that:
a. An underlying pneumonia complicating the COAD should have been suspected in view of Mr F's clinical history, history of having a fever the day before admission, and his presenting clinical condition.
b. Mr F should have been intubated on admission and an urgent CT scan performed in view of a GCS of 3 and O2 saturation of 78% in the absence of any NFR order.
c. No blood cultures were ordered before around 1000 hours at the same time antibiotics were ordered as the possibility of sepsis was not considered by the night ED and ICU medical officers.
d. ABGs were not ordered or performed before 0650 hours.
e. Mr F was not intubated when he arrived in ICU with a BP systolic pressure of 60 and his O2 saturation could not be obtained. In the absence of an NFR order this was nor appropriate.
f. There was a 4 hour delay in commencing an inotrope infusion in a critically ill hypotensive, peripherally shut down patient
g. There was a delay of 3 to 4 hours after triage before antibiotics were commenced.

2. There was a failure to record any vital observations at triage or closely monitor and record Mr F's vital observations while he was in ED. Failure to frequently monitor Mr F's reaction to the drug (GTN) was inappropriate.

Outcomes **Incident No 69**

The Issue	Quality and Safety Concerns
Patient decision making and planning for treatment, and end of life care	Substantiated
Notifications of deaths to the Coroner and decision making around post mortem	Substantiated
Relationships and communication within and across clinical teams	Substantiated
Documentation of treatment and care in health care records	Substantiated
Recognition and response to critically ill patients	Substantiated
Management response to adverse events, including incident reporting	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated
Quality of clinical care provided by visiting medical officers	Substantiated
Quality of clinical care provided by nursing staff	Substantiated
The Medical Emergency Team (MET) at Macarthur Health Service	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 70

Date of Incident Qtr 4, 2001

Summary of Incident **Incident No 70**

Ms E, aged 42 years, has a complex medical history relating to insulin dependent diabetes, epilepsy, asthma, vital encephalitis - that appears to have precipitated an organic psychosis/personality disorder with mild cognitive impairment; hypothyroidism, and osteoarthritis. Medical records relating to two of Ms E's 36th in late 2001 and 37th in mid 2002 psychiatric admissions to Campbelltown Hospital emergency department (ED) were reviewed.

The Commission's investigation of the care of Ms E during the admissions noted above, is based on a ASCCR memo dated 14 March 2002 indicating that a review of Mrs E's medical record, for an unspecified problem arising during and unspecified admission period, had occurred. The recommendation of the ASCCR was to "Increase awareness of importance of good medical records." It appears that significant issues relating to the care of Ms E were not recognised.

Ms E's 36th admission

Ms E was taken to Campbelltown Hospital ED by ambulance at 0335 hours in late 2001 after cutting her (R) wrist with a razor blade. Ms E described auditory hallucinations to the triage nurse that demons had tormented her about reality for about one month and were instructing her to harm herself. She had cut her (R) wrist in order to test reality and contacted a Helpline.

Ms E was triaged (N17) at level 3. This requires that she be medically assessed within 30 minutes. This did not occur for 1 hour 30 minutes during which time Ms E absconded from ED at around 0455 hours and was found walking along the road. Although she was attempting to run away, with reassurance, she returned to ED where she was seen by the ED/CMO locum (D47) within 10 minutes of her return and was prescribed antipsychotic medication. A Schedule II admission was undertaken.

It is noted that Ms E's blood glucose level (BGL) was taken around 2 □ hours after admission and repeated at intervals of 2 hours, 2 □ hours and 2 º hou rs until 1330 hours. Ms E was comprehensively assessed by a psychiatric registrar at 1015 hours whose provisional diagnosis was organic psychosis secondary to encephalitis, and ? borderline personality traits. The registrar noted that the VMO would be contacted. However, there is no record that this occurred. The VMO (D48) visited Ms E around 22 □ hours after admission.

Although admission was requested, it is noted that no (emergency bed) was available in the psychiatric unit, Waratah House, despite Ms E being acutely psychotic. Her transfer occurred 13 hours after presenting at ED. Ms E was discharged 74 days later.

Ms E's 37th admission

Ms E presented to Campbelltown Hospital ED in mid 2002 at 0048 hours in the company of her husband. She gave a history of relapse of auditory hallucinations that told her to hurt/cut herself. She was also reluctant to sleep due to bad dreams. She was triaged (N18) as level 4 requiring that she be assessed within 60 minutes. Despite being acutely psychotic, only one nursing vital observation taken at 0050 hours is recorded for the period (5 hours 22 minutes) Ms E was in ED. Although well known to the hospital and presenting with symptoms of acute psychosis involving self-harm, with a history of wandering away, a decision was made to accept Ms E's ìguarantee not to self harmî and allow her to wait in the waiting area of the ED under the supervision of her husband. When seen by the ED doctor (D50), it appears that, despite confirming the command auditory hallucinations to self-harm, Ms E was allowed to remain in the waiting room under the supervision of her husband. There is no evidence that her BSL was taken in ED despite her history of being a diabetic with poor control. The unidentified ED doctor saw her at 0230 hours. The illegible provisional diagnosis appears to be ìPsychosisî, and the treatment plan was to ìInform psychiatric regî.

Around two hours later a psychiatric registrar conducted a comprehensive examination of Ms E. The registrar observed that Ms E was highly agitated, was rocking, and unable to cope with the voices commanding her to hurt herself. During the assessment she tried to scratch herself with a small pair of scissors and resisted having them taken from her. The diagnosis was organic related psychosis, organic related psychiatric disease, and borderline personality disorder. It was decided that her safety could not be guaranteed at home and a Schedule II admission was executed.

The registrar contacted the VMO (D49) who advised admission to the subacute ward as a category C security risk. Ms E was transferred to Waratah House two hours later, at 0600 hours, where she remained for 35 days.

Allegations by Informants	Location 1	Location 2
Arrive ED 1127 to ICU 1315 ? Delay	Campbelltown - ED	
Only two blood sugar levels attended	Campbelltown - ED	

Issues Identified by HCCC	Location 1	Location 2
Management response to adverse events, including incident reporting	Campbelltown - Other	
Coordination and continuity of care	Campbelltown - ED	
Quality of clinical care provided by nursing staff	Campbelltown - ED	
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Campbelltown - ED	

Clinical Review Panel Opinions **Incident No 70**

This incident was reviewed by an HCCC medical adviser. It was not reviewed by an independent Clinical Review Panel. The medical adviser commented:

Investigation into Macarthur Health Service Incident Review

- Aspects of the care provided to Mrs E during her 36th admission, late 2001 - early 2002 were unsafe and inadequate for the following reasons:

a. While a triage level of 3 was appropriate, it was inappropriate for an agitated psychotic patient to wait 1.2 hours to be reviewed.
b. There were no nursing observations recorded on the ED observation chart for almost 9 hours, from 0750 to 1635 hours.
c. There was an unacceptable delay of 13 hours in transfer to Waratah House Psychiatric Unit.
d. No glucose chart was commenced in ED, in spite of a history of brittle diabetic control.
e. There was no medical direction given to nursing staff about the need for regular monitoring. However, it is believed that a competent RN would have been aware of the need to monitor the patient and make records.

- According to the Memo relating to an earlier admission, clearly there were significant clinical issues that were not identified by management. The Memo related to the importance of good medical records.

- Aspects of the care provided to Mrs E during her 37th admission, mid 2002, were unsafe and inadequate for the following reasons:

a. There was a poor admission assessment by the ED doctor, as there was no system review or examination and no management plan for Mrs E.
b. Only one nursing observation was recorded on the ED observation chart at 0050 hours, at the time of presentation.
c. No vital observations were taken between 0050 and 0600 hours when Mrs E was transferred to Waratah House.
d. No BSL was taken in spite of Mrs E being a diabetic with poor control.
e. No Blood Glusose chart was commenced in ED despite the brittle nature of diabetes control.
f. There were no medical direction given to nursing staff about the need for regular monitoring. However, it is believed that a nursing staff should have been aware of the need to monitor the patient and make records.
g. Triage category 4 is inappropriately low for a psychotic agitated patient. The patient waited over 1 and 1/2 hours for review and any antipsychotic medication.
h. There was an unacceptable delay of four hours after being reviewed in ED and transfer to Waratah House.

- Aspects of the care provided to Mrs E during her 38th admission, late 2002 - early 2003, were unsafe and inadequate for the following reasons:

a. Although the admission assessment by the MO was appropriate and a good management plan was prepared, there is no evidence of a review of Mrs E after admission at 1920 hours and an ICU registrar review from 2220 until 0135 hours, in spite of drowsyness and having unresponsive pupils on presentation.
b. The VMO was not contacted.
c. The ICU registrar was contacted by ED staff at 2220 hours and was due to review Mrs E in ED. However, the ICU registrar failed to attend and the patient was transferred to ICU at 0135 hours.
d. No Blood Glucose chart was commenced.

Panel opinion following SWSAHS response:
It is conceded that there is a record of Ms E's BSL in her record of her 36th admission.

The overall view of the care is that the issues initially identified are substantiated.
The medical assessments were delayed
The psychiatric assessments are thorough
It is acknowledged that no bed was available and noted that this is not uncomon.
It is acknowledged that Ms E presents a highly complex situation to manage and that this can affect the approach by clinical staff.
There are systemic issues around psychiatric admissions.

Commission Views and Comments **Incident No 70**

The Commision makes the following conclusions and comments:

After reviewing the care provided to Ms E during her 36th admission, the Commission found aspects of Ms E's care to be unsafe and/or inadequate for the following reasons:

1. It was inappropriate for an agitated psychotic patient to wait 1½ hours in an ED to be assessed by a medical practitioner and antipsychotic medication commenced. During this time Ms E left the ED in a psychotic state increasing the risk of harm to her-self or others.
2. Ms E was under- triaged as category 3.
3. While it is noted that Ms E remained in ED for 13 hours because a bed was not available, the delay was inappropriate given Ms E was clearly psychotic. Emergency admissions to psychiatric units must anticipate such admissions and plan accordingly.
4. No nursing vital observations were recorded on the ED observation chart for almost 9 hours, from 0750 to 1635 hours. There was an unacceptable delay of 13 hours in transfer to Waratah House Psychiatric Unit.
5. There was no medical direction given to nursing staff about the need for regular monitoring. However, it is expected that a competent RN would have been aware of the need to monitor the patient and make records.

After reviewing the care provided to Ms E during her 37th admission the Commission found aspects of Ms E's care to be unsafe and/or inadequate for the following reasons:

1. Ms E was under-triaged at category 4 when she was clearly acutely psychotic and required prompt medical assessment and treatment.
2. It was an unacceptable risk and inappropriate to allow an acutely psychotic patient to wait under her own recognisance in a general waiting area and she was clearly agitated and intent on self harm by the time she was reviewed by the psychiatric registrar.
3. There was a poor admission assessment monitoring of Ms E by ED staff.
4. Only one nursing observation was recorded on the ED vital observation chart and there is no evidence of continued monitoring.
5. Despite a history of poor diabetic control, there is no evidence that Ms E's BSL was taken in ED.
6. There were no directions given to nursing staff about the need for regular monitoring. Nursing staff should have been aware of the need to monitor a mentally ill patient and to make records.
7. There was an unacceptable delay of four hours after being reviewed in ED before Ms E was transferred to Waratah House, the psychiatric unit.

Investigation into Macarthur Health Service Incident Review

In late 2001 MHS acknowledged the need for an on-site psychiatric registrar to cover after hour periods at Campbelltown Hospital. In early 2003 an agreement was signed between the ED and Psychiatric Services for after hour service to ED. The date for implementation was mid 2003. The incidents relating to Mrs L occurred in 2002. Nevertheless, MHS has advised that a psychiatrist and psychiatric registrar were on call for both admissions. For the 36th admission, the registrar responded within around 5 hours of receiving the notification. However, transfer could not be effected as there were no bed available, including any beds of those patients on leave. In relation to the 37th admission, MHS maintain that, taking into consideration the time notification was made and the length of time required to assess and write up Mrs E's notes, the transfer to Waratah House was not delayed. While clarifying a number of issues in relation to the operation of the psychiatric service, the additional information does not alter the findings of the Commission.

Outcomes	**Incident No 70**
The Issue	**Quality and Safety Concerns**
Management response to adverse events, including incident reporting	Substantiated
Coordination and continuity of care	Substantiated
Quality of clinical care provided by nursing staff	Substantiated
Quality of clinical care provided by resident medical officers, career medical officers and junior registrars	Substantiated

Investigation into Macarthur Health Service Incident Review

Incident No 71

Date of Incident Qtr 1, 2002

Summary of Incident **Incident No 71**

Information provided by informant.

Low BP below 60/? --> No MET called.
Manager discouraged nursing staff from instigating a MET call.
The informant provided:
specific date of incident, and
patient surname, no initial. (The surname is relatively common.)

On 2/6/03 MHS informed the Commission that it had hundreds of listing for the same surname, and that none of them had been an inpatient on the date identified by the informant.

The incident was not identified by SWSAHS.

Allegations by Informants	Location 1	Location 2
Failure to call MET		

Clinical Review Panel Opinions **Incident No 71**

Commission Views and Comments **Incident No 71**

The Commision makes the following conclusions and comments:

This incident could not be investigated as the patient could not be identified.