Health and Disability Services
Complaints Office

Report of investigation into the implementation of recommendations relating to Albany Hospital arising from the death of Mr Kieran Darragh Watmore

June 2012

Glossary

ACSQHC	Australian Commission on Safety and Quality in Health Care
AH	Albany Hospital
AHPRA	Australian Health Practitioners Regulation Agency
AIMS	Advanced Incident Management System
AMA	Australian Medical Association
ANMC	Australian Nursing and Midwifery Council
AvERT	Adverse Events Review Team
CEO	Chef Executive Officer
DoH	Department of Health
EQuIP	Evaluation and Quality Improvement Program
HaDSCO	Health and Disability Services Complaints Office
IV	Intravenous
MER	Medical Emergency Response
OD	Operational Directive
OSQHC	Office of Safety and Quality in Health Care
PCA	Patient Controlled Analgesia
PCIA	Patient Controlled Intravenous Analgesia
PMS	Performance Management System
RCA	Root Cause Analysis
RND	regional Nurse Director
SQuIRe	Safety and Quality Investment for Reform
WACHS	Western Australian Country Health Service

Table of Contents

Executive Summary

The ramifications of the death of Mr Kieran Watmore, whilst receiving care at Albany Hospital, have been profound.

The State Coroner and Australian Health Practitioners Regulation Agency conducted an inquest and investigation, respectively, into the circumstances of Mr Watmore's death. The Coroner found it to be a preventable death and made six recommendations to mitigate the risk of this occurring again. The Australian Health Practitioners Regulation Agency took disciplinary action with respect to the relevant nursing staff and drew a number of systemic concerns to the attention of the Health and Disability Services Complaints Office.

This investigation by the Health and Disability Services Complaints Office found that extensive work has been undertaken by the Department of Health, Western Australian Country Health Service and Albany Hospital in response to Mr Watmore's death. The work is well underway and the public health services involved should be commended for the efforts made so far. There is, however, still action that is required to consolidate the improvements made at Albany Hospital. The recommendations arising from this investigation are intended to complement existing activities but stipulate timeframes, targets and some refinement of the those actions.

Acknowledgement

It is acknowledged that it has been a painful and protracted journey for all parties involved. Condolences have been previously expressed publicly and privately to Mr Kieran Watmore's family and friends. Recognition is again made here of the tragic loss of this young man's life. The effects of his death have been widely felt and weigh heavily on his family and friends, the community of Albany, Albany Hospital staff and many staff of the Western Australian Country Health Service and the Department of Health.

1. Introduction

1.1 Context

In part, this report summarises various actions taken by public health entities following a preventable death at Albany Hospital in August 2008. The conclusion from the State Coroner's report[1] is presented in full at Appendix 1 of this report. It provides some of the context for this investigation.

According to the Department of Health's *Western Australian Strategic Plan for Safety and Quality in Health Care 2008-2013*[2] the full extent of how preventable clinical incidents contribute to adverse events is now well documented in large, replicated international studies. In 1992 the first Quality in Australian Health Care Study estimated that adverse events were associated with up to 16.6% of hospital admissions, and suggested that nearly half of those events may have been preventable[3].

The outcomes of these adverse events vary but sometimes result in the death of the patient.

1.2 Setting

Within the Great Southern Region, Albany Hospital is one of the hospitals managed by the Western Australian Country Health Service. The Western Australian Country Health Service is a statutory body corporate working in close liaison with the Department of Health. It is responsible for health care delivery across regional and remote Western Australia.

The Great Southern has a population of around 55,000, of which 3% are indigenous Australians. The majority of the population live in the main towns of Albany, Denmark, Katanning and Mount Barker. Albany is the regional centre and home to around 57% of the Great Southern's total population.

1.3 Background

As found by the State Coroner, Mr Kieran Watmore was a generally fit and healthy 17 year old male who was admitted to Albany Hospital on 27 August 2008 with tonsillitis. Mr Watmore was prescribed patient controlled morphine for pain management and admitted to the ward under the care of nursing staff. He was assessed by a medical practitioner five hours after his arrival at the Emergency Department. The medical practitioner prescribed penicillin and increased Mr Watmore's morphine. Mr Watmore was found collapsed at 6:55 am on 28 August 2008 and attempts were made to resuscitate him but he was pronounced dead at 7:42 am.

[1] E61 Inquest report handed down by the State Coroner dated 30 September 2009.
[2] E57 Department of Health Western Australian Strategic Plan for Safety and Quality in Health Care 2008-2013
[3] E57 Department of Health Western Australian Strategic Plan for Safety and Quality in Health Care 2008-2013

Mr Watmore's family was advised at the time by the hospital that his death was due to a fatal allergic reaction to penicillin. On 21-22 July 2009 and 26-28 August 2009 the State Coroner carried out a formal Inquest. In the report of the Inquest handed down on 30 September 2009, the State Coroner found that Mr Watmore died from fatal asphyxiation. The Coroner made a number of recommendations with respect to systemic and other matters related to Mr Watmore's care. Currently the Coroner has no statutory power to enforce the implementation of his recommendations.

The Australian Health Practitioners Regulation Agency[4] also conducted two separate investigations into the relevant medical practitioner and several members of the nursing staff responsible for Mr Watmore's care. Australian Health Practitioners Regulation Agency's investigations into the relevant nurses are complete. The Health and Disability Services Complaints Office however, understands that the investigation into the medical practitioner by Australian Health Practitioners Regulation Agency has not yet been finalised.

Australian Health Practitioners Regulation Agency's role is to protect the public by undertaking a number of functions, one of which is to investigate notifications and complaints with respect to registered health practitioners. In doing so, its role is limited to dealing with individual practitioners and their conduct— Australian Health Practitioners Regulation cannot deal with systemic issues that it considers may also be relevant to an investigation that they have conducted.

During the investigation of relevant nursing staff from Albany Hospital, Australian Health Practitioners Regulation identified a number of potential systemic concerns that may have contributed to the circumstances surrounding Mr Watmore's death. Consequently, Health and Disability Services Complaints Office received a letter from Australian Health Practitioners Regulation, dated 15 October 2010, drawing the Director's attention to these systemic issues.

1.4 Scope of investigation

The circumstances surrounding Mr Watmore's death have been the subject of significant public scrutiny and have been formally investigated by two external bodies as outlined above. Internal investigations have also been conducted by Albany Hospital. Those internal investigations resulted in a number of recommendations being made. Both the Coroner and Australian Health Practitioners Regulation raised issues addressing systemic failures that were found to have contributed to Mr Watmore's death. The recommendations and issues raised by these bodies are detailed in section 1.5 of this report.

While many of the Coroner's recommendations relate to public health in Western Australia as a whole and require Statewide action, this investigation focused only on the recommendations as they apply to Albany Hospital.

[4] In this report AHPRA will be the term used rather than referring to the Nurses and Midwives Board of WA and Medical Board of WA that existed as separate bodies at the relevant time but now sit within the AHPRA structure. Western Australia became part of the national arrangement in October 2010. National Boards now exist for a number of health practitioner groups including medical practitioners, nurses and midwives.

As the Coroner's recommendations were made explicitly to protect the public of Western Australia by minimising the risk of a similar preventable death, it is important that these recommendations are implemented as far as is possible and practicable, and in a timely manner. It is important that Department of Health and other State health service entities be responsive to recommendations that have been made by external agencies when these recommendations are designed to protect Western Australian health consumers. It is also in the public interest that the State health service entities engage appropriate processes and procedures for implementing such recommendations.

The systemic matters identified by the Coroner and Australian Health Practitioners Regulation did not have associated timeframes for action. This investigation process has therefore proposed appropriate timeframes for implementation. The measure of timeliness of the health service entities' responses to the Coroner's recommendations can only be considered generally as the State health service entities were not to know at the time that this investigation would take place.

A less obvious consequence of this investigation and the proposed timeframes for implementation of the recommendations may be that it signals an end to re-examining the circumstances surrounding this event and instead heralds a shift forward towards a more patient-centred and patient-responsive system of health care.

1.5 Recommendations and systemic issues identified by the State Coroner and Australian Health Practitioners Regulation Agency

1.5.1 Coroner's Recommendations

1. *The Health Department work with hospitals which do not have medical staff on duty at all times and are reliant on nursing staff contacting on-call doctors to ensure that there are in place clear policies or guidelines which will provide guidance to nursing staff as to when to call the on-call doctor and what to do in the event that a doctor is unable or reluctant to attend or cannot attend within a reasonable timeframe. As much as possible the policies and guidelines should be consistent throughout the State.*

2. *Albany Hospital to review their arrangements so far as is practicable to limit the hours worked by medical practitioners and to, if possible increase after hours availability of doctors to the hospital.*

3. *Hospitals throughout Western Australia adopt a policy, which would require medical review of any patient who experiences an unexplained drop in oxygen saturations from a relatively normal level to a level of 90% or below.*

4. *All hospitals in Western Australia adopt a policy with respect of oxygen therapy to the effect that while no patient is ever to be denied oxygen in an emergency situation and the first attending nurse, midwife, medical practitioner or physiotherapist can administer oxygen without an order, once the patient is stabilised a written order for future oxygen therapy management of the patient*

is required and that order be retained at the same location or form part of the medication or drug chart.

5. *For patients given patient controlled analgesia a standard form should be used throughout Western Australia to record observations. The form should enable multiple entries to be made and record observations such as the rousability score of the patient in addition to vital signs including oxygen saturations as well as recording the infusion rate, bolus amounts given etc.*

6. *All hospitals in Western Australia adopt an agreed policy in respect of observations of patients receiving patient controlled analgesia. Consideration be given to adopting the practice recommended by Dr Pearlman in this regard, namely that there should be full observations conducted on at least a half hourly basis for the first two hours in an opiate naïve patient, decreasing to one hourly for the next two hours and then two hourly for the next four hours, or as determined by the patient's condition. Further the policy should require the regime to recommence in the event of any significant variation in dose which could impact on the patient's condition.*

1.5.2 Australian Health Practitioners Regulation Agency

The systemic issues identified by the then Nurses and Midwives Board of WA and communicated to HaDSCO were:

1. *Lack of recent performance appraisals for nursing staff.*
2. *No responsibility taken by the hospital to ensure staff were abreast of evidence based best practice for narcotic infusions.*
3. *Lack of a contemporary policy for the management of narcotic infusions for pain relief which lead to substandard guidance for nursing staff.*
4. *Core competency assessments not undertaken by the organisation.*
5. *A cultural approach to staff allocation within ward areas instead of appropriate allocation according to patients needs and staff competencies.*
6. *Inappropriate staff allocation at night resulting in ambiguity regarding leadership of the team and the roles of the team members.*
7. *Unsatisfactory standard of documentation.*
8. *Deficit in knowledge, responsibilities, accountability and actions in the delegation of duties by the registered nurse to the enrolled nurse; and in the acceptance by the enrolled nurse of duties outside her scope of practice.*
9. *Nursing managers have not taken responsibility for ensuring that policies and guidelines are in place.*
10. *Deficit in direction and leadership of staff at ward level.*
11. *Shortage of monitoring equipment for patients requiring close monitoring of their condition and inappropriate allocation of equipment that was available.*
12. *No timely investigation into the death was instigated by the Hospital, and no reports were made to the relevant Boards.*

1.6 Section 45 investigation

The Health and Disability Services Complaints Office is authorised to conduct investigations with respect to individual complaints made to the Office. It may also undertake an investigation if directed to do so by the Minister for Health. Section 45(b) of the *Health and Disability Services (Complaints) Act 1995* (the Act) provides that:

> *Where the Minister is of the opinion that -*
>
> *it is in the public interest on a matter of general importance relating to health that an investigation be carried out,*
>
> *the Minister may direct the Director to conduct an investigation under this Part with such terms of reference as the Minister may specify.*

Following the receipt from Australian Health Practitioners Regulation Agency of the list of systemic issues it identified as being relevant, the Director approached the Minister for Health to determine whether an investigation should be conducted under section 45(b) of the Act.

The Minister specified terms of reference for the Director's investigation based on both the Coroner's recommendations and systemic issues raised by AHPRA. The investigation's Terms of Reference[5] are included in section 2 of this report. In summary, the Terms of Reference were to consider the extent to which recommendations for change and improvement have been implemented with respect to Albany Hospital to reduce the risk of a similar preventable death, the responses of the various health service entities and to make any further recommendations.

Being mindful of the number of internal and external investigations that had already been made into Mr Watmore's death, it was decided that Health and Disability Services Complaints Office's investigation would not re-examine the circumstances of Mr Watmore's death or the part played by any individuals involved in his care. Rather, the investigation would focus more generally on systemic issues that may have contributed to such a death occurring.

[5] E62 Terms of Reference signed by the Minster on 20 January 2011.

2. Investigation Terms of Reference

The Terms of Reference specified by the Minister for Health for this investigation are:

1. *To assess the extent to which the State Coroner's recommendations in his Record of Investigation dated 30 September 2009 into the death have been implemented with respect to Albany Hospital.*

2. *To assess whether the Department of Health, including the WA Country Health Service and the Office of Safety and Quality, has made any further recommendations with respect to Albany Hospital arising from the death of this patient, and if so, the extent to which those recommendations have been implemented.*

3. *To determine whether Albany Hospital has conducted an internal investigation into systemic problems identified as a result of this death, and if so, the measures identified to rectify such problems, and the extent to which Albany Hospital has implemented those measures.*

4. *To examine the role to date of the Department of Health in ensuring that systemic problems identified with respect to Albany Hospital are improved, and to assess whether the Department's leadership response has been satisfactory.*

5. *To make any further suggestions to improve the relevant standards of care provided by Albany Hospital in order to minimise the risk of further preventable deaths occurring.*

6. *To make recommendations regarding the ongoing monitoring of and reporting on the timely implementation of all relevant recommendations with respect to Albany Hospital*.

3. Investigation activities

Key documents for the investigation were obtained from Albany Hospital, Department of Health (DoH), Western Australian Country Health Service (WACHS) and the Office of Safety and Quality in Health Care (OSQHC). These documents included Operational Directives and guidelines, policies, site instructions, medical charts, human resources reports, audit and other reports, patient medical records, minutes of meetings, training records and records of substandard performance programs.

The Chief Executive Officer (CEO) of WACHS provided a formal response to Terms of Reference 2 and 4 as requested by the investigator.

The investigator undertook a site visit on 9 and 10 June 2011.

Research was undertaken with respect to recognised standards and current practices in relevant areas of health service delivery. The investigator also liaised

with and interviewed relevant staff of various agencies including Australian Health Practitioners Regulation Agency (AHPRA), DoH, WACHS, OSQHC, Albany Hospital, Australian Commission on Safety and Quality in Health Care (ACSQHC), and the Coroner's Office.

Some documentation came to the attention of the investigator at a stage after the investigation and report writing process was thought to have been completed. However, the nature of that documentation and of the conclusions and recommendations previously reached were such that the investigator was able readily to incorporate its relevant content into this report. The timeframes for the various health entities to report to the Minister on the recommendations contained in this report have not been extended despite this new evidence. The health entities received this report's recommendations in April 2012 in their final form, and draft recommendations were provided to them in December 2011. The health entities have also advised HaDSCO that they have been working to those recommended timeframes.

4. Structure of Report

The body of this report is presented under each Term of Reference. The evidence gathered against each Term of Reference is then summarised. A reference list is provided in section 11 of the report. Each document is given an E (for evidence) number that is footnoted within the report.

Considerable evidence was gathered as part of this investigation, but what is presented in the report is intended to illustrate the main actions taken in response to Mr Watmore's death, rather than being an exhaustive list of all material that was gathered or could have been gathered during the investigation process.

Term of Reference 1, which relates specifically to the Coroner's recommendations, has six parts, with the Coroner's recommendations as headings. Comments with respect to whether or not the recommendations have been implemented follow each section of evidence. The Health and Disability Services Complaints Office's (HaDSCO) findings with respect to each recommendation are then outlined.

The systemic issues raised by AHPRA are listed under Term of Reference 2. The evidence gathered for each issue or group of issues is then summarised. Again, HaDSCO's findings with respect to each issue or group of issues are then presented.

The remaining Terms of Reference are dealt with more simply by summarising evidence gathered during the investigation, and then presenting HaDSCO's findings.

HaDSCO's recommendations for further action with respect to the Terms of Reference are detailed under Term of Reference 6 in section 10 of the report.

5. Term of Reference 1

To assess the extent to which the State Coroner's recommendations in his Record of Investigation dated 30 September 2009 into the death of Mr Watmore have been implemented with respect to Albany Hospital

5.1 Coroner's Recommendation 1

The Health Department work with hospitals which do not have medical staff on duty at all times and are reliant on nursing staff contacting on-call doctors to ensure that there are in place clear policies or guidelines which will provide guidance to nursing staff as to when to call the on-call doctor and what to do in the event that a doctor is unable or reluctant to attend or cannot attend within a reasonable timeframe. As much as possible the policies and guidelines should be consistent throughout the state.

Eight main strategies have been adopted to implement this recommendation at Albany Hospital:

- A new medical model
- 24 hour medical cover
- Clinical Leads
- Rules for WA Country Health Service Medical Practitioners
- A new Adult Observation Chart
- A new WACHS Early Recognition and Response to Clinical Deterioration Policy
- A revised Medical Emergency Response Policy
- Essential Skills Training

5.1.1 A new medical model

Under the former medical model, general practitioners staffed the hospital on a roster system during the day and on-call at night.

A new medical model to provide support for medical services has been evolving at Albany Hospital since 2009. This has developed into the current model that provides a three team approach to staffing for medical practitioners - salaried doctors, fly-in locums and local general practitioners from one private practice service. This is managed by a complex roster arrangement to ensure that staffing needs are met and are consistent with guidelines for safe working hours.

5.1.2 Twenty four hour medical cover

Albany Hospital Emergency Department has had 24-hour cover by a medical practitioner since 1 October 2009. These doctors respond to emergency calls from wards after hours. Further, from 19 January 2010 a senior medical practitioner has provided 24 hour cover in the Albany Hospital High Dependency Unit.

5.1.3 Clinical Leads

A Clinical Lead position in each of the speciality areas provides leadership and oversight of the clinical care provided. This leadership role did not exist under the former medical model. Oversight now extends to the increased number of junior doctors that are part of the new medical model.

The clinical oversight requires the Clinical Leads positions to review trigger conditions, clinical incidents, AIMS[6] reports and complaints. The Clinical Lead is also expected to lead regular Unit meetings.

5.1.4 Rules for WA Country Health Service Medical Practitioners

The *Rules for WA Country Health Service Medical Practitioners Policy* dated 17 June 2010[7] provides guidance regarding patient care, attendance to patients and on-call obligations**.**

5.1.5 New Adult Observation Chart

A new evidence based adult general observation chart[8] was introduced into Albany Hospital in late 2010. This charting system involves a 'track and trigger' protocol that is in accordance with the national *Recognising and Responding to Clinical Deterioration* program coordinated by the ACSQHC.[9]

The 'track and trigger' protocol sets mandatory escalation procedures if a patient deteriorates, together with timeframes for most actions. In addition, the Chart calls for increased surveillance in certain circumstances. The Chart can be individualised for patients who present with compromised but expected observations that fall outside the usual parameters. This enables the responsible doctor to individualise the level of intervention required. This Chart clearly sets out the obligations in different circumstances of deterioration.

Albany Hospital staff have been trained in the new Chart. The Chart's use is audited to check for compliance.

Another chart has also been developed by Albany Hospital to complement the Adult Observation Chart. The LIME Chart[10] is used by both nursing and medical staff to record telephone communications regarding patient care. The LIME Chart uses the same parameters for action as the Adult Observation Chart. It provides checklists for staff when making their assessments prior to telephone communications. It requires the relevant medical staff to record observations and

---

[6] Advanced Incident Management System

[7] E13 Rules for WA Country Health Service Medical Practitioners Policy 17 June 2010

[8] E37 sample Adult Observation and Response Chart

[9] E39 Australian Commission on Safety and Quality in Health Care: Evidence based adult general observation chart.
E11 Australian Commission on Safety and Quality in Health Care: Recognising and responding to Clinical Deterioration March 2009.
E40 Australian Commission on Safety and Quality in Health Care: National Consensus Statement

[10] E38 WACHS Great Southern Hospital Telephone Communication Record - ISOBAR

make recommendations that will then be discussed with the receiving doctor or nurse. On-call doctors are provided with these charts for use when called at home.

5.1.6 WACHS Early Recognition and Response to Clinical Deterioration Policy

The *Early Recognition and Response to Clinical Deterioration Policy* was released in July 2010 and alerts staff to the early stages of deterioration and the 'track and trigger' system[11]. It describes roles and responsibilities of the staff when monitoring patients, recognising deterioration and then acting.

5.1.7 Medical Emergency Policy

The new WACHS Great Southern *Medical Emergency Policy*[12] dated January 2010 outlines the roles and responsibilities of the various staff when a Code Blue[13] is initiated (the new Adult Observation Chart directs staff to call a Code Blue in specific circumstances). The Policy refers to the ACSQHC draft *Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration*.

5.1.8 Essential Skills Training

The WACHS Great Southern *Medical Emergency Policy* is supported by training in essential skills for Albany Hospital nursing staff. A new *Training and Development Policy*[14] dated December 2010 outlines a planned and systematic learning and development strategy that identifies essential training needs and a range of coordinated learning opportunities through Professional Development. It outlines the various responsibilities of line managers, Staff Development Units and employees.

5.1.9 Compliance with Coroner's Recommendation 1

WACHS and Albany Hospital have undertaken a range of activities to implement the Coroner's Recommendation 1 within an environment of other change. This is evidenced by the fact that nurses now have access to 24 hour medical support from doctors who are on duty within the hospital.

This engenders greater support for nurses than was previously available and lessens the likelihood of a doctor being reluctant to respond to a request by a nurse for clinical support. In addition, doctors are now made aware of their responsibilities by the clear rules that apply to the employment of medical staff in WACHS as evidenced in the *Rules for WA Country Health Service Medical Practitioners.*

---

[11] E43 WACHS Early Recognition and Response to Clinical Deterioration Policy
[12] E53 WACHS Code Blue: Medical Emergency Response Policy
[13] A Code Blue is defined in the Policy
[14] E7 WACHS Workforce and Development Policy

This initiative is reinforced by the introduction of the new Adult Observation Chart, which includes a 'track and trigger' system if a patient's condition deteriorates. This provides clear guidance and policy as to when nurses should seek assistance from a doctor.

The new WACHS *Great Southern Medical Emergency Policy* and *Early Recognition and Response to Clinical Deterioration Policy* provide further guidance for nursing staff to take action when a patient is deteriorating. It allocates clear roles and responsibilities for all relevant staff within a health service and complements the Adult Observation Chart.

To ensure appropriate action is taken by staff in emergency situations, Albany Hospital has commenced revised essential skills training to certify that all staff are adequately trained and competent in the actions required to deal with a medical emergency.

5.1.10 HaDSCO's Findings

Attracting and retaining nursing and medical staff is a well-recognised problem throughout Australia; not only in regional areas. It is not a problem that is easily resolved but rather one that requires leaders of health services to be vigilant and flexible in their approach to finding new solutions as circumstances change.

The new medical model that has been introduced at Albany Hospital has addressed the immediate problem of providing appropriate support for nursing staff to reduce the risks to patient care. It will require ongoing monitoring by WACHS and Albany Hospital to ensure that 24 hour medical support is afforded to nursing staff.

The introduction of Clinical Leads positions further strengthens the medical model by ascribing responsibility to particular medical staff. It was noted by the investigator at a site visit that there is a degree of resistance by some medical staff to attend Clinical Unit meetings. Attendance is, however, a condition of the contract for service for medical staff under the Medical Service Agreement[15] . It should be noted that fly-in locum staff sometimes experience difficulties in attending due to the timing of flights. If these Unit meetings are to be an effective method of providing more leadership and rigour in the oversight of patient care, more work is required to clearly specify clinical responsibilities.

It is recognised that these new arrangements are still evolving. However, it is essential that where it has been identified that individuals have particular responsibilities, senior management of WACHS and Albany Hospital must ensure individual staff accountability.

Having made that observation, there was strong evidence at the site visit of the changing culture within Albany Hospital. For example, the Obstetrics Unit sought the opportunity to have more oversight of post-partum care that enabled a change in supervision and care arrangements. In addition, at the second meeting of the

[15] As advised by WACHS regional staff during the site visit on 9 and 10 June 2011.

Medical Unit, two general practitioners were present who had not previously attended.

The new Adult Observation Chart is one of five charts currently being trialled by the ACSQHC, and is thus credible, though not yet established as the standard. Observation charts throughout Australia are currently undergoing changes as a result of the work being undertaken by ACSQHC. Action taken by Albany Hospital is consistent with the program from the *National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration*, April 2010.

Once the trial of charts is completed, and if a standard chart is determined by ACSQHC, then WACHS and Albany Hospital will need to amend the current Chart accordingly.

While the Adult Observation Chart provides a good platform for a more evidence based approach to decision-making where a patient is deteriorating, it can only be effective if applied consistently. It was evident at the site visit that audits[16] of the new charts indicate that full compliance has not been achieved. In addition, Albany Hospital is monitoring[17] and analysing the number of Code Blues or Medical Emergency Response (MER) calls that are made to determine whether they comply with the Policy. It has been found to date that more MER calls were made, and that they were made at an earlier stage of patient deterioration. This is a positive change.

5.2 Coroner's Recommendation 2

Albany Hospital to review their arrangements so far as is practicable to limit the hours worked by medical practitioners and to, if possible increase after hours availability of doctors to the hospital.

Two main strategies have been adopted by Albany Hospital to implement this recommendation:

- A new medical model
- 24 hour cover by an in hospital doctor

5.2.1 New medical model

As described in section 5.1.1 of the report, a new medical model to provide support for clinical services has evolved at Albany Hospital since 2009. This has developed into the current model that provides a three-team approach to staffing for medical practitioners.

Evidence provided to the investigation confirmed that this three-team approach is supported by a complex roster arrangement[18], aiming to ensure that patient needs are met and the rosters are in accordance with guidelines for safe working hours[19].

[16] E41 Great Southern Intranet E Hour
[17] E42 WACHS Great Southern Early Recognition and Response to Clinical Deterioration CPI Meeting
[18] E45 Roster Information – Albany Hospital email.

Some of the factors that influence medical staffing were evidenced at the site visit and in other discussions by the investigator with relevant WACHS and Albany Hospital staff, including:

- Albany Hospital is currently recruiting more salaried medical officers and planning to engage more junior doctors in 2012. The model is being adjusted as different situations dictate with a trend to appointing more salaried medical officers.
- General practitioners are still included in the new medical model as they have local knowledge, can provide continuity of care, are Australian trained and are an available local resource.
- Most of the locums fly in from Perth or Queensland. This means rosters are limited to fit in with flights. Sometimes due to other work commitments or travel circumstances, doctors self-regulate and identify their own fatigue. There is local support for locum doctors who indicate that they are too fatigued to work a shift. Senior management at Albany Hospital are able to find a replacement doctor using a local general practitioner.
- Doctors are rostered for duty in accordance with the *Department of Health Medical Practitioners (WA Country Health Service) AMA Industrial Agreement 2011*. Junior doctors are also rostered under the terms of this Agreement.
- All calls overnight are routed via the Operations Manager to reduce the on-call disturbances. The appropriate calls are then referred to the in-hospital doctor located in the Emergency Department.

5.2.2 Twenty four hour cover by an in-hospital doctor

Albany Hospital's Emergency Department has instituted 24 hour cover by a medical practitioner since 1 October 2009. These doctors respond to emergency calls from wards after hours. Since 19 January 2010 a senior medical practitioner has provided 24 hour cover in the hospital's High Dependency Unit. As a result of these two changes the hours worked by the general practitioners within Albany Hospital have reduced significantly as they no longer work after 10pm.

5.2.3 Compliance with Coroner's Recommendation 2

Albany Hospital has taken appropriate action to implement the Coroner's Recommendation 2. This is evidenced by the new medical model that provides after hours and on-site medical cover. This did not exist at the time of Mr Watmore's death.

The hours that doctors work is predicated on the availability of staff. Albany Hospital has improved its staffing profile to reduce hours worked by doctors and to ensure that doctors are available within the hospital on a 24 hour basis.

---

[19] Safe Working Guidelines are contained in the Industrial Agreement. The AMA (taken from the AMA website) also provides guidelines for safe working hours for junior doctors. Queensland Health has also undertaken work in the area and developed what they call a Standard (taken from Queensland Health website).

5.2.4 HaDSCO's Findings

The ability of Albany Hospital to provide adequate medical cover is an ongoing problem as it is for other regional hospitals. A series of WACHS, Great Southern Memoranda[20] indicate that changes have occurred over time. The current medical model operating at Albany Hospital is similar to models that have existed in other regional hospitals.

The three-team approach was designed to provide coverage to reduce the hours worked by doctors. It has effectively reduced the on-call hours of general practitioners. The model in place at present provides for 24 hour medical cover. This quite dramatic change to staffing arrangements is commendable. It is recognised that it would not have been an easy change due to competing and conflicting demands, but seems to have been effectively managed by WACHS and Albany Hospital.

The *Department of Health Medical Practitioners (WA Country Health Service) AMA Industrial Agreement 2011*[21] provides conditions on the working hours and rostering for doctors. The clauses dealing with working hours are complex and provide guidelines for junior doctors as well as senior practitioners. In many aspects the working hours clauses of the Agreement state that the conditions be met "as far as practicable".

Two months[22] of rosters were obtained as part of the investigation. These were compared to the Agreement's guidelines for junior doctors, and in almost all cases the rosters complied strictly with the guidelines. Where there was variation, it appeared to fall within the flexibility allowed by the Agreement. Given the complexity of the Agreement, it appears from the sample of two months, that Albany Hospital is managing the issue of rostering well.

Although the availability of medical staffing has improved, a risk still exists at Albany Hospital in the event that a doctor is too fatigued or ill to undertake rostered duty. The risk appears to be reduced by the current and emerging model as more salaried doctors are engaged and are therefore likely to have worked less hours. Evidence was also provided to the investigation that there is local support for doctors who are too fatigued or ill to undertake duty whereby other doctors can provide support for a portion of the entire shift.

Albany Hospital's senior management is responsible for re-arranging staffing to deal with the absence of a doctor rostered to work. They advise that patient safety is the first priority, followed by staff availability. As such, contingency plans such as transferring patients to other facilities are used in some situations.

[20] E47 Memorandum WACHS Great Southern : to all VMPs and Salaried Medical Staff

[21] E46 Department of Health Medical Practitioners (WA Country Health Service) AMA Industrial Agreement 2011. This agreement is negotiated between the DoH and the Australian Medical Association (AMA).

[22] Two months rosters were selected at random by the investigator.

A further risk is that Albany Hospital has no direct control over the hours worked by non -salaried doctors such as locums and general practitioners outside of the hours worked at Albany Hospital. As with other hospitals or health services, Albany Hospital is reliant on the professional responsibilities undertaken by the individual practitioner. These medical practitioners have a duty to recognise and take steps to minimise the risk of fatigue in themselves and other practitioners under the Medical Board of Australia's Good Medical Practice[23] (Code of Conduct) (specifically sections 6.3.2, 9.2.5 and 9.3.4 of the Code). The other requirements is for doctors to comply with various clauses in their contracts that relate to codes and guidelines. Where doctors are known to have other employers WACHS's practice is to ask them to provide evidence that the other employer is aware of their obligations to WACHS as the primary employer. The second employer may also have a policy which limits the 'other' work that can be done.

Efforts are being made in other medical domains to determine safe working hours and address fatigue in medical practitioners. For example, the Royal Australasian College of Surgeons released a position statement in 2007[24] which outlines expectations for hours worked and on-call arrangements. It also includes guidance to surgeons in relation to junior doctors.

Queensland Health has also developed a policy[25] and standard[26] with respect to fatigue including a risk assessment tool and fatigue risk issues register in 2011. The Australian Medical Association (AMA) is undertaking its second audit of working hours for medical practitioners and medical students[27] in 2011.

The AMA also released a position statement in 2011 in relation to the health and wellbeing of doctors and medical students[28]. This includes alerts with respect to finding a balance between work and leave. The matter of fatigue and the need for safe working guidelines for medical practitioners is becoming more prominent in Australia.

The 2011 Industrial Agreement for salaried doctors provides for a review of rostering patterns for doctors in training to establish safe work parameters. Part of this was the agreement to examine the AMA Safe Hours National Code of Practice. These discussions commenced in 2011. The DoH is currently evaluating rostering data that it can access to assist in providing details regarding rostered hours of work, on call and overtime obligations. The DoH advises it is confident that the review will be undertaken in the timeframe commented which is by 30 September 2013. In addition to this process a fatigue management policy for WA is currently being developed. It is anticipated that this policy will be finalised in 2012.

[23] E64 Medical Board of Australia's Good Medical Practice
[24] E32 Royal Australasian College of Surgeons Standards for Safety Working Hours and Conditions for Fellows, Surgical Trainees and International Medical Graduates.
[25] E33 Queensland Health: Medical Fatigue Risk Management Policy 2011.
[26] E34 Queensland Health: Medical Fatigue Risk Management Implementation Standard 2011
[27] E35 Australian Medical Association audit of working hours for medical practitioners and medical students 2011.
[28] E36 Australian Medical Association position statement in relation to the health and well being of doctors and medical students 2011.

It is strongly suggested that the effectiveness of a form of declaration by non-salaried doctors that they will be fit and well to undertake work is considered by DoH in reviewing safe working arrangements for doctors as part of the industrial process as well as within the context of developing the fatigue management policy.

5.3 Coroner's Recommendation 3

Hospitals throughout Western Australia adopt a policy, which would require medical review of any patient who experiences an unexplained drop in oxygen saturations from a relatively normal level to a level of 90% or below.

Three main strategies have been adopted by Albany Hospital to implement this recommendation:

- The Adult Observation Chart
- The LIME Chart
- Staff training and auditing

5.3.1 Adult Observation Chart

As described in section 5.1.5 of this report, the new Adult Observation Chart requires escalation of care if a patient's vital signs deteriorate. For example, a medical review (by telephone or in person) must be undertaken within 30 minutes if the patient's oxygen saturation levels fall below 90%. The actions required are described on the Chart. A method of escalation is also provided if a medical review is not completed within 30 minutes.

Furthermore, if the oxygen saturation levels fall below 84% a MER call is required. The Chart provides for mandatory action by staff at different trigger points related to a patient's vital signs.

5.3.2 LIME Chart

The LIME chart which is used for recording telephone communication between doctors and nurses is a local development based on the Adult Observation Chart[29]. The same parameters and triggers are used. Albany Hospital took the initiative to develop this Chart given its particular regional setting whereby doctors and nurses regularly communicate via the telephone.

5.3.3 Staff Training and Auditing

Refer to sections 5.1.5 and 5.1.8 of the report under Coroner's Recommendation 1 and HaDSCO's Findings in that same section of this report. Auditing of the Adult Observation Chart at Albany Hospital is ongoing, although 100% compliance of recording and acting has not been achieved in the samples that have been audited to date.

[29] E38 WACHS Great Southern Telephone Communication Record - ISOBAR

5.3.4 Compliance with Coroner's Recommendation 3

Albany Hospital has undertaken a range of activities to support the implementation of the Coroner's recommendation. The new Adult Observation Chart fundamentally addresses the Coroner's recommendation, although the Chart does not require medical review in person. It does, however, mandate that a nurse make a MER call if a medical review does not occur, which would then ensure a medical review would be conducted in person by a doctor.

5.3.5 HaDSCO's Findings

As stated in section 5.1.5 of the report, the new Chart is one of five currently being trialled by the ACSQHC and is thus credible but yet to be established as a standard. The LIME Chart is a derivative of the Adult Observation Chart. It is also being trialled, though only locally.

Whilst Albany Hospital has made considerable progress to introduce a 'track and trigger' system, which accords with the national approach by the ACQSHC, it is not possible to state whether it is truly imbedded in the practices of medical and nursing staff. Evidence of the auditing of the use of the charts indicates that full compliance has not been achieved.

Further auditing, training and refining consistent with the national approach is essential to improve compliance. ACQSCH's work in this area strongly supports the view that it is difficult to achieve compliance with charting. However, improved compliance can be achieved through feedback and refinement processes[30].

5.4 Coroner's Recommendation 4

All hospitals in Western Australia adopt a policy with respect of oxygen therapy to the effect that while no patient is ever to be denied oxygen in an emergency situation and the first attending nurse, midwife, medical practitioner or physiotherapist can administer oxygen without an order, once the patient is stabilised a written order for future oxygen therapy management for the patient is required and that order be retained at the same location or form part of the medication or drug chart.

Two main strategies have been adopted to implement this recommendation at Albany Hospital:

- Oxygen Therapy Administration Policy
- Staff training and auditing

[30] E39 ACSQHC Evidence based Adult Observation Chart and E12 School of Psychology, University of Queensland October 2010 Developers Guide for Observation and Response Charts.

5.4.1 Oxygen Therapy Administration Policy

WACHS Great Southern Internal Memorandum dated 29 October 2009[31] alerted medical practitioners to the need to prescribe oxygen therapy including a written order, stickers stating the requirement for method of administration, flow rate, date of commencement, target oxygen saturation and delivery system to be used. It required the prescription to be signed and dated by the medical practitioner. It also alerted medical practitioners to the full policy on the WACHS website.

An *Oxygen Therapy Administration in Hospital Policy*[32] was released by WACHS in November 2009. This policy requires a prescription be prepared by a doctor for the administration of oxygen, but a patient should not be denied oxygen in the absence of a written order. The order is documented using the Oxygen Therapy Prescription Sticker or an oxygen prescription form, to be placed on the medication chart. A registered nurse is responsible for ensuring that the patient's response is evaluated and documented as appropriate to the clinical state of the patient, but not less frequently than four hourly. The policy stipulates that a review be undertaken by a medical practitioner depending upon the clinical state of the patient, but not less than every 24 hours.

A Statewide Operational Directive (OD) was then developed by the DoH and released on 17 May 2011[33]. The OD was developed in consultation with the Thoracic Society of Australia and New Zealand and coordinated by the Office of the Chief Medical Officer of Western Australia.

5.4.2 Staff Training and auditing

Relevant comments are provided in section 5.1.5 and 5.1.8 of the report dealing with the Coroner's Recommendation 1.

5.4.3 Compliance with Coroner's Recommendation 4

Albany Hospital has taken action to support the implementation of the Coroner's recommendation. The Oxygen Therapy Policy complies with the stated Coroner's recommendation. The Operational Directive complies with the 2009 WACHS Policy.

5.4.4 HaDSCO's Findings

Albany Hospital has successfully established a policy that implements the Coroner's recommendation 4. ACSQHC does not provide a standard for the prescription of oxygen. A search of some of the literature identified an article[34] entitled *Quality improvement report. An audit of the effect of oxygen prescription charts on clinical practice.*

[31] E44 WACHS – Great Southern Internal Memorandum Emergency Department, Inpatient care and Related matters
[32] E23 WACHS Oxygen Therapy Administration in Hospital Policy
[33] E3 State-wide Operational Directive: Use of Acute Oxygen Therapy
[34] E60 Postgrad Med J 2010;86:89-93 doi:10.1136/pgmj.2009.087528

The article stated that the lessons learned from the change in charting indicated that oxygen prescription section on hospital drug charts improved the prescription of oxygen but did not improve clinical practice. Additional strategies are required to improve the administration of oxygen therapy in hospitals.

Although only one article was available for review, it supports the approach that has been taken by Albany Hospital that a requirement for a prescription for oxygen by itself it is not sufficient. This aspect is again part of the suite of actions within the *Recognising and Responding to Clinical Deterioration* program being undertaken by WACHS and Albany Hospital which are outlined in sections 5.1.5, 5.1.6, 5.1.7, 5.3.2 and 6.1.1 of this report.

No further action is required by Albany Hospital with respect to this recommendation apart from the usual auditing of compliance with policy.

5.5 Coroner's Recommendation 5

For patients given patient controlled analgesia a standard form should be used throughout Western Australia to record observations. The form should enable multiple entries to be made and record observations such as the rousability score of the patient in addition to vital signs including oxygen saturations as well as recording the infusion rate, bolus amounts given etc.

Two main strategies have been adopted to implement this recommendation at Albany Hospital:

- A revised PCIA Prescription form (WACHS GS TMR 114)
- Observations and Records of Analgesia Chart (WACHS GS TMR 97A).

5.5.1 PCIA Prescription form

Albany Hospital's Patient Controlled Intravenous Analgesia (PCIA) Chart was introduced in February 2009. The form[35] has subsequently undergone further improvement reviews. It provides some guidance to staff with respect to the monitoring or observations required. The form allows for the detailing of the administration of PCIA.

5.5.2 The Observations and Records of Analgesia Chart

The Observations and Records of Analgesia Chart[36] provides for multiple recordings of sedation, nausea, pain score, pulse, blood pressure, temperature, oxygen saturation, infusion rate, bolus etc.

5.5.3 Compliance with Coroner's Recommendation 5

Albany Hospital has undertaken two key activities to implement the Coroner's recommendation. The Prescription form requires that one hourly observations must

[35] E24 PCIA Prescription Form
[36] E58 WACHS Great Southern: Observations and Record of Analgesia Chart

be made that record volume infused by the patient as well as conscious state, along with breathing and other routine observations. Two hourly pain scores should be recorded which includes pain, nausea and sedation scores. The form also provides instruction for escalating if a patient's condition deteriorates.

The Observations and Record of Analgesia Chart enables the recording of sedation, nausea, pain score, pulse, blood pressure, temperature, oxygen saturation, infusion rate, bolus etc. This addresses the Coroner's recommendation adequately.

5.5.4 HaDSCO's Findings

The revised Prescription form and Observation and Records of Analgesia Chart combine to enable staff to not only document the prescription of PCIA but also to document observations with respect to the status of the patient whilst receiving that care.

The vital signs included in the Observation and Records of Analgesia Chart include all of the physiological observations recommended in the *ACSQHC Consensus Statement: respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, and level of consciousness*.

Both the Observation and Record of Analgesia Chart and the Adult Observation Chart can be in use simultaneously. Both charts provide for the noting of the use of other charts. Some refinement of the use of these charts may be necessary after further auditing (as described in section 5.1.10 of this report).

5.6 Coroner's Recommendation 6

All hospitals in Western Australia adopt an agreed policy in respect of observations of patients receiving patient controlled analgesia. Consideration be given to adopting the practice by Dr Pearlman in this regard, namely that there should be full observations conducted on at least a half hourly basis for the first two hours in an opiate naïve patient, decreasing to one hourly for the next two hours and then two hourly for the next four hours, or as determined by the patient's condition. Furthermore the policy should require the regime to recommence in the event of any significant variation in dose which could impact on the patient's condition.

Four main strategies have been adopted to implement this recommendation at Albany Hospital:

- Observation and Record of Analgesia Chart
- Vital Signs Site Instruction Policy
- WACHS Vital Signs Policy
- Staff training and auditing.

5.6.1 Observation and Record of Analgesia Chart

The revised Observation and Records of Analgesia Chart includes recording for patients on PCIA. It was developed at Albany Hospital and has been revised since Mr Watmore's death. It includes oxygen saturation recording.

5.6.2 Vital Signs Albany Hospital Site Instruction

A Vital Signs Site Instruction[37] was disseminated at Albany Hospital in October 2010. This Instruction provides advice about vital signs monitoring including patients who are receiving patient controlled analgesia (PCA) and intravenous opioids. Section C *Routine Post Operatively*, D *Patient Controlled Analgesia (PCA) for surgical and non-surgical* use and E *Opioid Intravenous (IV) Infusion Observations* on page 2 of the Site Instruction provides advice to staff regarding observation regimes.

5.6.3 WACHS Vital Signs Policy

A WACHS *Vital Signs Policy*[38] sits above the Site Instruction and establishes a minimum standard for vital signs monitoring that is consistent with the *National Consensus Statement: essential elements of recognising and responding to clinical deterioration*.

The development of a Statewide policy is ongoing. The Office of the Chief Medical Officer has examined protocols from Western Australian tertiary hospitals as well as key interstate sites to develop common patient controlled analgesia protocols. The draft protocol has been subject to focussed consultation. Implementation plans for the oxygen policy and PCIA clinical guidelines are currently being developed, including the identification of responsibility for these areas within WA Health hospitals and health services.

5.6.4 Staff training and auditing

Evidence supports Albany Hospital's claim that staff training and compliance auditing has occurred. In addition, the OSQHC reports that Compass trainers conducted additional train-the-trainer education sessions in metropolitan and rural sites on 23 and 27 May 2011 prior to the metropolitan trial. This will facilitate the training of more staff at each WACHS site including Albany Hospital.

5.6.5 Compliance with Coroner's Recommendation 6

Albany Hospital has undertaken four key activities to support the implementation of the Coroner's Recommendation 6.
The observation chart enables the recording of numerous observations (13 on each page) of a range of vital signs. This is in line with the Coroner's Recommendation 5.

[37] E30 Vital Signs Albany Hospital Site Instruction
[38] E31 WACHS Vital Signs Policy

The Site Instruction requires a regime of observations for patients. Sections C, D and E relate to PCIA patients. In particular, the Instruction states that patients receiving Patient Control Analgesia (PCA) should have observations taken every 15 minutes for the first hour, then every 30 minutes for two hours, then maintain one hourly pulse, respiration, SpO_2, pain and sedation score with four hourly blood pressure and temperature.

In addition, it states that if intravenous opioids are given to an unventilated patient then a different regime is to be used. This includes the requirement to increase observations where there is a change in the rate or dose of opioid. The Instruction also includes a Special Note that consideration should be given to admitting the patient to the High Dependency Unit if taking intravenous opioids.

The Site Instruction is not consistent with the Coroner's recommendation to follow Dr Pearlman's practice, although the Site Instruction stipulates more regular and frequent observations. However, they are not as simply stated in the Site Instruction as in Dr Pearlman's recommended practice. Also the Site Instruction does not deal with the specific situation of an opiate naïve patient, as it applies the same frequent regime to all patients.

Albany Hospital advises that a review of the Coroner's recommendations against the Site Instruction occurred but no evidence has been provided to substantiate that. The 2009 Vital Signs Site Instruction, however, has more frequent observations than those of Dr Pearlman's and the Hospital advises that this is the reason it was not altered to match Dr Pearlman's regime.

It is not clear that all the charts and Instructions that may be used when monitoring vital signs for one patient have been reviewed as a package. For example an extract from the Patient Controlled Intravenous Analgesia (PCIA) Prescription and Management form is provided below:

> ***Observations***
> ***1 hourly whilst PCIA insitu***
> _ *Record volume infused and conscious state.*
> _ *Observe breathing pattern for depth and regularity and record respiratory rate.*
> _ *All other routine observations, including post – operative patients.*
> ***2 hourly record pain scores – omit if patient asleep.***
> _ *Pain scores 0 = No Pain, 10 = Worst pain imaginable*
> _ *Nausea Score 0 = None, 1 = Nausea, 2 = Vomiting,*
> *3 = Nausea or vomiting unresolved, 4 = Resolved*
> _ *Sedation Score 0 = No sedation/aware/alert,*
> *1 = Mild occasionally drowsy, easy to rouse,*
> *2 = Moderate frequently drowsy, slow to rouse,*
> *3 = Severe somnolent, difficult to rouse,*
> *4 = Unconscious, unrousable,*
> *X = Normal sleep/acceptable respiratory rate.*

This is not as clear at that stated in the Site Instruction as described in this section above. So, it remains that some minor refinement of these documents may be

required to ensure that it is clear to clinical staff the regimes that are required and what should be recorded.

5.6.6 HaDSCO's Findings

Dr Pearlman's regime provides for a regime of observations of a patient who is receiving PCIA. The Site Instruction referred to in this report provides for more frequent observations therefore not the same as Dr Pearlman. It would seem that more observation than less would be an improvement.

Having reviewed the various charts and policies that may be used when managing a PCIA patient, some refining of the information is needed to ensure that all information is consistently clear. The wording of the documents should be consistent to make it less likely to be misinterpreted and also to reinforce the need for these more frequent observations.

6. Term of Reference 2

To assess whether the Department of Health, including the WA Country Health Service and the Office of Safety and Quality, has made any further recommendations with respect to Albany Hospital arising from the death of Mr Watmore, and if so, the extent to which those recommendations have been implemented.

The issues raised by AHPRA will be addressed here as they involved concerns about systemic issues that are further to the Coroner's recommendations. This provided the relevant health service entities the opportunity for further action or to make other recommendations for improvements to be taken with respect to Albany Hospital.

The systemic issues raised by AHPRA are regrouped under general headings for convenience. Some matters overlap with the Coroner's recommendations and where that occurs a reference to the Coroner's recommendation is made instead of repeating the same information. However, firstly a section is included which describes the broad approach to change that acts as a backdrop to what has occurred at Albany Hospital since Mr Watmore's death.

6.1.1 Further recommendations by DoH, WACHS and OSQHC

WACHS advised that a broad approach to change occurred as a result of Mr Watmore's death, together with other developments occurring elsewhere in the State and at a National level. By the time the Coroner's report was handed down, a wider change process was already underway. At WACHS level the Coroner's recommendations feed into that process. In addition, Albany Hospital conducted an internal review of the Coroner's recommendations and referred matters with Statewide implications and relevance to the DoH. Local actions were also assessed against the recommendations to ensure they would be addressed.

Pillar 2 of the WACHS *Safety, Quality and Performance Action Plan 2010-11*[39] outlines the actions, timeframes and responsibilities for further work on the *Recognition and Response to Clinical Deterioration Program*[40].

There has been a substantial development of health and clinical policy over the past two decades in the form of Operational Circulars and Directives. These policies are available on the Department of Health's website. WACHS advises that it takes considerable time to develop and implement the most appropriate policy that can be applied across multiple sites

WACHS is moving towards a standard approach in terms of Site Instruction policies. Previously, different health service sites were able to develop their own Site Instructions in isolation. This led to a proliferation of Site Instructions that varied from site to site. Site Instructions must now be approved at Regional level.

[39] E16 WACHS Safety, Quality and Performance Action Plan 2010-11
[40] E16 ACSQHC *Recognition and Response to Clinical Deterioration Program*

This improved governance structure reduces the risk of a policy being inconsistent with contemporary evidence based practice.

A more recent development is the establishment of a WACHS Clinical Policy Reference Group[41], which will support the development of WACHS clinical policies by reviewing such policies prior to release. As such, the Reference Group forms part of the revised governance structure.

With new policies that have a significant clinical risk or where there is a considerable change in policy, a whole policy change package[42] has been developed. This includes a change of practice plan, auditing schedule, training package and competency assessment. This process slows down the release and implementation of new policies but is seen as more effective for sustainable change and increased governance with more capacity for review. This is a relatively new process and is still evolving. It should be noted that where a policy change or new policy requires urgent release the Executive Director Medical Services, WACHS has the authority to sign off on those policies without going down the policy change package pathway.

The OSQHC published a report[43] in 2010 that briefly outlines the work of the DoH Coronial Liaison Unit. The unit was established in 2005 within OSQHC to facilitate the allocation of health service findings from coronial inquests for implementation in hospitals and health services.

The importance of clinical observations was highlighted in the 2010 report as a result of the Coroner's inquest into Mr Watmore's death. The report states that WA Health has developed a Statewide oxygen management policy open for consultation as well as supporting the implementation of initiatives from the *National Recognising and Responding to Clinical Deterioration Program,* including the use of standardised observation charts in local hospitals and health services. The Statewide policy was released in 2011[44].

6.1.2 HaDSCO's Findings

Evidence was provided to the investigation that supports WACHS' claim that a comprehensive approach was taken in response to Mr Watmore's death. The approach incorporates the Coroner's recommendations as well as the issues raised by AHPRA (see sections 6.2 to 6.7).

The work that has been undertaken to date by DoH, WACHS and Albany Hospital has been considerable but is unfinished. It is important to recognise that patient safety and health care is evolving at a rapid pace, and requires a culture of continual improvement. To support this continuous change it is strongly suggested that health service providers have clear, delegated responsibility to implement agreed contemporary practice standards. Further comment in relation to the governance arrangements is made in sections 8.1.1 and 8.1.2 below.

[41] E21 WACHS Clinical Policy Reference Group: Terms of Reference
[42] E22 WACHS Change of Practice Update - Triage
[43] E25 OSQHC From Death We Learn 2010.
[44] E3 Operational Directive OD 0325/11 Use of Acute Oxygen Therapy in Western Australian Hospitals

6.2 Nursing staff with appropriate competencies

AHPRA issue 1. Lack of recent performance appraisals for nursing staff.

AHPRA issue 2. Staff assessments of core competencies were not undertaken by the organisation.

Four main strategies have been adopted in response to this issue at Albany Hospital:

- Improve the capacity for reporting of performance appraisals
- Review the Assessment Tool for nursing staff
- Continue to monitor the rate of performance appraisals
- Work with AHPRA to improve communication systems regarding registration of nursing staff.

WACHS uses the DoH *Performance Management System (PMS) Policy* as the overarching policy.

The expectations for Performance Appraisal in relation to nursing staff is set out in the document, *Performance Agreement "your vision, your future*"[45]. This requires an annual performance review for all nurses. It outlines the need for the use of the Australian Nursing and Midwifery Council (2006) Standards[46].

6.2.1 Improve the capacity for recording

PMS forms are available from the Great Southern intranet site to which all staff have either direct or indirect access. More computers have been made available on wards and there are now computers that staff can access within the Albany Hospital library in a specifically allocated room. All managers have access to computers.

PMS and Substandard Performance activities for nursing staff occurs within the ward or department of Albany Hospital. Nurse Managers are required to set up schedules for PMS to ensure staff have appropriate reviews and training.

As a result of accreditation requirements, reports of the rates of appraisals that include the names of nursing staff and their status are completed as a matter of course. These reports are provided to the Regional Nurse Director (RND).

The managers forward completed performance development summary sheets to the Great Southern Learning and Development Coordinator who makes arrangements for the data to be entered into the payroll system.

[45] E26 Performance Agreement "your vision, your future"
[46] E55 Australian Nursing and Midwifery Council (2006) Standards

6.2.2 Revised Assessment Tool

A revised assessment tool[47] has been developed by WACHS to enable assessment against the 2006 Standards. This tool was released for use in Albany Hospital early in the second half of 2011.

6.2.3 Rate of Appraisals and Communication with AHPRA

The DoH has a target of 80% for all nursing staff to receive an annual appraisal. The RND is responsible for tracking both performance appraisal and registration of nursing staff. Part of both of these requirements is that nurses are assessed for competence in the relevant areas or scope of practice. This is outlined in WACHS' *Guidelines and Protocols for use in Nursing Practice Policy*[48] which provides an extensive list of guidelines and protocols that provide the context for nursing staff.

An example of the variation in rate of appraisals that now exists is that in its Emergency Department, Albany Hospital has 95% (of 23 nursing staff) compliant with required appraisals. This contrasts with the overall rate of appraisals for nursing staff at Albany Hospital that has risen from 36% as at June 2011[49] to 56% as at August 2011[50].

The investigator was advised that the AHPRA Register on that website is used to check the status of employed or agency nurses. AHPRA is still developing systems to inform employers of restricted practice orders. At present the nurse is responsible for informing the employer of restricted practice orders. Registration is monitored monthly by the RND to ensure that lapsed or conditional registration is picked up. In addition, State Administrative Tribunal proceedings are checked with respect to any conditional registration matters.

According to WACHS, substandard performance by nursing staff, that involves serious or high-risk matters, are trend-tracked to trigger action. Clusters of similar areas of substandard performance are reviewed to determine causes and appropriate remedial action such as training, new procedure or change of equipment.

Substandard performance is escalated up the leadership structure and eventually the CEO of WACHS is required to deal with the matter. The CEO is the only person within the Area Health Service with the authority to discipline staff.

6.2.4 HaDSCO's Findings

Considerable time has elapsed since Mr Watmore's death and the Coroner's consequential inquest. It was evident from that report and then reinforced by the

[47] E27 WACHS Great Southern Self Assessment Tool: Review Against the ANMC Competencies Standards for the Registered Nurse.
[48] E48 WACHS Guidelines and Protocols for use in Nursing Practice Policy
[49] E9 Performance Appraisal Rate Report June 2011
[50] E49 Performance Appraisal Rate Report August 2011

investigations by AHPRA that ensuring nursing staff are competent is of paramount importance to patient safety.

To determine whether the DoH target of 80% current performance appraisals is met, it is essential to understand the data set that is reported. At present, according to WACHS, the payroll system that records the appraisals includes staff who:

- are on long-term leave (maternity leave or sick leave)
- have resigned but are receiving payout for accrued leave until the payment finishes
- are on secondment.

These staff show as non-current for their appraisals and thus create errors in the data. Therefore, the reports from the payroll system are not necessarily reflective of the actual appraisals that have occurred. A greater percentage of appraisal may have taken place.

Another factor raised by Albany Hospital is that there is a lack of time allocated for staff to undertake the appraisals. WACHS advised that the budgeting for nursing staff is based on nursing hours and is a complex formula with two main distinctions. One is productive hours which does include acuity of care, the other is non-productive hours. Non-productive hours include education and training, leave and performance management. Budgets for nursing staff are then provided which in turn allocates nursing staff to the wards according to the formula. While there may be debate at hospital level regarding the appropriateness of nursing budgets and allocation of time for performance appraisals, this is not the view held at WACHS level.

As currently reported the rate of performance appraisals for nursing staff has increased significantly to 56% as at August 2011. The rate of performance reviews, however, should consistently meet the DoH target of 80%.

The responsibility for attaining the target rests firstly with the RND and finally with the CEO of WACHS. In this case, it would not be appropriate to reduce the target but rather mandate that the target be reached.

While there may be reasons why performance appraisals have not been completed to comply with the target set by DoH, assessing the competence of nursing staff who provide direct patient care is essential. The public have a legitimate expectation that nursing staff are competent to undertake the scope of practice that is required to care for patients in their care. It is also a requirement of their registration.

Although significant changes have occurred and the rate of appraisals has increased there is no reason why the DoH's 80% target cannot be reached and WACHS should take all necessary steps to ensure the 80% target is reached. It is unacceptable for the reported rate of appraisals to be below the target. In addition, as previously stated WACHS must develop a more accurate method of recording appraisal data so that managers responsible for analysing the data and

accountable for targets are provided with information to enable them to take appropriate action.

6.3 Lack of policy support for nursing staff with respect to narcotic infusions

AHPRA Issue 3. No responsibility was demonstrated by the hospital to ensure staff were abreast of evidence based best practice for narcotic infusions.

AHPRA issue 4. The hospital did not have a contemporary policy or guidelines for the management of narcotic infusions for pain relief which lead to substandard guidance for nursing staff. The Policies and guidelines in place at the hospital at the relevant time were not commensurate with contemporary care provision for patients with a narcotic infusion in progress.

6.3.1 HaDSCO's Findings

These issues are dealt with under the Coroner's Recommendations 5 and 6 (see sections 5.5 and 5.6 of the report).

6.4 Lack of appropriate staff allocation processes and delegations for nursing staff on the ward

AHPRA issue 5. A cultural approach to staff allocation within ward areas rather than appropriate allocation according to patients needs and staff competencies.

AHPRA issue 6. Inappropriate staff allocation at night enabled ambiguity to occur within the leadership of the team and the roles of the team members.

AHPRA issue 7. Poor delegation of nursing duties with a deficit in knowledge, responsibilities and accountability and actions in the delegation of duties and nurses working outside their scope of practice.

AHPRA issue 8. Nursing managers have not taken responsibility for ensuring that policies and guidelines are in place.

AHPRA issue 9. There was an apparent deficit in direction and leadership of staff at ward level.

Five main strategies have been adopted at Albany Hospital to address AHPRA's concerns:

- Revised Shift Coordinator role
- Training for the Shift Coordinator role
- Performance appraisal and registration of nursing staff
- Improved clinical handover procedures
- Senior Nurse Leadership

6.4.1 Shift Coordinator

Shift Coordinator roles existed historically in hospitals including Albany Hospital. The role was not well defined at Albany Hospital and did not provide the necessary support required for nursing staff on the wards. A Site Instruction that outlines the role and responsibly of the Shift Coordinator was subsequently issued by Albany Hospital in November 2010[51]. It outlines the patient allocation decision-making framework as well as handover procedures.

During the site visit in June 2011 Shift Coordinators were observed in practice during a day shift and a night shift.

The day shift handover was effected firstly in an office behind the nurses' station with all incoming staff and the outgoing Shift Coordinator. The Shift Coordinator used a printout from an electronic whiteboard that is used to manage patients in the ward. The list is updated by the Shift Coordinator to reflect the current situation for each patient. Nursing staff are allocated to groups of patients to manage during that shift by the Shift Coordinator. Nursing staff make notes in relation to medications, any issues in patient management, any reviews by medical or other staff, and planning for discharge. Discussions at the shift handover were detailed regarding medications—how much, how often and what method. Attention was given by the Shift Coordinator and nursing staff to any patient alerts or out of the ordinary patient issues.

The office-based handover was then followed by a bedside handover with the Shift Coordinator, outgoing shift nurse and incoming shift nurse. More detailed discussions about the care plan, medications and monitoring took place. It was observed that nurses questioned the existing care plan and medications and were provided with further explanation and information as required.

A further observation was undertaken at the commencement of the night shift. This handover was very similar to the day shift in terms of level of detail and staff allocation. Three matters that were discussed are of particular interest to this investigation as they involved matters that were related in some ways to areas of concern in Mr Watmore's care:

1. A detailed discussion took place with respect to a MER that occurred during the day shift. Nurses questioned why the MER occurred, the outcome, as well as the care plan that had been modified as a result. The MER had occurred due to an error in administrating medications that had already been administered prior to the patient's admission - in effect a double dose.

2. A second matter discussed was in relation to the dose of analgesic prescribed for a child. The incoming nurse recognised an error and checked for the correct dosage prior to it being administered. Without the check the child would have been overdosed.

[51] E28 WACHS – Great Southern Albany Hospital: Site Instruction: Shift Coordinator

3. A third discussion involved changes to observation parameters specific to a patient. New parameters had been put in place as the patient had an allergic reaction (hives) following administration of medication. This changed the observation regime.

6.4.2 Training for the Shift Coordinators

Two training sessions have been scheduled in 2011 for the Shift Coordinator role. These programs are attended by staff voluntarily in some circumstances, although the Manager is able to recommend the course to particular staff. Not all current Shift Coordinators have received this training program.

6.4.3 Performance appraisal and registration

See section 6.2 entitled 'Nursing staff with appropriate competencies' and the underlying subsection.

6.4.4 Clinical Handover

Work has commenced within the quality improvement process at Albany Hospital to develop improved protocols for clinical handover[52].

6.4.5 Senior Nursing Leadership

A WACHS *Nursing and Midwifery Leadership Development Framework*[53] was released in February 2010 along with a self-assessment tool. These documents describe the mutual obligations that exist between an employee and an organisation with respect to leadership development.

6.4.6 HaDSCO's Findings

The introduction of the clearly articulated Shift Coordinator role addresses the concerns raised by AHPRA. The frank and open discussions that took place during the shift handovers at the site visit were supportive of a changing culture. Staff experience and competence were matched with patient care needs. The detailed discussion in the presence of the investigator regarding the error in medications that had caused a MER call is indicative of a more open culture. Responsibility for the error was acknowledged and action taken to remedy the situation. The discussion was a good learning opportunity for all staff at the handover and the Shift Coordinator took the opportunity to demonstrate clear leadership.

The performance appraisal and registration process, clinical handover and Senior Nurse Leadership framework all support the development of a culture of high professional practice by competent nurses who demonstrate leadership at all levels. These are all sound initiatives that should continue to strengthen the leadership qualities in nursing staff at Albany Hospital.

[52] E56 WACHS Great Southern – Albany Hospital EQuIP Quality Improvement Report
[53] E50 WACHS Nursing and Midwifery Leadership Development Framework and Assessment Tool

In addition, consideration should be given to the development of a system to monitor the effectiveness of the Shift Coordinator's role. It had been proposed to use the rate of AIMS reports as one measure of the success of the role. Albany Hospital advised, however, that this is not possible. An alternative means to measure the success of this role should be developed.

Staff who undertake the role of Shift Coordinator must have or acquire the appropriate competences. This can be achieved by an assessment of prior learning or competence or training. If Albany Hospital determines that particular competencies or skills are necessary then an assessment or training must be provided for those staff who will undertake the role of Shift Coordinator.

6.5 Documentation in medical records

AHPRA issue 10. Documentation was unsatisfactory and did not meet the expected standards of nurses in relation to contemporary and logical recording.

Two main strategies have been adopted in response to this issue at Albany Hospital:

- Auditing of the Adult Observation Chart
- Performance Appraisals and Registration.

6.5.1 Auditing of Adult Observation Chart

Ongoing auditing is occurring and staff training and advice is provided for non-compliance. See sections 5.1.5 and 5.3.3 of the report for more information.

6.5.2 Review of sample Medical Records

A random sample of 10 Albany Hospital patients' medical records were selected for review during the site visit by the investigator.

Most records showed some use of stickers to indicate which occupational group had made the notes in the integrated notes, such as Medical, Physiotherapy, Aboriginal Liaison and Pharmacy.

Most records were clearly documented, however there were still occasions where:

- hand writing was illegible
- telephone prescriptions were not signed off by the doctor the next day
- writing up of ceased medication varied; in one record it was done in three different ways on the same chart.
- consent forms were not always well documented.
- generally doctors' handwriting was less clear and less detailed than nursing and other staff.

6.5.3 Performance Appraisals and Registration

Clear, accurate and timely documentation is part of the standards required by nursing staff. Assessment of this is undertaken during performance appraisals and assessment against the ANMC. See sections 6.2.2 and 6.2.3 about how the process of assessment is managed at Albany Hospital.

6.5.4 HaDSCO's Findings

Clear and complete medical records are a principal component of sound clinical practice and essential from a patient safety point of view.

Given that audit results indicate that documentation is not always complete, it is essential that ongoing monitoring or auditing of charts is required, as this provides relatively quick feedback to staff and management as to how well some of the documentation in medical records is being performed.

Competency Element 7.3 for Enrolled Nurses in the ANMC Standards[54] requires that communication, reporting and documentation are timely and accurate. For example, Enrolled Nurses should document nursing care in a comprehensive, logical, legible, accurate, clear and concise manner using accepted abbreviations and terminology when appropriate.

The annual performance appraisal process that requires staff to be assessed against these types of standards provides further opportunity to improve medical record documentation. If appraisals are conducted as required, then it is likely to have a flow-on effect with improved documentation. Again, this demonstrates the essential nature of regular performance appraisals in a healthcare setting.

It is important when a gap in compliance such as documentation is identified that this feedback flows through to clinical staff and becomes a focus of the PMS and especially the appraisal and assessment phase. This completes the quality improvement circle.

6.6 Appropriate equipment in the right place to improve patient outcomes

AHPRA issue 11. There was an apparent shortage of monitoring equipment for patients requiring close monitoring of their condition and allocation of equipment was not based on patient acuity and level of care required.

6.6.1 Equipment audit

Albany Hospital advised this aspect of AHPRA's concerns had not previously been raised as a risk at Albany Hospital in relation to Mr Watmore's death. In response, an audit of the equipment has since been undertaken and the following reported.

The PCIA device used is disposable and is available in stock. Monitoring equipment is mobile and C ward has access to eight vital signs monitors, including non-invasive blood pressure, pulse oximetry and temperature. In addition, a further

[54] E55 Competency Element 7.3 for Enrolled Nurses in the ANMC Standards

six mobile pulse oximerty units are available on the ward. Albany Hospital has 38 vital signs monitors across the facility, which nursing staff can request an orderly to source for them. The C ward includes four day procedure beds, which have mobile pulse oximetry available for each of these bays, and these can be accessed by C ward staff.

Albany Hospital advised that the monitoring equipment had always been in place and available to clinical staff on C ward and other clinical areas of the hospital.

6.6.2 HaDSCO's Findings

AHPRA advised that the concern with respect to monitoring equipment was raised in evidence during its investigation of nursing care provided to Mr Watmore. The amount of equipment now available appears sufficient for monitoring patients. If a patient with higher needs is identified it may be appropriate to move them to the High Dependency Ward. This is already addressed in policy at Albany Hospital. No further action is required.

6.7 Response to Sentinel Event

AHPRA issue 12. No timely investigation into the death was instigated by the Hospital, and no reports were made to the relevant Boards.

6.7.1 Sentinel Event Policy and other action

It is DoH policy[55] that all sentinel events be investigated and the recommended method for that investigation is a Root Cause Analysis (RCA). Both these actions were undertaken by Albany Hospital (see information under Term of Reference 3).

According to the RCA Guidelines[56] on the current Office of Safety and Quality in Healthcare website, to be thorough, an RCA must include:

- a determination of the human and other factors most directly associated with the event or close call and the processes and systems related to its occurrence (there is rarely only one underlying cause).
- analysis of the underlying systems through a series of 'why questions' to determine where redesigns might reduce risk. Identification of risks and their potential contributions to the event or close call.
- determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist.

WACHS advise the RND is responsible for ensuring that the appraisal of nurses' competencies and registration is undertaken and maintained. Further, the responsibility to make a report (now notification) to the Board sits at regional level with the RND.

[55] E1 Operational Directive: Interim Directive: Sentinel Events.
[56] E14 Root Cause Analysis Guidelines

In October 2009, following the Coronial inquest, the WACHS Great Southern Nurse Director made a report to the then Nurses and Midwives Board of WA with respect to specific nursing staff at Albany Hospital who provided care for Mr Watmore. This was as a result of an investigation that was undertaken and reported on by the Nurse Director and dated 27 October 2009. That report[57] is discussed further in sections 7.1.1 and 7.1.2.

6.7.2 HaDSCO's Findings

Albany Hospital complied with the Sentinel Events Policy to conduct an investigation following Mr Watmore's death. The recommendations that were made were sound and were implemented. The recommendations that were made focussed on systems issues.

No reports, however, were made to the Nurses and Midwives Board until after the Coroner's inquest report was released. It may be inferred then that the conduct of any nursing staff (or other staff) was not identified at the time as a contributing factor in Mr Watmore's death. As far as this investigation could determine, no investigation into any staff involved was conducted until after the Coroner's report.

In contrast, the Coroner's report questioned the appropriateness of action taken by staff. In addition, once the matter was referred to AHPRA concerns were also raised by that agency regarding the conduct of staff.

No evidence was identified in this investigation to suggest that any concerns were raised by Albany Hospital, WACHS or DoH with respect to staff until after the Coroner's Inquest. This questions the effectiveness of the RCA that was conducted with respect to identifying and referring staff matters to a different internal process that could review the conduct of staff.

It is recognised that the Coroner and AHPRA have particular expertise in undertaking investigations. However, an important part of patient safety is that staff within public health service entities are able to conduct a comprehensive investigation that identifies all relevant contributing factors of a sentinel event. In fact, the guidelines[58] for a RCA stress the importance of asking 'why and what' to try to establish all relevant contributing factors. The RCA Guidelines also state that the review should be undertaken by a small team of 3-5 members who are familiar with the area in which the incident occurred, though not involved in the incident itself. This approach does not facilitate strong impartiality, especially when it involves a regional hospital. In fact it places enormous pressures on staff undertaking this important role.

It may be the case that the staff conducting the RCA were not sufficiently well equipped to conduct the investigation or that the focus was only on systems issues, or the process was not sufficiently or independently monitored. Whatever

[57] E65 WACHS Great Southern: *Internal Investigation into Nursing Issues Relating to the Death of Kieran Watmore*
[58] E14 Root Cause Analysis Guidelines

the reason, it prevented timely reports being made to the relevant registration boards.

This then calls into question the usefulness of a system of regulation that relied upon Albany Hospital adequately investigating incidents to identify staff that lacked necessary competencies. In this case an external body (Coroner's Court) identified issues of staff competence. It is not feasible for the Coroner or AHPRA to be involved with the investigation of all sentinel events. Rather, a sufficiently robust system must exist within public health services to support the regulation of health practitioners and thus patient safety.

As referred to in section 8.1.1 of this report, the CEO of WACHS now sees all Sentinel Events Reports. In addition, the WACHS Adverse Event Review Team (AvERT) meets fortnightly to review the Sentinel events investigations and agreed actions. This team has senior staff members from the different regions on a rotational basis. The Terms of Reference of the AvERT deal with conflicts of interest. The purpose and functions of AvERT are also provided in the Terms of Reference[59]. Whether or not this provides sufficient safeguards remains to be seen.

It may be useful to include in the annual evaluation of the AvERT an assessment of whether its advice is consistent with any findings of external agencies in relation to the same event. It may also be appropriate for WACHS (although the Sentinel Event Policy is a DoH policy so it may need to extend further) to include in any RCA team investigating a death, a suitability qualified external person to improve the rigour of the governance structure and provide support to regional staff who must undertake this extremely difficult task.

In acknowledging the difficulty in making available a suitably qualified external person it may be wise for WACHS (or DoH) to develop specific protocols in a Code of Conduct for RCA teams. These protocols could outline how competing interests in these situations are handled. This can add transparency to the process for those who review the makeup of the team as the RCA process is reported up the line. The protocols may include a brief statement from each member of the RCA team of their particular role in the team including their relationship to the health care site and staff involved in the incident.

Again, the issue of Performance Appraisal for clinical staff is a vital component that supports the pillars of patient safety. Knowing whether a staff member is competent with respect to their scope of practice is essential. Assessment of the *Australian Nursing Midwifery Council (ANMC) National Competency Standards* is considered by the Australian nursing regulatory authorities to be important to ensure initial and continuing competence. The assessment process is needed to:

- determine the eligibility for registration or enrolment of people who have undertaken nursing courses in Australia
- determine the eligibility for registration or enrolment of people who wish to practice in Australia but have undertaken nursing courses elsewhere

[59] E15 WACHS AvERT Terms of Reference

- assess nurses who wish to return to work after being out of the workforce for a defined period
- to assess qualified nurses who are required to show they are fit to continue working[60].

This assessment forms part of the performance appraisals system. The standards of practice are set out in ANMC National Competency Standards[61] for the various nursing groups. Current performance appraisal (and thus the assessment of competence against standards) is an essential part of patient safety and practitioner regulation. All public health service entities have a responsibility to ensure that health practitioners are appraised annually to enable those same staff to be assessed for competence to provide the patient care assigned to them and to legitimately maintain their registration.

[60] E54 Australian Nursing Council: Principals fro the Assessment of National Competency Standards for Registered and Enrolled Nurses.
[61] E55 Australian Nursing and Midwifery Council National Competency Standards for Enrolled Nurses

7. Term of Reference 3

To determine whether Albany Hospital has conducted an internal investigation into systemic problems identified as a result of the death of Mr Watmore, and if so, the measures identified to rectify such problems, and the extent to which Albany Hospital has implemented those measures.

7.1.1 Internal Investigation

It was and still is a policy of the DoH (revised policy[62]) that in the event of a sentinel event, such as Mr Watmore's death, reporting and investigation should be undertaken. Following Mr Watmore's death action was taken by Albany Hospital in accordance with the Sentinel Event Policy.

Improvements that were initiated as a result of the RCA process were to develop clinical guidelines for the management of tonsillitis, oxygen therapy and cardiac arrest. There was evidence that all recommendations had been actioned.

In addition, Albany Hospital advised that there was a system in place to track improvement recommendations called the Sentinel Event Notification System (SENS) across WACHS at the time of the RCA investigation. Since then a new software package has been purchased locally that will further enhance the management of recommendations and other aspects of patient safety in the Great Southern Region.

A Clinical Governance Support Officer now reports directly to the Regional Medical Director.

Following the Coroner's report Albany Hospital conducted an internal investigation which resulted in a report entitled WACHS Great Southern: *Internal Investigation into Nursing Issues Relating to the Death of Kieran Watmore*[63]*.* This investigation was into the nurses' conduct at the time of Mr Watmore's death. It should be noted that the investigator was advised that the 2010 dates in the report were a typographical error and should read as 2009.

There were several recommendations made with respect to the nurses' conduct including the need to notify the Nurses and Midwives Board of WA. As that Board investigated the matter and took action, no further comment will be made with respect to individual nurse conduct in this report. Other issues were raised with respect to systemic matters.

Although the systemic matters were raised as issues and not recommendations, it would seem that they were then responded to by Albany Hospital or WACHS as if they were recommended actions. For example, two issues were raised with respect to the clinical leadership on the ward. These issues have been addressed by the newly defined Shift Coordinator's role (see section 6.4.1). A Site

[62] E1 Operational Directive: Interim Directive: Sentinel Events
[63] E65 WACHS Great Southern: *Internal Investigation into Nursing Issues Relating to the Death of Kieran Watmore* dated 27 October 2009

Instruction[64] outlines the patient allocation decision-making framework as well as the handover procedures.

Separately the issue of a deficiency in the nurses' knowledge and skills to recognise and manage the deteriorating patient was addressed by the new Observation and Record Chart (see section 5.3.1), staff training (see section 5.1.8) and the WACHS Early Recognition and Response to Clinical Deterioration Policy[65] (see section 5.1.6).

A number of issues raised regarding the prescription of a narcotic for pain relief and its delivery by PCA were responded to by the creation of a PCA chart (section 5.5.1) and the new Vital Signs Albany Hospital Site Instruction[66] (see section 5.6.2) and staff training (see section 5.5.4).

The matter of pain management was partly dealt with as a result of the new guidelines for managing tonsillitis arising from the RCA that was completed following Mr Watmore's death (see section 7.1.1).

In addition it should be noted that the Albany Hospital internal report supports the findings of this investigation report with respect to the RCA process not identifying all the systems issues noted by the Coroner.

7.1.2 HaDSCO's Findings

Following Mr Watmore's death, Albany Hospital made an AIMS report and undertook a RCA consistent with DoH policy. Recommended actions arising from that investigation have been implemented. In addition, there is evidence that Albany Hospital has initiated actions to improve the tracking of the outcomes of RCAs to ensure improvements occur.

The investigation into the nurses' conduct, although well after the fact, identified issues that were being dealt with, or had been dealt with, by either Albany Hospital or WACHS.

This concludes the work required to comply with this Term of Reference.

Comments with respect to the appropriateness of the RCA improvement outcomes are included in section 6.7.2 of this report. It is essential that regional staff are supported by a more rigorous system to ensure all contributing factors to a sentinel event are identified and dealt with appropriately.

[64] E28 WACHS - Great Southern Albany Hospital: Site Instruction Shift Coordinator.
[65] E43 WACHS Early Recognition and Response to Clinical Deterioration Policy
[66] E30 Vital Signs Albany Hospital Site Instruction

8. Term of Reference 4

To examine the role to date of the Department of Health in ensuring that systemic problems identified with respect to Albany Hospital are improved, and to assess whether the Department's leadership response has been satisfactory.

The systemic issues identified by APHRA have been addressed under Term of Reference 2 in sections 6.2 to 6.7 of this report. That information will not be repeated here. Instead, a section is included that describes the leadership response by DoH.

8.1.1 Department of Health leadership response

Following the Coroner's report Albany Hospital conducted an internal investigation which resulted in a report entitled WACHS Great Southern: *Internal Investigation into Nursing Issues Relating to the Death of Kieran Watmore*[67]*.* Most of the outcomes of that investigation are discussed under Terms of Reference 3. In addition, however, that investigation considered the recommendations made by the Coroner and the report indicated what, if any, responses had been made by the health entities by October 2009. All those responses have been identified and discussed in this investigation report in sections 5.1.1, 5.1.4, 5.1.7, 5.2.1, 5.4.1, 5.5.1 and 5.6.1.

WACHS provided a report entitled *Albany Clinical Practice Policy Compliance* [68] dated 1 and 2 February 2010 which was commissioned by the CEO of WACHS. The report was based on a site visit and audit. The report demonstrates the monitoring by the leadership of WACHS of the Albany change process. In summary, the report cites many examples of areas that still required improvement. A considerable number of recommendations were made within the report under general headings of:

- clinical policy and practice
- governance and integrated quality improvement risk management
- clinical leadership, professional development and team work.

Although this investigation did not seek to match these recommendations from this audit report with the evidence of the work that has been undertaken at Albany Hospital, many of the recommendations made in the report align with evidence gathered and reported in this section. For example, the reestablishment of the Regional Clinical Governance Committee and the network of committees that feed safety and improvement strategies up and down the line. In addition, more access by regional staff to the Regional Patient Safety and Quality team was recommended as already indicated in this section of the investigation report. In other sections of this report, increased access to computers by Albany nursing staff (section 6.2.1) is already noted. At the June 2011 site visit undertaken during

[67] E65 WACHS Great Southern: *Internal Investigation into Nursing Issues Relating to the Death of Kieran Watmore* dated 27 October 2009

[68] E 63 Albany Clinical Practice Policy Compliance Review 1 and 2 February 2010.

this investigation it was evident that efforts were made to ensure only current hard copies of policies and forms were available to clinical staff on wards. In addition, the WACHS intranet site provides a ready access to up-to-date policies for clinical staff.

WACHS advised that a Statewide plan of work provided the broad focus for DoH. This cascades down to the Area Health Services Operational Plan, which includes a Safety, Quality and Performance Action Plan. This flows to regional plans within WACHS. The regions are required to report back to the WACHS Patient Safety and Quality Unit (PSQ) on a six-monthly basis with respect to actions within their plan. This reporting includes opportunities for face-to-face reporting to the PSQ to engender a more facilitative culture.

WACHS also advised that in recent years it has taken action towards a more patient centred culture, which is still evolving. It is characterised by developing structures that enable consumers to participate and have a voice in the delivery of health services. In addition, WACHS has tried to engender a culture of facilitation and monitoring by the executive, and innovation and responsiveness by local health service sites. This, along with other strategies, is expected to create a culture that is more patient centred.

WACHS Executive has developed a cascading arrangement of reporting for WACHS committees:

- The WACHS leadership structure has an Area Executive. The Area Executive meets weekly by tele-conference, and monthly face-to-face. Sentinel events are reported to these meetings.
- The peak clinical governance committee within WACHS is the Clinical Governance and Patient Safety Committee. That committee meets second monthly and reports to the Area Executive.
- The AvERT committee deals specifically with sentinel event, clinical incident and related risk issues. It is represented on the Executive by the Executive Director of Medical Services who provides reports and advice regarding that committee's work and decisions.
- The regions report formally on progress against their Safety and Quality Action Plans to the WACHS Patient Safety and Quality Unit (PSQ) on a six monthly basis.
- Face-to-face meetings, video conference and teleconference meetings between regional Safety and Quality staff and PSQ are also held for training, networking and reporting.
- Regional Medical and Nurse Directors meet as separate groups each month by teleconference, and jointly each second month face-to-face. At the face-to-face meetings, at least two hours are devoted to current safety and quality issues.
- The Great Southern region is well advanced in its implementation of Clinical Advisory Groups, which link regional clinicians with Patient Safety and Quality staff and data.

While a network of committees and reporting provides hard data regarding patient care and safety, the WACHS Executive remains aware that staff networking created by the cross-regional committee work helps to provide more information

about what is happening at different health service sites. The many networks created allow the questioning of actions and new policies. It also supports the sustainability or robustness of these actions. In turn, it creates shared learning opportunities that did not exist before. The cost of creating and maintaining these various committees and networks is considerable but is viewed by WACHS as essential to support the change in values required within the area health service to a patient centred (therefore safety and quality centred) health care approach.

WACHS advised that funding is specifically allocated annually to patient safety and quality as an indication of its importance. Eight million dollars is allocated to the SQuIRe program[69] across the State. Funding has also been allocated to create a Coordinator for the Deteriorating Patient Program work as it is deemed by WACHS as essential work. WACHS advised that opportunity also exists for health care sites to develop business cases for new work that is required to improve patient safety.

As outlined in section 6.7.2, the AvERT meets fortnightly to review the Sentinel events investigations and agreed actions. This is a senior management team consisting of a core membership of senior PSQ personnel from WACHS Area Office, and rotational membership of senior staff from the different regions. The Terms of Reference of the AvERT provide for dealing with conflicts of interest. The purpose and functions of AvERT are also provided in the Terms of Reference[70]. When reviewing an adverse event report any concerns about the investigation or the action plan will be referred back to the health service site by the team. Lessons to be learnt are also able to be picked up by the regional representatives on the team. This system reduces the risk of a health service investigating a matter and only looking inwardly or being 'site blinded'. The team approach provides the opportunity for an examination by 'disinterested' parties. All recommended actions are referred to OSQHC for tracking. The health service must also provide a three monthly update of progress against the action plan for the sentinel event. Outstanding actions are reported to the WACHS Executive.

As stated earlier, all sentinel events are now also notified to the CEO of WACHS. This includes what actions have been recommended to be taken. The CEO reviews the appropriateness of these actions. Furthermore the sentinel events notification enter the system from a number of avenues—from a clinician, a complainant, non-clinical staff or partners in care (eg St John Ambulance). As a possible indication of the change in culture the reporting of sentinel events is now more often from clinicians than previously. This may also indicate that a more robust governance system is being created.

The systems for data collection and reporting to support the intended work of the various committees and teams that review patient care and safety issues have been evolving. The systems have only been developed to such a level more recently and the development of the committees has flowed from that. WACHS expects that these committees will mature in their effectiveness over time.

[69] E52 SQuIRe2 – CPI Guide: Background, Measurement and Reporting December 2009
[70] E15 AvERT Terms of Reference

8.1.2 HaDSCO's Findings

Evidence was presented to the investigation that supports the claims that WACHS' management, with the support of OSQHC, have played a lead role in the changes that have taken place at Albany Hospital. It was clear that Albany Hospital has initiated local improvements which are consistent with the work of the National *Recognising and responding to clinical deterioration* program.

It was also evident that the role and responsibility of leaders within WACHS, OSQHC and DoH are still evolving. Patient safety will continue to be an issue that deserves attention by the health service leadership teams. As clinical care changes with emerging technology, economic pressures, society's expectations and changing demographics, new issues of patient safety will present themselves. It is hoped that a system of leadership that is based on a patient centred framework will be better equipped to adequately deal with these risks.

9. Term of Reference 5

To make any further suggestions to improve the relevant standards of care provided by Albany Hospital in order to minimise the risk of further preventable deaths occurring.

9.1.1 HaDSCO's Findings

The national *Recognising and responding to clinical deterioration* program coordinated by the ACSQHC is a sound basis for ongoing work in minimising risk of further preventable deaths. Albany Hospital is undertaking considerable work that falls within that program and is supported by WACHS in doing so.

In addition, the Australian Council on Healthcare Standards accreditation process provides a sound foundation for a change process within Albany Hospital. The core accreditation program of the Evaluation and Quality Improvement Program (EQuIP), guides organisations through a cycle of self-assessment, organisation-wide survey and periodic review.

With respect to Mr Watmore's type of preventable death, Albany Hospital is undertaking work within frameworks that provide a strong foundation. It must continue to be supported by DoH and WACHS' senior management to further minimise the risk of other preventable deaths. The suite of policies, site instructions, operational directives, staff training, clarified roles and responsibilities, altered staffing profiles and auditing (sections 5.1, 5.3, 5.4, 5.5), new committees and teams (section 8.1.1), described in this report strongly demonstrate that the health service entities have taken action on a range of fronts to minimise the risk of further preventable deaths occurring.

10. Term of Reference 6

To make recommendations regarding the ongoing monitoring of and reporting on the timely implementation of all relevant recommendations with respect to Albany Hospital.

10.1 Recommendations for further action or monitoring

As outlined in section 3 the timeframes for the various health entities to report to the Minister on the following recommendations have not been extended despite the investigator recently receiving new documentation. The health entities received this report's recommendations in April 2012 in their final form, and the draft recommendations were provided to them in December 2011. The health entities have also advised HaDSCO that they have been working to those recommended timeframes.

10.1.1 Recommendation 1

Albany Hospital should continue the regime of auditing the use of the Adult Observation Chart. The results for the period from 1 January 2012 to 30 June 2012 should be reported to the Minister for Health by 30 September 2012.

10.1.2 Recommendation 2

Once the Australian Commission on Safety and Quality in Health Care trial of Adult Observation Charts is complete, and if a standard chart is established by the Australian Commission on Safety and Quality in Health Care, Albany Hospital should review its chart to ensure compliance. Albany Hospital should report the results of the review to the Minister for Health within 6 months of the trial's end date.

10.1.3 Recommendation 3

The Department of Health, in reviewing safe working arrangements for doctors as part of the industrial relations process agreed in the Department of Health Medical Practitioners (WA Country Health Service) AMA Industrial Agreement 2011 as well as within the context of developing a fatigue management policy, should explore the option of a declaration that requires non-salaried medical practitioners to state that they are fit for their allocated shift. The Department of Health should report to the Minister for Health by 30 December 2012 their consideration of this option in both processes.

10.1.4 Recommendation 4

Western Australian Country Health Service, in consultation with Albany Hospital, should develop a plan by February 2012 to achieve and maintain the Department of Health's target rate of 80% for current performance appraisals for nursing staff at Albany Hospital by 1 July 2012. The plan should include a system that the Western Australian Country Health Service improve the report extract scripting to

enable accurate measuring of the performance development compliance. Western Australian Country Health Service should provide the plan to the Minister for Health by 30 June 2012.

10.1.5 Recommendation 5

Albany Hospital should identify a means to place greater emphasis on staff achieving a high standard of documentation in medical records within the performance management process for clinical staff. Albany Hospital should report to the Minister for Health by 30 December 2012 on how this has been achieved.

10.1.6 Recommendation 6

Albany Hospital should make it compulsory for all staff undertaking the Shift Coordinator's role to be assessed for competence within one month of undertaking the role, or training be provided within that month. Albany Hospital should report to the Minister for Health on this inclusion in the Site Instruction: Shift Coordinator by 30 June 2012.

10.1.7 Recommendation 7

Albany Hospital should report to the Minister for Health the method that will be used to evaluate the effectiveness of the Shift Coordinator's role by 30 June 2012.

10.1.8 Recommendation 8

Western Australian Country Health Service should include in the annual evaluation of the Adverse Events Review Team an assessment of whether its advice is consistent with any findings of external agencies in relation to the same event and develop performance indicators that clearly measure the effectiveness of this Team. Western Australian Country Health Service should report to the Minister for Health by 30 June 2012 on the inclusion of this requirement in the Terms of Reference of the Adverse Events Review Team and the performance indicators that are to be used.

10.1.9 Recommendation 9

Western Australian Country Health Service should ensure that an independent person with experience and expertise relevant to the circumstances of the death be included in any Root Cause Analysis Team that is investigating a sentinel event involving death. The degree of independence of this person should be indentified in the reporting by the Root Cause Analysis Team. Western Australian Country Health Service should report to the Minister for Health by 30 June 2012 on the inclusion of this requirement in the Root Cause Analysis Team process.

10.1.10 Recommendation 10

Albany Hospital should review the various charts and policies that apply to patients using Patient Controlled Intravenous Analgesia and ensure that they are all

consistently clear. Albany Hospital should report the outcome of the review to the Minister for Health by 30 June 2012.

Reporting pathway
It is noted that the normal chain of command for reporting matters to the Minister for Health is via the regional management of WACHS to the CEO of WACHS to the Director General of Health. These recommendations are not intended to circumvent that process. Albany Hospital and WACHS should report the actions from these recommendations in the usual manner.

Appendix 1.

State Coroner's Record of Investigation into the death of Kieran Darragh Watmore dated 30 September 2009

CONCLUSION

The deceased was an otherwise healthy and robust 17 year old male who had a history of tonsillitis and who attended at Albany Regional Hospital on the early afternoon of 27 August 2008 suffering from a bad case of tonsillitis.

At the time of his attendance at the hospital the deceased had been taking panadeine fort tablets which had not relieved his pain and an order was given by telephone for him to receive patient controlled analgesia in the form of morphine.

The deceased was transferred from the Emergency Department to ward C of the Albany Regional Hospital at 7:25pm that evening where his primary care was provided by Enrolled Nurse [name removed by HaDSCO].

The deceased was seen by a medical practitioner, Dr [name removed by HaDSCO], *at 9:30pm, following which he was given penicillin and the level of his patient controlled analgesia in the form of morphine was increased.*

The increased level of morphine was commenced at 10pm and at that stage the deceased's oxygen saturation levels were normal at 97% of room air.

The next observations taken at 2am recorded an alarming change in his condition as at that time his oxygen saturation levels had dropped to 88% and his respiration rate had increased from 22 to 26.

After that time it appears that observations were not taken on a regular basis and no further entries were made in the Temperature and General Observation Chart. No doctor was contacted and the deceased was not medically reviewed.

At about 6:55am on that morning, 28 August 2008, the deceased was found collapsed in his bed. It is possible that he had already died and although resuscitation efforts were made, by 7:42am it was clear that he had passed away.

The deceased died as a result of a number of factors which appear to have had a cumulative effect including the severe compromise of his upper airway which resulted from his acute tonsillitis and very swollen tonsils, the fact that he was receiving relatively high levels of morphine and the fact that as a result of his problems with breathing he may have suffered carbon dioxide retention. These factors together appear to have caused the death by way of fatal asphyxia.

The deceased should not have died when he did and had robust action been taken at the time of his ongoing deterioration which commenced at some time after 10pm on 27 August 2008 and was manifest by 2am, he would not have died when he did. While the evidence revealed a failure by nursing staff to adequately monitor or address a significant deterioration in the deceased's condition which was identified by

observations taken at 2am, it also revealed a number of systemic deficiencies which also contributed to the failure to adequately treat the deceased's worsening condition.

11. References

Several of these systemic deficiencies do not appear to have been restricted to Albany Regional Hospital and exist to a differing extent in other hospitals in Western Australia. It is in that context that a number of recommendations have been made with a view to preventing deaths from occurring in similar circumstances in the future.

Reference No.	Description
E1	**Operational Directive** **Subject :** Interim Operational Directive. Sentinel Events to be operated to the Director, Office of Safety and Quality in Healthcare. Expiration of Commonwealth Qualified Privilege Midnight 9 June 2011
E2	**WA Country Health Service - Great Southern.** **Albany Hospital Medical Advisory Committee Meeting** **Date:** Tuesday 16 June 2009 **Time:** 1245 - 1400 hrs
E3	**Operational Directive.** **Subject :** Use of Acute Oxygen Therapy in Western Australian Hospitals
E4	**Albany Hospital and Great Southern** Proposal for Changes to: Regional Induction (RI) Patient Assessment Workshops (PAW) Essential Skills Program (ESP) **Date:** October 2010
E5	**Basic Life Support Competency - Albany Hospital**
E6	**PAW 2010** Physical assessment workshop - new revised program
E7	**Title: Workforce Learning and Development Policy** **Effective:** 7 December 2010
E8	**WACHS - Great Southern** Performance Agreement 'You're Vision - Your Future' **Part 1**
E9	**Performance Appraisal Data as at 9th June 2011** PD Data WACHS Major Hospitals
E10	**WACHS - Great Southern Policy Albany Hospital** Documentation - Nursing
E11	**Australian Commission on Safety and Quality in Health Care** Recognising and Responding to Clinical Deterioration: Use of Observation Charts to Identify Clinical Deterioration **Date:** March 2009
E12	**School of Psychology, The University of Queensland** Developer's Guide for Observation and Response Charts **Date:** October 2010
E13	**Title: Rules for WA Country Health Service Medical Practitioners Policy** **Effective:** 17 June 2010

E14	**Root Cause Analysis (RCA) Guidelines**
E15	**WACHS Adverse Event Review Team** Terms of Reference **Effective:** 9th December 2010
E16	**WACHS Safety Quality & Performance Action Plan 2011-12**
E17	**WACHS Executive Agenda**
E18	**WACHS Executive or Leadership Team Meeting Agenda Summary Sheet**
E19	**Title: Clinical Governance and Patient Safety Subcommittee - Terms of Reference**
E20	**DRAFT** **Title: WACHS Obstetrics & Gynaecology Clinical Advisory & Patient Safety Committee - Terms of Reference**
E21	**WACHS Clinical Policy Reference Group - Terms of Reference**
E22	**WA Country Health Service** Change of Practice Update – Triage
E23	**Title: Oxygen Therapy Administration in Hospitals Policy** **Effective:** 23 November 2009
E24	**WACHS - Great Southern Hospital** Patient Controlled Intravenous Analgesia (PCIA) Prescription and Management Form
E25	**Office of Safety and Quality in Healthcare** From Death We Learn 2010
E26	**WACHS - Great Southern** Performance Agreement 'You're Vision - Your Future' Part 2
E27	**WACHS Great Southern - Self Assessment Tool** Review Against the ANMC Competencies Standards for the Registered Nurse
E28	**WA Country Health Service - Site Instruction** WACHS Great Southern - Albany Hospital **Title: Shift Coordinator**
E29	**EQuIP5 Standards and Criteria**
E30	**WA Country Health Service - Site Instruction** WACHS Great Southern - Albany Hospital **Title: Vital Signs Procedure** 2009

E31	**Title: Vital Signs Policy** **Effective:** 2 March 2011
E32	**Royal Australasian College of Surgeons** Standards for Safe Working Hours And Conditions for Fellows, Surgical Trainees and International Medical Graduates
E33	**Queensland Health Policy** Medical Fatigue Risk Management Policy
E34	**Queensland Health Standard** Medical Fatigue Risk Management Implementation Standard
E35	**Australian Medical Association** AMA Safe Hours Audit 2011
E36	**AMA Position Statement** Health and wellbeing of doctors and medical students 2011
E37	**Adult Observation and Response Chart**
E38	**WACHS - Great Southern Hospital** Telephone Communication Record - ISOBAR
E39	**Australian Commission on Safety and Quality in Health Care** Evidence-based adult general observation chart
E40	**Australian Commission on Safety and Quality in Health Care** National Consensus Statement: Essential elements for recognising and responding to clinical deterioration **Date:** 22 April 2010
E41	**Great Southern Intranet** E Hour: Early Recognition and Response to Clinical Deterioration **Date:** 12 July 2011
E42	**WA Country Health Service - Great Southern** Early Recognition and Response to Clinical deterioration CPI Meeting **Minutes 8 March 2011** 1100 The Shed Albany Hospital
E43	**Title: Early Recognition and Response to Clinical Deterioration Policy** **Effective:** 9 July 2010
E44	**Memorandum - WACHS Great Southern** **To:** Albany Doctors **Subject:** Emergency Department, Care of Inpatients and Related Matters **Date:** 29 October 2009
E45	**Roster Information - Albany Hospital (Email)**

E46	**Department of Health Medical Practitioners (WA Country Health Service) AMA Industrial Agreement 2011 PSAAG of 2011**
E47	**Memorandum - WACHS Great Southern** **To:** All VMP's and Salaried Medical Staff **Subject:** Emergency Department Changes from 1st October 2009 **Date:** 29 September 2009
E48	**Title: Guidelines and Protocols Endorsed for Use in Nursing Practice Policy** **Effective:** 2 November 2010
E49	**Performance Appraisal Data as at 30th August 2011**
E50	**WA Country Health Service** Nursing and Midwifery Leadership Development Framework: The Development Partnership **Date:** February 2010
E51	**WACHS Obstetrics and Gynaecology** Clinical Advisory Patient Safety Group Terms of Reference
E52	**SQuIRe2 - CPI Guide: Background, Measurement and Reporting** **Date:** December 2009
E53	**WACHS Great Southern - Albany Hospital** Code Blue: Medical Emergency Response Policy
E54	**Australian Nursing Council** Principles for the Assessment of National Competency Standards for Registered and Enrolled Nurses
E55	**Australian Nursing and Midwifery Council** National Competency Standards for the Enrolled Nurse
E56	**WACHS Great Southern - Albany Hospital** EQuIP 4 Quality Improvement Report
E57	**Western Australian Strategic Plan for Safety and Quality in Health Care 2008-2013**
E58	**WACHS - Great Southern Hospital** Observations and Record of Analgesia
E59	**WACHS Maternity & Newborn Services Governance Structure**
E60	**Journal article: *An audit of the effect of oxygen prescription charts on clinical practice.*** Postgrad Med J 2010;86:89-93 doi:10.1136/pgmj.2009.087528
E61	**Inquest report handed down by the State Coroner dated 30 September 2009.**

E62	**Terms of Reference signed by the Minister on 20 January 2011**
E63	**Albany Clinical Practice Policy Compliance Review 1&2 February 2010**
E64	**Medical Board of Australia's Good Medical Practice**
E65	**WACHS Great Southern:** ***Internal Investigation into Nursing Issues Relating to the Death of Kieran Watmore*** dated 27 October 2009