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REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act*

Response to the Coronial Findings in the matter of Ms Irene Magriplis

Pursuant to section 46B of the *Coroners Act*, I provide this Report on the findings and recommendations of the Territory Coroner, Local Court Judge Greg Cavanagh, dated 30 March 2017, regarding the death of Ms Irene Magriplis (the Deceased) (refer Attachment A).

This Report includes the response to the recommendations from the Chief Executive Officer (CEO) of the Department of Health, Ms Catherine Stoddart, and also includes submissions from the CEO of Darwin Private Hospital, to which some of the recommendations relate.

The Deceased, a 75 year old female, died on 30 May 2015 at 11.30 am at the Royal Darwin Hospital after deteriorating into multi-organ failure following surgery at the Darwin Private Hospital. The cause of death was 'septic complications following surgical resection of duodenal ampullary adenoma'.

Recommendations of the Coroner

Pursuant to section 34(2) of the *Coroners Act*, the Territory Coroner made the following recommendations in regards to the death of the Deceased:

211. I **recommend** that Darwin Private Hospital not permit high risk surgery to be undertaken where it does not have the resources to mitigate those risks.
212. I **recommend** that Darwin Private Hospital implement an escalation system to provide proper rapid team response when the rapid response criteria are met.
213. I **recommend** that should the Darwin Private Hospital continue to operate a High Dependency Unit that it should be properly and appropriately resourced and in conformity with Standard 9 of the National Standards on Safety and Quality in Health Care and the Guidelines of the College of Intensive Care Medicine of Australia and New Zealand.

214. I **recommend** that the Department of Health and the Top End Health Service consider these findings and recommendations in their dealings with and licensing of the Darwin Private Hospital.'

Response to Coroner's recommendations

A copy of the Coronial Findings was provided to the CEO of the Department of Health on 12 May 2017, in accordance with section 46A(1) of the *Coroners Act*.

A written response was received from the CEO of the Department of Health dated 23 August 2017 (refer Attachment B) as required by section 46B(1) of the *Coroners Act*, advising as follows:

- In response to the recommendation at paragraph 214, Darwin Private Hospital's next assessment against the *National Safety and Quality Health Service Standards* (National Standards) has been brought forward by four months to the end of September 2017.
- Post satisfactory inspection, a new licence will be issued for a six month period (rather than the usual 12 months) until 30 April 2018. This period will allow for full consideration of Darwin Private Hospital's compliance with the National Standards as identified in the September 2017 assessment.

The response also incorporated submissions from the Darwin Private Hospital advising as follows:

- In response to the recommendation at paragraph 211, in consultation with the General Surgeons Australia and the Royal College of Surgeons, the Darwin Private Hospital is engaging two General Surgeons to review and report on the hospital's ability to support surgeries of this complexity. This work is ongoing.
- In response to the recommendation at paragraph 212, the Darwin Private Hospital has revised its emergency escalation system to align with that used by Royal Darwin Hospital. This includes:
 - The Adult Observation Chart and clinical parameters for deterioration are now consistent between both hospitals.
 - The triggers for escalation now align with those of Royal Darwin Hospital and the actions for clinical review, rapid response and code blue have been revised.
 - An RMO Escalation of care flow chart has been introduced in keeping with the escalation protocol which outlines roles in patient deterioration and responsibilities during clinical review, rapid response and code blue.
 - The patient and carer escalation process has also been reviewed to encourage patients, families and carers to participate in the escalation of care.
 - The policy for clinical deterioration and patient escalation, which includes the escalation protocol, clinical criteria, response activation, review and audit process, has also been reviewed.

Consultation was held with key stakeholders and internal visiting medical specialists to ensure that the escalation system to manage patient deterioration is aligned across both hospitals.

- In response to the recommendation at paragraph 213, the High Dependency Unit of the Darwin Private Hospital was externally reviewed and it was noted that the unit functions primarily as an environment for close nursing observation, with primary responsibility for the patient remaining with the admitting medical specialist and equipment and nurse staffing levels to enable greater nursing intervention and monitoring than the ward area.

Consequently, the unit has been re-named as a 'Special Observation Unit' with revised policies and responsibilities that reflect this change, including: referral, admission and discharge processes; unplanned transfers; ward responsibilities; position descriptions and staff orientation; and patient information about the unit.

I am satisfied that the Department of Health has considered the recommendations of the Coroner and is taking necessary steps with respect to the recommendations made. I also note the steps taken by Darwin Private Hospital in addressing the recommendations made by the Coroner.

DATE: 21 SEP 2017



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NATASHA FYLES

CITATION: *Inquest into the death of Irene Magriplis*
[2017] NTLC 008

TITLE OF COURT: Coroners Court

JURISDICTION: Darwin

FILE NO(s): D0080/2015

DELIVERED ON: 30 March 2017

DELIVERED AT: Darwin

HEARING DATE(s): 6-8 March 2017

FINDING OF: Judge Greg Cavanagh

CATCHWORDS: **High risk elective surgery, inadequate medical treatment, inadequate resources at Darwin Private Hospital, inadequate escalation procedure, no internal review, referral to Medical Board**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel Department of Health	Stephanie Williams
Instructed by Sylvia Cecchin, Director Legal Services, Health.	
Counsel Darwin Private Hospital	Tamzin Lee
Instructed by Hunt & Hunt Lawyers.	
Counsel for Mr Treacy	Miles Crawley
Instructed by Paul Maher Solicitor.	

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Number of paragraphs:	215
Number of pages:	45

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0080/2015

In the matter of an Inquest into the death of
IRENE MAGRIPLIS
ON 30 MAY 2015
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Greg Cavanagh

Introduction

1. Irene Magriplis died of sepsis caused by bile leaking into her abdomen after elective surgery at the Darwin Private Hospital. The surgery was to remove a growth adjacent to her bile duct. At the time, Mr Treacy, the surgeon was of the opinion that this elective surgery was necessary. He now concedes it was not.
2. There were many points at which the bile leak should have been addressed. It was not. She should not have died. In my view her death was preventable.
3. The autopsy revealed that this 75 year old woman was healthy in every respect excepting for the results of the operation. That knowledge has only increased the trauma to her loving family.
4. Throughout her admission to hospital her family constantly raised with hospital staff her pain and the "burning inside her abdomen". It is not the first time as Coroner I have been told of people ably describing their symptoms to the medical fraternity only to be ignored. In this case her abdomen was awash with bile. The doctors at the hospital did not take the time to properly investigate her symptoms until it was too late.

5. She was in such pain after the operation that she was kept in recovery for five hours. Thereafter she constantly spoke of the extreme pain she felt, the burning in her abdomen. One can only imagine the frustration of Mrs Magriplis and her family.
6. At 7.30am on the morning after the operation her body went into septic shock. Her blood pressure dropped to 72/38. In the Royal Darwin Hospital that would result in a "Code Blue" emergency response. Not in the Darwin Private Hospital. The 'rapid response' policy there is to call the surgeon (who was performing other operations at the time).
7. Her surgeon stated that had he known the full facts as to the drainage from her abdomen overnight he would have taken her back to the theatre immediately. But he said he did not know the facts. He did not take the time to investigate. He had a long theatre list that day commencing at 8.00am.
8. It was another five and a half hours before Mrs Magriplis was transferred to the Intensive Care Unit at the Royal Darwin Hospital and only then after her blood pressure dropped to 70/30 and her respiration rate and oxygen saturation reached critical levels.
9. After completion of his theatre list Mr Treacy reviewed Mrs Magriplis at 6.50pm and then again at 8.00pm that evening.
10. He felt at that stage she had a quarter chance of death but decided against reoperation. It was not until she deteriorated further that he reoperated at 2.00am the next morning and repaired a broken stitch which had resulted in a three millimetre hole from which bile was leaking. By that time it was too late. Her organs shut down and she died.

Background

11. Irene Magriplis was born 6 June 1939 in Kalymnos, Greece. She came to Australia in 1959. She was married soon after to Pantelis Magriplis and they had four daughters; Marina, Evone, Maria and Panormitisa (Tina). She was

the matriarch of the family and a grandmother. She was looking forward to attending the weddings of three of her grandchildren in August 2015.

12. On 9 February 2015 she attended on her General Practitioner, Dr Glynatsis. She had abdominal pain, nausea and mild jaundice. Blood tests and a CT scan were arranged. Due to an abnormally dilated common bile duct an endoscopic retrograde cholangio-pancreatography (ERCP) was recommended.
13. Her General Practitioner referred her to Mr Treacy, a General Surgeon in Darwin. Mr Treacy saw her on 20 February 2015.
14. Mrs Magriplis did not have a good command of English and took her daughter, Marina to the appointment to translate.
15. The procedure was performed on 25 February 2015. Mr Treacy found a “fleshy tumour” in the common bile duct. A stent was inserted into the common bile duct during the procedure and a biopsy performed.
16. The biopsied sample showed only chronic inflammation. There was no evidence of malignancy. Mr Treacy reported to her General Practitioner that he had booked Mrs Magriplis for another ERCP and removal of the stent on 15 April 2015.
17. On 5 March 2015, Mrs Magriplis along with her husband and daughter saw Dr Glynatsis. He said in evidence:

“I said to her ‘I prefer if there was any further treatment regarding surgery, that we proceed to a hepatobiliary unit down south’. And I made that again known to her when I saw her on 5 March. I did recommend that further surgery should be conducted elsewhere ... I agreed that she really needed to go interstate to a proper unit to have it further treated, because of the problems that can occur.”¹

¹ Transcript p.65

18. The second ERCP procedure was carried out on 15 April 2015. Mr Treacy removed the stent and undertook further biopsies. Mr Treacy wrote to the General Practitioner stating:

“If the repeat biopsies do not show a neoplasia I recommend interstate transfer for endoscopic ultrasound as I am suspicious of an adenoma or possible small carcinoma”.

19. The report on the biopsy specimens indicated a suspected ampullary adenoma with low grade dysplasia, but no malignancy.

High Risk Surgery

20. I heard evidence during the inquest from a Hepatobiliary, Pancreatic and General Surgeon, Dr Anubhav Mittal. He works at the Royal North Shore Hospital, Sydney and regularly undertakes both complex and simple hepatobiliary and pancreatic procedures. His unit performs the highest number of pancreatic resections in New South Wales.² He is also Conjoint Senior Lecturer in Surgery at the University of Sydney. I found him to be a very knowledgeable and impressive witness.
21. He gave evidence that a surgical resection of an ampullary lesion is high risk surgery. He said:

“Any operation that involves either the ampulla or the pancreatic duct or the pancreas is high risk because you can suffer catastrophic consequences of either things going wrong on the table or as in this case, things not going well in the post-operative period. So therefore it is high risk surgery. You can get pancreatitis. You can get leak from the joins. The pancreatic enzymes digest fat, protein and sugar and we are made of fat, protein, sugar, so they could end up digesting adjacent blood vessels etcetera. So for all of those reasons, any surgery of the ampulla or the pancreas is high risk.”³

22. He said such cases should be discussed with a multi-disciplinary team where all imaging and investigations are presented. He said:

² Transcript p.53

³ Transcript p.54

“It’s not just my opinion, but it’s also in the AGITG (Australasian Gastro-Intestinal Trials Group) guidelines, published in the MJA (Medical Journal of Australia), for example, that a multidisciplinary meeting made up of experienced HPB surgeons, radiologists, oncologists, ideally even gastroenterologists are required, not to deliver care, but to help in decision making when it comes to these complex cases”.⁴

23. Importantly, he said that such an operation should only be carried out in an adequately resourced hospital. Such a hospital would have a minimum of an intensive care unit (ICU) and 24 hour access to gastroenterology and interventional radiology.
24. I was told that Darwin Private Hospital, where the surgery was to be carried out, does not have an ICU. It does not have the resources for a multidisciplinary team and it does not have 24 hour access to gastroenterology.
25. On 27 April 2015 Mr Treacy saw Mrs Magriplis once more. Her husband and daughter were with her. Mr Treacy explained to Mrs Magriplis that she had a pre-malignant tumour and recommended resection. He said that without treatment she could get recurrent jaundice and the lesion could turn cancerous.
26. He told her it needed to be removed within 3 months. Her daughter told Mr Treacy that her mother was to attend three weddings of her grandchildren in August and asked if it could wait until then. Mr Treacy said it could not but that he would make an earlier date so that she would be fully recovered by August.⁵
27. Her husband said that he would like to get a second opinion from down south. He told Mr Treacy that their General Practitioner had suggested that it was best to go down south for the operation, preferably to Melbourne.

⁴ Transcript p.54

⁵ Transcript p.80

28. Mr Treacy said words to the effect of:

“Why do you need to drag your wife down south, when I can do the operation here. I have not done many operations similar, but I have in the same area. I am very confident the operation would be successful”.⁶

29. The daughter of Mrs Magriplis translated those words. Mrs Magriplis then said to Mr Treacy in broken English, “I trust you with my life”.
30. Mr Treacy then brought out the ‘consent form’. He said to me that he told Mrs Magriplis the risks of the surgery. The family say that is not so. They say he asked Mrs Magriplis to sign the blank consent form saying that he would complete it later.
31. The procedure was noted on the form as “Trans Duodenal Resection of Ampullary Adenoma”. The risks were noted as “Bile/Pancreas leak. Infection, DVT”.
32. Mr Treacy did not tell Mrs Magriplis that the surgery was high risk. He did not tell her that the hospital was not properly resourced for such an operation. He did not tell her that he did not have access to a multi-disciplinary team. He did not tell her that she might die from the procedure.
33. It is therefore unsurprising that she was happy to consent to the surgery without the benefit of the second opinion urged upon her by her General Practitioner and family.
34. On that same day, Mr Treacy wrote to the General Practitioner stating:
- “I have explained to Mrs Magriplis that she has a pre-malignant tumour and I am recommending resection. Without treatment she will get recurrent jaundice and the lesion can turn into cancer. Hence I have scheduled her for laparotomy and transduodenal resection of ampullary adenoma on the 27th May at the Darwin Private Hospital. The operation will take about three hours to do and she will be one

⁶ Transcript p.81, 126 Mr Treacy gave evidence that he has done 4 or 5 such operations since 1997 (Transcript p.122)

week in hospital with up to four weeks full recovery. I indicated that I am aiming for cure. She is aware of the potential risks of bile or pancreas leak at surgery.”

35. If he had a multidisciplinary team Mr Treacy might have undertaken more testing before coming to the conclusion that such high risk surgery was required. After excision of the tumour, the histopathology showed that there was no dysplasia or invasive malignancy.
36. If surgery had been required Mr Treacy might also have been advised to undertake a less invasive procedure such as an endoscopic resection. Dr Mittal told me that this was the appropriate operation in the circumstances and accompanied by less morbidity.
37. On 27 May 2015 surgery commenced at 10.16am. The procedure was completed at 1.11pm. Mrs Magriplis was then moved to the Recovery Unit (Recovery).
38. In Recovery the staff struggled to get Mrs Magriplis’ pain under control. She was given Fentanyl and Paracetamol intravenously. Eventually it was decided that the Patient Controlled Analgesia machine was not working.
39. During the time she was in surgery and Recovery her family waited outside. They couldn’t get any information on how Mrs Magriplis was going. Eventually they were told that she would have to stay in Recovery until her pain was under control.
40. At 3.45pm another machine was obtained to provide the Patient Controlled Analgesia. By 6.00pm it was decided that Mrs Magriplis could leave Recovery.
41. When she was eventually wheeled out, Mrs Magriplis told her daughter that she had extreme abdominal pain. She said she was burning inside, not feeling well and not breathing well. She looked pale. She was taken directly to the High Dependency Unit (HDU).

42. The HDU was an area on the ward with three beds that were monitored by one nurse. The nurse was a Registered Nurse but had no special training in intensive care procedures and no training for working in the HDU.
43. The family stayed in the HDU area while their mother was settled. She continued to complain of feeling nauseous, having extreme abdominal pain, being thirsty and burning inside. She was given Maxolon for the nausea and vomited.
44. The family noted the abdominal drain. There was light coloured, blood like fluid at the top of the drain and a thick discharge beneath. They spoke to the nurse about it. The nurse then spoke to a supervisor. However they were not given an explanation as to whether that was significant or not.
45. The family were told they couldn't stay overnight. Throughout the night Mrs Magriplis was kept on oxygen therapy of two to three litres per minute. Her respiratory rate was fairly constant until midnight. After that it became more erratic, dropping to 15 breaths a minute at 2.00am and then rising to 27 breaths per minute at 4.00am.
46. The observations were recorded on an "Adult General Observation Chart" (Chart). The Chart was of the "track and trigger" variety. It had a white area indicating normal observations bounded first by a yellow zone and then a red zone after that.
47. The instructions to the Chart stated that the yellow zone indicated the need for a clinical review. The following was in capitals, "IF A PATIENT HAS ONE (1) OR MORE CLINICAL REVIEW CRITERIA PRESENT, YOU MUST CONSULT PROMPTLY WITH THE NURSE IN CHARGE AND ASSESS WHETHER A CLINICAL REVIEW IS NEEDED ..."
48. One of the actions then required was the recording of repeat observations within 30 minutes.

49. At 4.00am the recording of 27 breaths a minute was in the yellow zone. There is no indication in the notes or on the chart that any action was taken including the taking of repeat observations within 30 minutes.
50. Indeed the very poor state of the recording in the medical notes generally (from nurses and doctors) is a significant issue in this case, as will become apparent.
51. The nurse on the shift from 9.00pm until 7.00am left one entry in the notes. It was at 4.15am. It stated:
- “NSG: Settled. Awake at times overnight. IVT continues. Art line insitu, IDC draining concentrated urine > 30mls\hr. IV Panadol attended. Tolerating ice. PAC attended. NIL concerns voiced ATOR, NGT on free drain. Dressing dry & intact. 1 x redon insitu. Care per pathway.”
52. The ‘consciousness’ scores dipped into the yellow zone from 11.00pm to 7.00am with the exception only of 4.00pm when the recording was in the normal zone. No concern was noted.
53. If the “pain scores” on the Chart are to be believed Mrs Magriplis had no pain until midday on 28 May 2015. However they are clearly not correct. They do not accord with the evidence from the family. They do not accord with the recollection of the anaesthetist, or at times the pain scores on the Patient Controlled Injector sheet.
54. The last observations taken by the night shift nurse were at 6.00am. At that time all but the ‘consciousness’ scores were in the normal zone.
55. The morning shift nurse arrived at 7.00am. After receiving the handover she told me that she would have called the doctor because the drain was full and “de-vacced”. She said he told her to change it. There is no note about the colour of the fluid.
56. The family arrived back at the HDU at about 7.00am also. Mrs Magriplis told her family she was still experiencing extreme abdominal pain and was

burning inside. The anaesthetist, Dr Harbison came by on his morning rounds. He said everything was fine.

57. At 7.30am the nurse took the first set of observations for that shift. She found that the blood pressure of Mrs Magriplis had fallen from 120/60 at 6.00am to 72/38 at 7.30am. That was deep into the red zone on the chart. Oxygen saturations were in the yellow zone at 93% despite being on 3 litres of oxygen per minute, her heart rate had risen sharply from 80 beats per minute to 100 beats per minute (albeit still in the normal zone). The nurse did not record other observations on the chart.
58. I heard evidence from Dr Charles Pain, the Executive Director of Medical Services at the Royal Darwin Hospital, that those observations at the Royal Darwin Hospital require a Code Blue to be called. A Code Blue is the highest emergency escalation for a patient.
59. The instructions to the Chart state that the red zone is the “Rapid Response” zone. The Instructions for that zone advise (in capitals):

“IF A PATIENT HAS ONE (1) RAPID RESPONSE CRITERION
PRESENT, CALL FOR A RAPID RESPONSE ...”

60. The further instructions state at point 4, “Repeat observations every 5 minutes until the team arrives”.
61. What that means seems clear on a reading of it. However it became a point of some confusion at the inquest. The General Manager of the Darwin Private Hospital, Dr Joanne Seiler, gave two different versions. She filed a statutory declaration on 3 March 2017 explaining what it meant:

“The system at DPH requires that where a patient exhibits one (1) or more of the base clinical review criteria, protocol for the initiation of a ‘clinical review’ must be initiated. This requires contact and reporting to the patients VMO. More serious indicators are identified as ‘rapid response’ criteria. If this is indicated a ‘Rapid Response

Call' or "Code Blue" is called which mobilises the RDH Rapid response team."⁷

62. However in evidence Dr Seiler told me that if the observations went into the yellow zone the protocol was to call the RMO (resident medical officer) and when it fell into the red zone the protocol was to call the VMO (visiting medical officer). However, there is nothing in the policy documents that makes that clear. On a document titled "Rapid Response Criteria" various criteria are set out. At the foot of the page the following is written:

"Immediately contact:

RMO OR

Admitting surgeon, Physician or Obstetrician (VMO)

In the event of a cardiac or respiratory arrest call a Code Blue immediately as per the Darwin Private Hospital protocol "

63. If that is indeed the escalation protocol it leaves patients at the Darwin Private Hospital as having an inferior escalation response to those in the Royal Darwin Hospital.
64. The system is also unlikely to be consistent with the *National Standards on Safety and Quality in Health Care*. Standard 9 requires escalation and rapid response systems "capable of delivering specialised, timely emergency assistance to patients whose condition is deteriorating".
65. In this case the nurse called Mr Treacy (the VMO). He attended for a review. It is not known exactly when he reviewed Mrs Magriplis because there is no time against his entry in the medical notes. However he had a lengthy theatre list that day and he indicated in evidence that due to that his attendance would have been before 8.00am.
66. On review, Mr Treacy noted that Mrs Magriplis was thirsty, in pain and had moderate naso-gastric bile output and a small volume of 70ml bile stained

⁷ Paragraph 34

fluid in the abdominal drain. He directed fluids for rehydration, chest physiotherapy and asked that blood be sent off for testing (the results not expected for some hours). Mr Treacy then went to theatre leaving Mrs Magriplis in the care of the nurse.

HDU

67. I heard from the three shift nurses that staffed HDU for the time Mrs Magriplis was there. The nurses were no longer working at the Darwin Private Hospital. Two of the nurses left to work at the Royal Darwin Hospital and the other at the time of the inquest, Registered Nurse Kelly Lawton, was working at Westmead Children's Hospital. She provided the following evidence:

"Most of the patients that we had in the HDU unit wouldn't necessarily go into other HD units in other hospitals. They would still necessarily be nursed on a ward, just with a lesser patient load. So our HD unit didn't always function as an actual HD unit. It was just closer monitoring overnight and during the shift.

Q. So what you're saying is that it probably shouldn't be classed as an HDU in the normal sense?

A. Yes.

Q. Just a place for higher observations?

A. Yes.

Q. That was your understanding, was it, when Mrs Magripilis was there?

A. Yes.⁸

Q. During your time at Darwin Private Hospital did anything change in relation to the staffing or operation of HDU that you observed?

A. There was lots of staffing changes. Nobody really wanted to work in there. It originally had a manager then that got taken away

⁸ Transcript p.36

and got absorbed back into the ward and run through the ward's manager.

Q. Why didn't people want to work there?

A. We just - most of us didn't feel safe in a three bed room by yourself. People forget you're there and sometimes when you do need help, it sometimes gets hard to get help.”⁹

68. The *College of Intensive Care Medicine of Australia and New Zealand Guidelines* recommend that a nurse in charge of the HDU have post registration qualification in intensive care. None of the three nurses on the three shifts while Mrs Magriplis was in the HDU had such qualification.
69. Dr Seiler signed a second statutory declaration on 7 March 2017 (the second day of the inquest) after hearing the evidence of the nurses. In that declaration she said that nurses allocated to HDU required advanced clinical skills and that Darwin Private Hospital had competency based packages available to teach and assess the skills of the nurses. However no packages, completed by the nurses, were attached. The one nurse that was able to be asked about that package (because she was recalled) told me that she had seen it around but didn't believe she had ever completed it or signed it.
70. The staffing of HDU also seemed at odds with paragraph 11 of the Darwin Private Hospital *High Dependency Unit Procedure Manual* which states:
- “The unit will be staffed by two HDU trained Registered Nurses and the DPH RMO at all times. The nursing staff will work on a ratio of 1:2 and this will be influenced by patient acuity”.
71. The evidence was that there was only one nurse for three patients and the RMO was only available if called.
72. Within Table 2 on page 10 of the *High Dependency Unit Procedure Manual* are the “Core Nursing Skills Required in the HDU”. One of the required skills is “Management of fluid balance”. It requires:

⁹ Transcript pp.38 & 39

“Accurate input and output recording. Ability to recognise and respond to fluid imbalance.”

73. The nurses on those three shifts appeared unable to properly and accurately write up the Fluid Balance Sheet. For the entries in the Fluid Balance Sheet on 27 May 2015 there were no progressive totals for either the intake or output. If the object of the sheet is to determine the fluid ‘balance’ then that creates a significant issue.
74. Various entries were clearly in the wrong columns and on two occasions figures were written and then crossed out, but no further entries made. On 28 May 2015 there were no outputs noted for the drain excepting for the entry at 7.00am where it stated “400 – change drain”.
75. The nurse told me that she wrote the progressive totals for that day including those after midnight (those before she came onto her shift). Those totals take into account the 400 millilitres on the change of the drain, but no other amounts from the drain. Not even the 70 millilitres that Mr Treacy saw just before 8.00am. No hourly amounts were recorded on the Sheet after midnight other than the 400ml.
76. I also heard from Dr Charles Pain that the HDU was unlikely to comply with the *College of Intensive Care Medicine of Australia and New Zealand Guideline*. To comply, a High Dependency Unit must be geographically part of the intensive care complex of the hospital and be operationally linked to the ICU.¹⁰

Failure to Recognise Fluid Draining from Abdomen

77. Mr Treacy told me that had he been aware there had been 400 millilitres in the drain overnight he would have taken Mrs Magriplis back to the theatre for reoperation immediately. If he had done so, the reoperation would have occurred 18 hours earlier. The failure to recognise that the drain had been changed is therefore of crucial importance.

¹⁰ Pain para 56

78. At that point in the evidence I asked Dr Treacy the following question:

“So am I to take it, if it was on the chart and you didn't look at the chart - you've made a crucial error - or if it wasn't on the chart the nurse has made a crucial error? Is that right?”

79. Mr Treacy answered, “Yes”.¹¹
80. He said he did not see the notation of 400 millilitres in the Fluid Balance Sheet on his review that morning. That may have been the case. The nurse told me that it would have been written along with the other observations at the end of the hour. That was 8.00am. It is therefore possible that she wrote it shortly after Mr Treacy had reviewed Mrs Magriplis and left for the operating theatre.
81. That raises a significant issue: If a nurse writing on the Fluid Balance Sheet is the only system ensuring that the deteriorating condition of Mrs Magriplis was recognised and treated appropriately, the system is unsafe.
82. Of course part of the system is the hourly updates to the Fluid Balance Sheet. If they had been done there would have been hourly amounts in the drain, more easily seen and detected.
83. The nurses told me there was another system. They said that the drain couldn't be changed without a direction from the treating doctor. The nurse that came on shift at 7.00am told me that she would have phoned Mr Treacy. With the intervening period neither she nor Mr Treacy could recall that specific phone call. If the call was made, one might have expected Mr Treacy to recall it thirty or so minutes later when he saw Mrs Magriplis.
84. However, also on the Fluid Balance Sheet from the night before was 280 millilitres in the “drain” column made up of a number of entries recorded prior to midnight.¹² One might think a doctor looking at the Sheet and seeing

¹¹ Transcript p.137

¹² Mr Treacy disputes that all of these figures should have been in that column (email to Paul Maher dated 5 February 2017). However should they have been sighted they

no notations for the last 8 hours might look over the page, the more so given the rapid deterioration of Mrs Magriplis.

85. The other system in place was the track and trigger system requiring an escalated response. However, as mentioned, that was ineffective.

Communication

86. If the VMO, the anaesthetist and the nurse were the “rapid response team” as the General Manager would have me believe, they apparently didn’t communicate as a team on the rapid deterioration of Mrs Magriplis. That might have been because they were not together in the one space at the one time. Or it might be that Mr Treacy was on his way to doing other things. Or, that they simply didn’t see themselves as a “rapid response team”,
87. Nevertheless, one would anticipate there should have been discussion with the nurse. That would have assisted the investigation into the shock that Mrs Magriplis was clearly suffering. Mr Treacy did not appear to turn his mind to the possibility of septic shock despite bile being in the drain and despite bile leakage being one of the noted risks of the surgery. He sought no tests be done to determine whether Mrs Magriplis was suffering from sepsis.
88. He thought it more likely hypovolemic shock (although he also checked for cardiogenic shock). Her pain was 8 out of 10. He told the family the pain was due to the surgery and that she should keep pressing the button for her pain. The daughter of Mrs Magriplis told me that by that time she was too weak to press the button.
89. Mrs Magriplis continued to complain of the extreme pain she was in and the burning she was experiencing inside her lower abdomen. Her daughter told me:

would have alerted Mr Treacy to the fact that the 70mls was not the total drainage since operation.

“She never stopped telling me she was in pain. Never. The whole time from the start to – they put her to sleep. Her words were always, ‘I’m in pain Marina. I’m burning. I’m tired,’ and I kept telling her, ‘It will be okay, Mum’.”

90. One might ask what further or better description was required that her abdomen was awash with bile. She was in shock. She was in agony and telling the doctor she was burning inside.
91. The frustration of the family was immense. It was still present when telling the story in court. Marina described how the pleas of her mother were continuously ignored and brushed aside by the doctors and nurses.

Deterioration

92. The blood pressure of Mrs Magriplis stayed in the red zone until 9.30am. It then began to rise. By 10.00am her blood pressure had risen sufficiently to be in the “normal” area of the Chart.
93. However at 11.00am her oxygen saturations dropped into the red zone and by 12.00pm her blood pressure was once more in the red zone along with her respiration rate. At the time Mr Treacy was still in the operating theatre. He told me that he communicated through his anaesthetist in the theatre (who could take the calls).
94. The nurse called Dr Harbison. She said he gave her support. He prescribed Fentanyl for pain. But there was no rapid response. There was no Code Blue.
95. At 12.25pm Mr Treacy left the theatre and at 12.30pm conducted a review. The note relating to that review is not where one might think it would be amongst the other medical notes. It is on a separate sheet in the part of the file that related to the ERCP day procedures. That may indicate that the review was not at the bedside.¹³ The note states:

“Low BP 70/30, Low urine 30 ml/hr & dark colour – Thirsty

¹³ The family of Mrs Magriplis did not see Mr Treacy in HDU at that time.

JVP ?2-3cm

ASSESS – Frail, [words difficult to decipher]

PLAN Albumin 500 ml/hr, CXR

If fails to respond, may need inotropes (in RDH)

Fast please”

96. There was no mention of the drain. At that time it is likely there was more bile stained fluid in the drain. When Mrs Magriplis was admitted to ICU the Royal Darwin Hospital notes state, “Drain – bile stained drainage 150mls (Mr Treacy aware)”. Mr Treacy told me those words mean he was told.
97. Mr Treacy ordered more fluids and a chest X-ray. He seemed not overly concerned at that time, although thinking that her blood pressure might need to be supported by inotropes (not available in HDU). He continued with his theatre list until 5.56pm.
98. When asked whether at that time he would have looked at the Fluid Balance Sheet, he said:

“I've asked myself this question and that 400 was in the chart and I only identified it was there months later so I must not have looked at the chart and seen it or else it was not written in the chart at that time because I was not aware until months later that the drain bottle had been changed and that there was 400mls. So I don't know whether it was that I didn't look at the chart or whether it wasn't written there. As I have indicated, I would look at those charts.”¹⁴

Transfer to ICU

99. Dr Harbison however spoke to staff at the ICU sometime after 12.30pm. The time is not known because there is no note of the call. However after that call the ICU Registrar arrived to examine Mrs Magriplis. She was soon thereafter transferred to ICU. The timing of when that happened is not at all certain. The documents state that she was discharged from Darwin Private

¹⁴ Transcript p.137

Hospital at 2.40pm. However there is an admission note in the Darwin file at 2.30pm. The notes of the initial investigations in ICU were written up at 3.45pm.

100. The best timing is probably from the nurse in the HDU who told me she started writing up her notes of the shift, before handing over the Darwin Private Hospital file, at 1.10pm. She did so while at ICU awaiting the admission of Mrs Magriplis.

101. On arrival at ICU Mrs Magriplis was still in pain with a pain score of 5-6 out of 10. She was commenced on a noradrenaline infusion to support her blood pressure, antibiotics for the sepsis and due to her rapidly falling oxygen levels, even on 100% oxygen, she was intubated and ventilated at about 6.00pm.

102. Dr Mittal wrote in his expert report:

“At 1530 day 1 post-op when the patient was transferred to the Intensive Care Unit at Royal Darwin Hospital, she had normal liver and renal function but had worsening circulatory and respiratory failure. She had upper abdominal pain and difficulty breathing. These facts combined with the presence of bile in the abdominal drain should have prompted an immediate return to theatre for suspected biliary peritonitis and a leak from the duodenum or small bowel elsewhere as difficult adhesions had been divided in the first procedure.”

The CT Scan prior to 8.00pm

103. After the review at 6.50pm Mrs Magriplis was sent for an urgent CT scan of her abdomen and pelvis. Dr Mittal told me that was unlikely to assist because what is looked for is free gas and free fluid that would ordinarily be indicative of a perforation or leak. But in the first post-operative day there will be both free gas and free fluid in the abdomen. That is the normal response of the body after surgery. He also said that it was potentially

damaging because it was exposing an unwell patient to contrast agent that was nephrotoxic and may damage the kidneys.¹⁵

104. Mr Treacy reviewed Mrs Magriplis at 6.50pm and then spoke to the family. He told them that she would be taken for a CT scan and depending on the results of that she may need to be taken back to the operating theatre for a “wash out of her abdomen”.

105. The CT scan results were at best ambiguous. They did not rule out a bile leak but did not confirm one. By the time Mrs Magriplis returned from the scan her temperature was 38.1 degrees.

Continued failure to identify drain volume

106. When asked whether that review was an opportunity to see the notation of the 400ml in the Fluid Balance Sheet, Mr Treacy stated:

“I do not believe - and I am quite certain of this - that the Darwin Private Hospital notes were with the patient at that time.”¹⁶

107. He was asked what confirmed to him that was the case. He said:

“You can appreciate that she had come to the intensive care unit and I was trying to catch up with all that I had been hearing by telephone in the operating theatre that afternoon leading up to and during and after her transfer, so I was getting second-hand information relayed. I would then want to make my own individual assessment of all of the information, and I can recall being frustrated that I could not do that.”¹⁷

108. Due to those answers I had the nurse from the HDU recalled. She told me she took the original file over and wrote her notes in it while waiting the admission of Mrs Magriplis to ICU.

¹⁵ Transcript p.57

¹⁶ Transcript p.138

¹⁷ Transcript p.139

109. I also heard evidence from Panormitisa, one of the daughters of Mrs Magriplis. She said she saw the nurse take the Darwin Private Hospital notes to ICU.
110. I have no doubt that the Darwin Private Hospital file was available to Mr Treacy in ICU.

Review at 8.00pm

111. At 8.00pm Mr Treacy reviewed Mrs Magriplis again. He was of the opinion that she was suffering pancreatitis and bilateral chest infection. He did not consider there was any benefit from reoperating. He sought a second opinion from another surgeon. However he did not request a review. He telephoned the surgeon and provided the facts as he saw them. One of those facts was that there was no bile in the drain.¹⁸ The surgeon agreed with Mr Treacy that there was no indication to reoperate.

112. Dr Mittal wrote in his report:

“The volume of bile in the abdominal drain can be unreliable as drains can get blocked or drainage can be positional. Therefore, the decision not to take the patient to theatre at 2000 should not have been based on the volume of bile that had come out of the abdominal drain.

Temperature elevation or not is irrelevant at this juncture, and the worsening condition of the now critically ill patient should have, yet again prompted a return to theatre.

In my opinion, the decision to return to theatre was delayed and the reasons given for this delay are not justifiable.”

Reoperation

113. Mr Treacy reviewed Mrs Magriplis again at 1.20am (29 May 2015). At that time he gave consideration to “the possibility of abdominal inflammation from bile leak”.¹⁹

¹⁸ Statement of Dr Ruth Hardstaff

¹⁹ Statutory Declaration of Mr Treacy dated 12 October 2015 paragraph 30

114. She was taken back into theatre at 2.00am. Mr Treacy found a 3 millimetre hole in the duodenum and bile throughout the abdomen. He said of the earlier operation:

“I put in several stitches, one of those stitches and I don't know why, either came undone, or cut through, or for whatever reason at one point at one location within the bowel, the duodenum, there was a gap and bile was leaking from that gap at the site where a previous incision had been made in the bowel.”²⁰

115. He closed the hole and washed out the abdomen. He left the abdomen open in the expectation of repeating the wash out.

Death

116. However, it was too late. Mrs Magriplis continued to deteriorate and went into multi-organ failure. At 11.30am that morning a meeting was held with the family and the very poor prognosis was explained.

117. The family sought second opinions. They were provided and it was confirmed that there was nothing that could be done at that point to save the life of Mrs Magriplis. She died at 11.30am the following day, 30 May 2015.

118. An autopsy was performed by Dr John Rutherford. In his opinion she died of “septic complications following surgical resection of duodenal ampullory adenoma”.

RESPONSES

119. The responses to the death of Mrs Magriplis by both Mr Treacy and the Darwin Private Hospital are deserving of comment.

Mr Treacy

120. On 12 October 2015 Mr Treacy made a statutory declaration about his involvement in the care and treatment of Mrs Magriplis. The declaration was

²⁰ Transcript p.122

primarily a recount of the events. In that declaration he wrote:²¹

“I reviewed Mrs Magriplis at 8.00am on 28 May 2015 in the High Dependency Unit. I noted she was thirsty, in pain. No cough. I noted moderate naso-gastric bile output and a small volume of 70ml bile stained fluid in the abdominal drain overnight.”

121. He wrote also about the assessment of Mrs Magriplis on admission to ICU:²²

“There was a total of 150ml of bile stained fluid present in the abdominal drain since operation.”

122. Both of those statements are incorrect because to each there needs to be added the 400mls that was in the drain changed between 7.00am and 8.00am on the morning of 28 May 2015. Mr Treacy told me that it was months after the death of Mrs Magriplis that he first became aware of the 400ml of fluid.²³

123. On 20 April 2016 Mr Treacy’s lawyer responded to the expert report of Dr Mittal. The letter from the lawyer was presumably on instructions.²⁴ In that letter at paragraph 13, the following was stated:

“There was only a very small amount of bile (70ml) in the drain that appeared within several hours of the patient returning to the ward after the operation, and was noted by Mr Treacy the following morning. There was minimal if any further bile stained fluid out of this abdominal drain thereafter.”²⁵

124. Mr Treacy made another declaration on 6 March 2017. He did not mention that his earlier declaration and the letter from his solicitor were in error. He did not mention that he had discovered that there was 400ml of fluid changed just prior to his arrival at HDU on the morning of 28 May 2015. He did not mention that it was of such significance that if he had seen it in the

²¹ Paragraph 21

²² Paragraph 25

²³ Transcript p.137

²⁴ Indeed it was later confirmed that paragraph 13 was written by Mr Treacy.

²⁵ Paragraph 13

chart he would have immediately taken Mrs Magriplis back to the operating theatre.

125. When the nurse gave evidence on the first occasion (she was later recalled) she said she changed the drain because it was full and fluid immediately ran into the fresh drain. Mr Treacy's Counsel, Mr Miles Crawley, did not cross-examine her about changing the drain or the 400ml entry in the Fluid Balance Sheet.²⁶
126. On 8 March 2017 Mr Treacy was led through his evidence-in-chief by his Counsel. Mr Treacy did not mention during that evidence that his previous statements were misleading and incorrect or that he had discovered the notation on the Fluid Balance Sheet.
127. It was not until Counsel Assisting asked him specifically about the evidence of changing the drain that Mr Treacy told me that he hadn't seen the notation of the 400ml at the time and he believed if it was there he would have seen it.
128. In submissions Counsel Assisting criticised Mr Treacy for his failure to disclose such a crucial fact at an earlier point in time.
129. At the end of the submissions by Counsel for Mr Treacy I invited him to specifically address those criticisms. The following exchange took place:

"CORONER: No, no, don't sit down. So as between the nurse and Dr Treacy in terms of credibility, what am I to make of Dr Treacy's responses in two affidavits and one long detailed letter no doubt on instructions to Mr Maher where at no stage until yesterday afternoon does he mention dramatically the liquid?

MR CRAWLEY: Sir, Dr Treacy has explained what he did and why he did it. He's not sought to deflect the blame by saying someone didn't tell me something and had I known I would have done something different. That's essentially that situation.

²⁶ Transcript pp.48-51

THE CORONER: Treacy's saying he dramatically realised two months later. There's no doubt about it, he realised how important that was.

MR CRAWLEY: Yes.

THE CORONER: There's not even a hint on anything in all his responses until yesterday afternoon about it. What am I to make of that? Counsel Assisting says effectively that it goes to his credibility. Have you got a response or not?

MR CRAWLEY: Yes, I have. I say Sir that Dr Treacy was responding by saying what he did and why he did it. To the extent that you're investigating his conduct, that is his response.

THE CORONER: Thank you.

MR CRAWLEY: He said what he did and he's said why he did it. Now without seeking to make excuses saying well if someone had told me something different I would have done something different, he accepts the failings insofar as his conduct was concerned and he indicates how he's changed his conduct and in my submission, that's as far as it needs to go."

130. It went further. The following day Mr Maher, the solicitor for Mr Treacy, sent a letter to Counsel Assisting. The letter in part stated:

"I enclose with this letter a copy of a letter emailed to me by Mr Treacy on 5 February 2017, written shortly after he had had the opportunity to examine the coronial file and the first tranche of supplementary documents received from your office, which I had posted to him on a USB on 20 January 2017. This was the first time he had seen the fluid chart entry referring to 400mls in the drain. You can see that Dr Treacy was very surprised to see what was on that chart and that this was for him a most significant issue. Subsequently, these events occurred:

1. In the week prior to the inquest Dr Treacy met with me and counsel. Uppermost in Dr Treacy's mind was the fluid chart and the reference to 400mls of fluid. He told us, as he later confirmed in his evidence, that he would routinely check these charts if they were available, but he was certain he had not seen that entry. He was personally wanting these matters to be put to the coroner.

2. My advice to him was that it would be inappropriate to press before the coroner the view that one or more of the nursing staff had failed to make a timely entry in the fluid chart, or that they had failed to ensure the chart was available for Dr Treacy to check when he attended Mrs Magriplis, or that they failed to draw his attention to something as important as the changing of the drain.
3. I pointed out that a coronial inquest is not a civil claim, the coroner is not interested in allocating blame, and he is unimpressed when parties attempt to do so.
4. My advice was therefore that the significant fact for the coroner was that Dr Treacy believed there was only a small amount of bile in the drain, and that should be his evidence-in-chief. If in cross-examination, the fluid chart became significant, then it would be appropriate to openly and comprehensively deal with the matters Dr Treacy had raised, but that would be preferable to doing so in chief as it would (or should) then not be seen as attempting to allocate blame.
5. Had Mr Treacy had his way, he would have raised the fluid chart in his evidence-in-chief with alacrity. It now appears that my advice had achieved exactly the opposite result to that which was intended, but Dr Treacy should not be blamed for that. I can absolutely assure you that Dr Treacy did not fail to speak of the fluid chart in his evidence-in-chief through a desire to conceal it and to avoid allegations that he may have erred.
6. I also ask you to reflect upon Dr Treacy's answers in cross-examination. As soon as you mentioned the fluid chart he openly stated that it was a matter which had been causing him great concern. He did not hesitate to agree with His Honour's suggestion that this meant that either he or the nurses at DPH were at fault. He did not in any way downplay the significance of the entry and he did not attempt to enter into a debate about who was to blame, notwithstanding that his evidence was that he would have noticed it had it been available to him."

131. It is a most unusual course to provide such further evidence and submissions after the inquest, especially as Counsel for Mr Treacy was asked to deal with those very issues in the inquest. However given that my findings may have a significant impact on Mr Treacy I believed it appropriate to consider the letter and attached email.

132. It is sought that I accept that Mr Treacy in not disclosing his discovery about the 400ml was simply trying to shield nurses from being blamed or perhaps shield himself from looking as if he was blaming the nurses or both.
133. It is an interesting proposition. It seeks to join, as if inextricably linked, the failure to detect the fluid and the blame of the nurses. Yet just the day before his Counsel had not linked them. He had told me that Mr Treacy was not making excuses and accepted his errors.
134. What Mr Treacy said he discovered was that Mrs Magriplis had a significant amount of fluid draining from her abdomen 17 hours after the operation. At the point he is said to have discovered it, he had already made declarations that were factually incorrect.²⁷
135. If the discovery of the fluid was not linked to blaming the nurses there was no reason not to rectify the incorrect declarations. If the discovery was linked then I am asked to accept that he chose to leave those incorrect declarations as part of the record before me rather than blaming the nurses.
136. I note the advice to Mr Treacy was to be open with his answers only “if” the fluid chart became significant. I find it difficult to accept that he did not correct those false accounts for fear only of laying blame on the nurses.
137. Even on the most favourable view of the facts (for Mr Treacy) there are significant issues. The most favourable view would be that the nurse failed to seek permission to change the drain and didn’t write up the Fluid Balance Sheet until after Mr Treacy had seen Mrs Magriplis just prior to 8.00am on 28 May 2015.
138. However, there is no doubt that at that time the notations in the ‘drain’ column of the Fluid Balance Sheet had been made up to midnight. The notations in the drain column added up to 280ml. The last entry at midnight

²⁷ Although the time when he said he made the discovery was variously ‘months’ or 21 months after the death of Mrs Magriplis.

is 70ml. Before that was 10ml at 9.00pm, 20ml at 8.00pm, 80ml at 7.00pm and 110ml at 6.00pm. There are other figures before that and they may or may not relate to the drain.

139. It is not possible that Mr Treacy saw those notations and continued to hold the view that the 70ml he saw in the drain was the total amount since the operation.
140. That leads to the likelihood that Mr Treacy did not view the Fluid Balance Sheet when he saw Mrs Magriplis on the morning after the operation. He must have assumed that what he saw in the drain was the total since the operation. On a favourable interpretation, perhaps he felt entitled to make that assumption because he hadn't received a call about changing the drain.
141. Having said that, the weight of the evidence is that the nurse did seek permission from Mr Treacy to change the drain. The nurses on the night and day shifts were adamant that a drain would not be changed at the Darwin Private Hospital without seeking the permission of the surgeon. The nurse on the day shift conceded that she couldn't recall making the call almost two years after the event but insisted she would have done so. I accept her as a frank and honest witness.
142. In circumstances where Mrs Magriplis was clearly in shock and Mr Treacy was directing more fluids be given one might think failing to look at the Fluid Balance Sheet less than ideal.
143. The failure to look at the Fluid Balance Sheet clearly continued even when writing the statutory declaration for the coronial investigator on 12 October 2015 and the letter from his lawyer on 20 April 2016.
144. He also cannot have looked at the nursing notes on those occasions because at 1.10pm on 28 May 2015 the nurse wrote in the notes these words:

“Reardon drain changed as bottle was full & had de-vacced.”

145. One of the interesting aspects in relation to the email from Mr Treacy to his lawyer is his conclusion after his discovery. He stated:

“Had I noted 400 in the chart, or seen 400ml in the drain, I would have been more concerned and noted the fact.”

146. That was written on 5 February 2017, a month before the inquest. On 8 March 2017 he told me unequivocally he would have taken Mrs Magriplis straight back to theatre. That is clearly a significantly more urgent response than being more concerned and making a note.

147. It may well be that it has taken Mr Treacy sometime to come to the conclusion that Mrs Magriplis should have been taken back to the theatre immediately. Perhaps it was not fully formed on 5 February 2017. It might also suggest that if he saw or knew about the 400ml on 28 May 2015 he may not have given it the attention it deserved.

148. However, it should also be said that by the end of the inquest Mr Treacy had accepted many of the errors made. The final submissions of his Counsel were appropriate and significant given the responses prior to that time. He stated in part:

“There are a number of points that if something had been identified or done differently the outcome may have been affected ...

The very first thing is the initial diagnosis of the nature of this growth. It is tragic that we know that despite having been believed to have been a malignant or pre-malignant tumour, in fact from tests done after it was removed, in fact it was neither. And that is a very major thing. If that had been identified at the outset then the procedure undertaken would not have been undertaken ... it was not a situation where because of the potential for cancer it needed to be a complete removal to make sure it was all got and would not recur. What we have is a situation, there were two ERCPs as you know. The first one found chronic inflammation, nothing more but noted the word of caution that the biopsy may not be entirely representative. So it was repeated.

In fact in both of those endoscopies Dr Treacy noted the appearance of the tumour which to him seemed pre-malignant or malignant. You

may recall he made reference to the friability of the tumour which made him suspect cancer and that guided to a large extent the actions thereafter.

The biopsy that was taken of the second – on the second ERCP was reported as being a suspected ampullary adenoma and basically that confirmed that we are dealing with a pre-malignant or if not a malignant tumour. And that was what guided Dr Treacy.

Now we know that was wrong and Dr Treacy knows that was wrong. Dr Treacy told you how at the time there was no histopathologist in private practice in Darwin but the tendency – that the usual practice was for surgeons to send their path samples off to Perth to be assessed. That had he had a local person he could have spoken to and more importantly could have actually have viewed the slides themselves to determine what he was dealing with.

Now we have the advantage that that now has changed and there is such a pathologist in Darwin. So at that point if the same procedure happened again there would be that additional material to help make that original diagnosis accurate. That's the first step.

But the point simply is that there is now present in Darwin another specialist with whom he can consult and there indeed has been set up a multidisciplinary team from different specialities that can discuss the case with as well.

And the significance of that is that he will have the benefit of other people's experience and views rather than purely his own assessment as supported as he saw it by the pathology results. So that's a positive improvement in relation to the situation in Darwin as it is at the moment.

The next question is that of second opinion. Dr Treacy's evidence was that he said to the patient that they of course are entitled to seek a second opinion but he recognises the way in which he expressed himself was discouraging of that course and that was inappropriate and not his intention. So that although Mrs Magriplis was very keen to have it in Darwin, the way in which he expressed himself encouraged her in that belief rather than giving her a more balanced assessment of the question of a second opinion. So that is an area again where he recognises a shortcoming and he recognises an improvement is required in terms of dealings with his patients and explaining those aspects.”²⁸

²⁸ Transcript pp.210-212

149. It is gratifying those insights were gained through the course of the inquest and they were put so honestly and frankly.
150. What is so striking about the treatment provided to Mrs Magriplis, however, is that at almost every point, it was problematic as noted in the following paragraphs.

The failure to undertake sufficient testing to determine whether the high risk surgery was required

151. Doctor Mittal told me that in his practice they would have asked for an endoscopic ultrasound. He said that procedure provides information on the dimensions of the tumour and can also be used for a fine needle aspiration that would again confirm whether it was cancerous or not. He said:

“The advantage of the fine needle aspiration is that we can get a deep ultrasound guided biopsy so you know exactly where you are targeting and that you indeed have good tissue samples. The other option, if you suspect the lesion involves the common bile duct, we would ask for a spy glass, which is a fibre optic examination. And that can actually look into the bile duct, visualise the lesion and then take a more substantial biopsy.”

152. Mr Treacy turned his mind to seeking an endoscopic ultrasound through a gastroenterologist in Adelaide. However after the results of the second ERCP he did not believe that it was required. His decision in that respect would have been assisted greatly by the involvement of a multi-disciplinary team.

Failing to form or consult a multidisciplinary team about the diagnosis and manner in which to proceed with a high risk and complex case

153. In the *Medical Journal of Australia* on 4 May 2015 there was an editorial on the rise of pancreatic cancer. The following was stated:

“An avenue to optimise outcomes for patients is to ensure that all receive high-quality care in the most appropriate setting ... it is thus important that all patients without metastatic disease are reviewed by a multidisciplinary team in a major centre to determine the resectability of their pancreatic tumours. In addition, resections

should be performed in hospitals that carry out a large number of these procedures annually, as this has been shown to improve survival.”²⁹

Failure to inform Mrs Magriplis of the risks

154. The information that doctors are required to give patients is governed by the law and detailed in guidelines issued by the *National Health and Medical Research Council* (NHMRC). Those guidelines include the following:

“Doctors should give information about the risks of any intervention, especially those that are likely to influence the patient’s decisions. Known risks should be disclosed when an adverse outcome is common even though the detriment is slight, or when an adverse outcome is severe even though its occurrence is rare.”³⁰

155. The information to be given includes:

“other options for investigation, diagnosis and treatment, the degree of uncertainty of any diagnosis arrived at, and the degree of uncertainty about the therapeutic outcome.”³¹

156. The failure to inform Mrs Magriplis of the options available for diagnosis, the high risk involved in the surgery and the other options available to Mrs Magriplis to mitigate those risks played a key role in the eventual outcome.

Dissuading Mrs Magriplis from seeking a second opinion

157. The Code of Conduct for medical practitioners states that good medical practice involves (among other things):

“Supporting the patient’s right to seek a second opinion.”³²

158. The NHMRC guidelines also state:

“The doctor should ... allow the patient sufficient time to make a decision. The patient should be encouraged to reflect on opinions, ask more questions, consult with the family, a friend or advisor. The

²⁹ MJA 202(8) 4 May 2015 p402

³⁰ p.11

³¹ p.11

³² 2.2.8

patient should be assisted in seeking other medical opinion where this is requested.”³³

159. The dissuasion of Mrs Magriplis is particularly difficult to understand. It was clearly to her advantage to obtain treatment where the high risks could be appropriately mitigated.

Undertaking the high risk surgery in a hospital without the resources to mitigate those high risks

160. Not only was the Darwin Private Hospital not a hospital that fitted the description of a hospital that did a large number of similar operations annually, it did not have a multi-disciplinary team, an ICU or gastroenterology.

Failing to properly investigate the fall of her blood pressure to critical levels on the morning of 28 May 2015

161. Mr Treacy was called to review Mrs Magriplis between 7.00am and 8.00am on 28 May 2015 because her blood pressure had dropped to a critical level and was in the red zone (the rapid response criteria) of the track and trigger Chart.
162. Mr Treacy noted that her blood pressure was less than 100, that she was in pain and that she had bile in the drain.
163. We know now that at that time Mrs Magriplis was in septic shock. Even at the time however, there was sufficient reason to investigate whether that was the case.
164. When asked whether obtaining blood gas would have been appropriate, Mr Treacy said:

“I was concerned that she had low blood pressure and I was interested in her response. I did not request a blood gas because my - because I was relying upon the blood results to give me a result

³³ p.12

within, I would hope, two or three hours. I was not looking at wanting a result within five minutes.”

Failing to identify the amount of fluid drained from her abdomen

165. The Fluid Balance Sheet was at the foot of the bed on a table. Mr Treacy is unlikely to have looked at it for the reasons already noted.
166. The nurse was in attendance when Mr Treacy was in the HDU. It must follow that it is also unlikely that he spoke to her about the fluid levels.
167. The seeming failure to look at the Fluid Balance Sheet or talk to the nurse about the fluid balance remains perplexing.

Failing to take Mrs Magriplis back to the operating theatre until it was too late

168. Mr Treacy said that had he recognised the 400ml and the change of the drain he would have taken Mrs Magriplis back to theatre immediately. However, even without that, there were significant signs that Mrs Magriplis should have been taken back to theatre.

169. Dr Mittal stated:

“Look, its not unheard of that in the early post-operative phase there may be a leak of bile or pancreatic juice from an anastomosis, from a join. However, if that occurs, which clearly it did in this case, and was indicated by bile present in the drain, then the course of action depends on how the patient is doing. So if the patient is doing okay and doing well, you would follow a conservative approach, because you don’t want to jump back and make things worse. However, if the patient is not well, and is clearly developing first systemic inflammatory response syndrome, followed by multi-organ dysfunction syndrome, you want to intervene early so you can, one, see and improve the situation, two, wash things out, and three, provide wide drainage.”

170. Dr Mittal indicated that the time at which Mrs Magriplis should have been returned to theatre was after transfer to the ICU when it was noted she had worsening circulatory and respiratory failure:

“These facts combined with the presence of bile in the abdominal drain should have prompted an immediate return to theatre.”

Failing to call for a Rapid Response Team at 12.30pm when the blood pressure, respirations and oxygen saturations of Mrs Magriplis all fell into the red zone

171. It was plain that the improvement in blood pressure after the administration of fluids at 8.00am had only been temporary. When Mr Treacy reviewed Mrs Magriplis at 12.30pm she had deteriorated further.
172. However Mr Treacy continued to persist with providing more fluids. He did however indicate that if that was not successful she would need to be taken to the Royal Darwin Hospital and wrote “fast please” as an indication that she may need to go back to theatre.
173. However by that time she was in a critical condition, not only was her blood pressure failing once more but her respiratory function was failing. In the Royal Darwin Hospital a Code Blue would have been called (for the second time). A Code Blue was not called at any time. Dr Harbison did make a call to ICU and the Registrar was sent over to review Mrs Magriplis.

Attending to other patients during 28 May 2015 while Mrs Magriplis deteriorated

174. On the first occasion Mrs Magriplis’ blood pressure fell into the red zone Mr Treacy attended. It is not known for how long. But he then went to operating theatre leaving Mrs Magriplis in the care of a nurse with no specific training for HDU or ICU.
175. The nurse was able to call Dr Harbison and she said he provided her with good support. However that is significantly different than a Rapid Response Team or the care that Mrs Magriplis would have received in ICU should a Code Blue have been called.

176. On the second occasion that Mrs Magriplis' blood pressure dropped she was clearly very unwell and deteriorating and yet again, Mr Treacy was content to leave her with the nurse.
177. This is not a case of a single error or even a series of errors. The whole care and treatment of Mrs Magriplis appears flawed from the beginning and at each significant step thereafter.

Darwin Private Hospital

178. The Darwin Private Hospital provided their formal response to the Coronial Brief of evidence at 4.50pm on Friday 3 March 2017. The inquest began the following Monday. That was in the context of the General Manager of Darwin Private Hospital being advised of the inquest on 25 August 2016. On 2 February 2017 lawyers for the Darwin Private Hospital requested a copy of the coronial brief.
179. The response provided on 3 March 2017 was a statutory declaration by the General Manager of the Darwin Private Hospital, Dr Joanne Seiler. She indicated that throughout her career she has held positions as an academic, Clinical Nurse Manager, Director of Operations and Director of Nursing. She said she has been involved in the management of Hospitals and Health Services for over twenty years and had a doctorate in Business Administration.³⁴
180. Paragraph 4 of her declaration was in these terms:

“DPH is one of the forty eight (48) hospitals operated by Healthscope Limited (Healthscope). Healthscope is committed to the provision of optimal private health care for residents of Darwin and the Northern Territory. Healthscope prides itself on patient centred care. We strongly support transparent public reporting of healthcare quality data, and inquiry into the treatment and management of individual patients.”

181. Paragraph 28 stated:

³⁴ Paragraphs 1 & 2, Statutory Declaration dated 3 March 2017

“DPH is committed to providing the highest quality of care to patients. To achieve this reviews are conducted of all sentinel events, requirements for escalation of care to another facility and mortality by a Patient Care Review Committee.”

Sentinel Event

182. Attached to the declaration were 27 annexures. One of them, a Healthscope Policy titled, “Incident Management-Patient”. In that Policy “sentinel event” was defined:

“Sentinel Event – An Event in which death or serious physical or psychological harm to a patient has occurred or may occur. An adverse outcome that has the potential for a medical malpractice claim and/or Coronial case.”

183. In that same Policy it was stated:

“Near Miss, Incident and Sentinel Event identification, notification, management, analysis and sharing of lessons learnt are an integral component of the Healthscope safety and quality and risk management program.”

184. Another Policy titled “Sentinel Event Management”. Under “Procedure” at point 6 of the Policy stated:

“A Root Cause Analysis (RCA) if applicable, or Critical Systems Review, is to be conducted in compliance with Healthscope Policy 2.02.”

185. A copy of Healthscope Policy 2.02 was not provided. However a diagram at page 9 of the Sentinel Event Management Policy noted that a “Riskman” entry went to the General Manager who directed the RCA or Critical Systems Review that was then fed into a shared learnings report and from there to the Risk Register.

186. On 16 January 2017 Counsel Assisting sent a letter to the General Manager of Darwin Private Hospital. It stated:

“Could you please provide a copy of all documentation (including letters, emails and reports):

1. Prepared due to the death of Irene Magriplis; and
2. Submitted to Healthscope head office in relation to her death.”

187. There was no response to that request. The General Manager was asked about that when giving evidence. She provided a ‘Riskman’ report and confirmed that was the only document fitting the request. There was no Root Cause Analysis. There was no Critical Systems Review.
188. I asked her why that was so when the policy clearly defined the deterioration and death of Mrs Magriplis as a sentinel event. She initially said it was because, “Mrs Magriplis did not die in the Darwin Private Hospital”.³⁵ When I pointed out that the place of death was not part of the definition, I was told it was because Healthscope did not classify the death of Mrs Magriplis as a sentinel event. Dr Seiler provided the following evidence:

“The risk man that we submitted is reviewed by Healthscope and it was not defined as a sentinel event”.

Q. I’m sorry, who does the defining?

A. The National Risk Quality Manager.

Q. And why does the National Risk Quality Manager do the defining?

A. It’s their job.”³⁶

189. It was disappointing that Healthscope was willing to allege that they conduct reviews into all sentinel events in the very case they did not.
190. As I have often said, the Coroner’s Court is not a court of perfection. Most people at some time fall into error. But having recognised the error it is important that it not be repeated. To ensure that, there must be a review performed seeking to understand why the systems permitted the errors and where improvements can be made.

³⁵ Transcript pp178,179

³⁶ Transcript p.179

191. As has been noted above, in this case there was not just one error. There were many. Some were specific to the Darwin Private Hospital. For instance, there was very little control over what was done by VMO's in the hospital, poor note keeping, apparent failure of communication between the doctors and nurse, failure to have an adequately resourced HDU and failure to have an adequate escalation policy.

Sub-optimal Care

192. However, Healthscope seemed unwilling to recognise any lack of care or error. The General Manager of Darwin Private Hospital insisted in her evidence that the treatment provided to Mrs Magriplis at the Darwin Private Hospital had been "optimal":

"Q. Do you believe that Ms Magriplis obtained optimal private health care from the Darwin Private Hospital?

A. In relation to the care that we provided Ms Magriplis in the time that she was with us we provided optimal care. It is unfortunate the result but the care that we provided I believe was optimal."³⁷

193. Similarly, when asked about the Darwin Private Hospital escalation policy of calling the doctor compared to the Royal Darwin Policy where a Code Blue would be called:

"Q. As a system, is the Darwin Private Hospital system less robust than the Royal Darwin Hospital system?

A. I don't know the Royal Darwin system that well, so I can't compare. I can say that within our hospital this is the policy that we have and we followed it on this particular day.

Q. Do you think ...that if a Code Blue had been called it would have been more optimal private health care than simply calling the VMO and the anaesthetist?

A. I can't – I can't comment on that."³⁸

³⁷ Transcript p.175

³⁸ Transcript p.187

194. Eventually there was some concession from Dr Seiler. When asked about the pain levels of Mrs Magriplis, the poor note keeping by the doctors and nurses, the apparent poor communication levels between the doctors and nurses and the poor state of the Fluid Balance Sheet she agreed that was sub-optimal and in the case of the latter probably lead to sub-optimal care.³⁹

Royal Darwin Hospital

195. Dr Charles Pain the Executive Director Medical Services, Clinical Governance and Health Systems Improvement for the Top End Health Service provided a statutory declaration dated 27 February 2017. In contrast to the Darwin Private Hospital he acknowledged that a review should have been undertaken and provided information as to the lessons that might be learned.
196. I thank Dr Pain for his thoughtful and helpful evidence. He stated in his conclusions:

“One of the key lessons from the sad case of Mrs Magriplis is that we must improve the capability of our joint systems for recognising and responding to deteriorating patients at RDH and DPH.”

System Improvement

197. In his last statutory declaration signed on 6 March 2017, Mr Treacy provided the following as improvements that he said had occurred in his practice since the death of Mrs Magriplis:

- a. He has enhanced existing and developed new lines of communication and collaboration with local and interstate colleagues;
- b. He has been involved in the recruitment of another Hepato-Biliary Surgeon to Darwin;
- c. He shares rooms with the new surgeon and speaks with him daily;

³⁹ Transcript p.190-193

- d. He has arranged for the visit to Darwin of a Gastroenterologist that specialises in Endoscopic Ultrasound to upskill and educate Mr Treacy and hospital staff;
- e. A new pathologist now works in Darwin with whom Mr Treacy can discuss cases.”

198. Mr Treacy also outlined system changes at the Royal Darwin Hospital. He said they were:

- “a. The general surgery units had been rearranged so that there is a dedicated Hepato-Biliary and Gastro-Intestinal unit;
- b. The unit conducts weekly ward rounds of the public and private hospitals. At the end of the ward round all complex cases are reviewed and all surgical events reviewed at the Royal Darwin Hospital Surgery Morbidity and Mortality meetings;
- c. A complex case committee has been established in Royal Darwin Hospital at which complex cases can be reviewed and discussed.
- d. Surgical Credentialing services have been enhanced at the Royal Darwin Hospital;
- e. A co-ordinator of surgical audit services has been appointed at the Royal Darwin Hospital;
- f. A resident Gastroenterologist has been recruited;

199. Mr Treacy told me there had been changes at the Darwin Private Hospital. The import of what he stated was that there were new colour coded track and trigger systems where nurses understood the threshold and called a “code blue”. He also said that they now had a “second call” specialist list so that if one specialist is on leave, out of town or unavailable the other could be called.

200. In his conclusion, Mr Treacy stated:

“If I was presented with such a case now, I would have the benefit of, and would utilise, the availability of a local second opinion. I would be less reliant upon my own clinical findings, even if supported by pathology reports. I would discuss the case with the

pathologist and a colleague, and subject to those discussions would be more likely to proceed with endoscopic therapy.

Post surgery, with the benefit of the new systems, I would expect earlier identification of deterioration and its likely cause and call for specialist retrieval resources in response at an earlier time.”

201. There is some doubt whether those changes have occurred or are simply under consideration. For instance, under the heading of “DPH Response to the Death of Mrs Irene Magriplis” in Dr Seiler’s statutory declaration of 3 March 2017 there is an outline of the changes. They are:

- “a. Consideration of a ‘nominated VMO’. It is said, “this would require DPH VMO’s to nominate an alternate VMO to review their patients if they are unable to attend the DPH and physically review their patients”. That would appear to align to the “second call” specialist that Mr Treacy mentioned. However in this case it is said only to be under consideration.
- b. An updated escalation protocol. The protocol makes it clear that there is still no escalation to the Royal Darwin Hospital Rapid Response Team before a Code Blue is called and a Code Blue is only called for respiratory and cardiac arrests. In that regard nothing has changed since May 2015.”

202. It is therefore not possible from the evidence before me to determine what changes have been made and whether or not they are effective in strengthening the systems such that the circumstances of this case are unlikely to be repeated.

203. Pursuant to section 34 of the *Coroner’s Act*, I find as follows:

- (i) The identity of the deceased was Irene Magriplis born on 6 June 1939, in Kalymnos, Greece.
- (ii) The time of death was 11.30am on 30 May 2015. The place of death, Royal Darwin Hospital in the Northern Territory.
- (iii) The cause of death was septic complications following surgical resection of duodenal ampullary adenoma.

(iv) The particulars required to register the death:

1. The deceased was Irene Magriplis.
2. The deceased was of Greek descent.
3. The deceased was a pensioner at the time of her death.
4. The death was reported to the Coroner by Marina Diakogiannis, the daughter of the deceased.
5. The cause of death was confirmed by Forensic Pathologist, Dr John Rutherford.
6. The deceased's mother was Polimnia Skardasi and her father was Nickolaos Rigas.

204. Section 34(2) of the *Act* operates to extend my function as follows:

“A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated.”

Comment

205. There are times when using the more neutral terms of “error” or “a series of errors” are inadequate as a description. This is such a time. To do so has a propensity to disguise the scale of the inadequacies in the medical treatment of Mrs Magriplis.

206. Despite many of those inadequacies there should have been systems that prevented them having a fatal outcome. However, there were not:

- a. There was no multidisciplinary team at Darwin Private Hospital to assist in making a proper diagnosis and determining the most appropriate treatment.
- b. The surgery was high risk and Darwin Private Hospital allowed it without having adequate resources and systems to mitigate those risks.

c. The risks were heightened rather than mitigated because Darwin Private

Hospital did not have:

i. an adequate HDU; and

ii. an adequate escalation policy for deteriorating patients.

207. To learn from such failures Darwin Private Hospital and Healthscope must be willing to identify and admit failures and follow their own policies to review them and improve. In this inquest they have not demonstrated an ability or willingness to do that.

208. Other protective requirements, such as the provision of all material information to a patient so as to enable informed consent are enshrined in the law, the Code of Conduct for medical practitioners and the Guidelines of *National Health and Medical Research Council*. They were not followed by Mr Treacy. Likewise the requirements to provide support for obtaining a second opinion.

209. I may make recommendations and reports pursuant to section 35(2):

“(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.”

Referral

210. I **refer** these findings to the Medical Board of Australia.

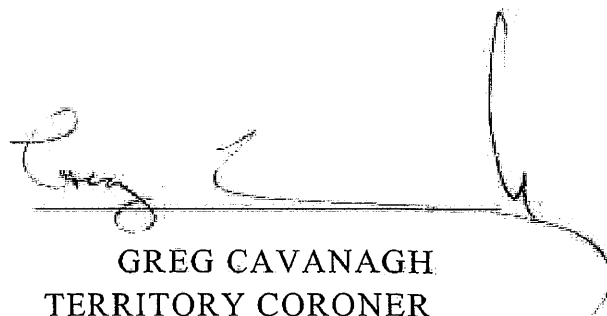
Recommendations

211. I **recommend** that Darwin Private Hospital not permit high risk surgery to be undertaken where it does not have the resources to mitigate those risks.

212. I **recommend** that Darwin Private Hospital implement an escalation system to provide a proper rapid team response when the rapid response criteria are met.

213. I **recommend** that should the Darwin Private Hospital continue to operate a High Dependency Unit that it be properly and appropriately resourced and in conformity with Standard 9 of the *National Standards on Safety and Quality in Health Care* and the Guidelines of the *College of Intensive Care Medicine of Australia and New Zealand*.
214. I **recommend** that the Department of Health and the Top End Health Service consider these findings and recommendations in their dealings with and licensing of the Darwin Private Hospital.

Dated this 30th day of March 2017



GREG CAVANAGH
TERRITORY CORONER



DEPARTMENT OF
HEALTH

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File Ref: DD2017/5823

The Hon Natasha Fyles MLA
Attorney-General
Minister for Justice
GPO Box 3146
DARWIN NT 0801

RECEIVED
25 AUG 2017
203/2462-NKF
MINISTER FYLES'
OFFICE

Dear Attorney-General

Re: Coronial Findings – Irene Magriplis [2017] NTLC 008

Section 46B (3) of the *Coroner's Act* requires the Department of Health to provide a written response to the Coroner's recommendations to enable the Attorney-General to table a report in the Legislative Assembly.

I provide you the following statement of action taken by Northern Territory Health and Darwin Private Hospital in the relation to the Findings in this matter.

Recommendation 214: Department of Health and the Top End Health Service consider these findings and recommendations in their dealings with and licensing of the Darwin Private Hospital.

Darwin Private Hospital licensing arrangements

Darwin Private Hospital (DPH) is currently licensed by the Department of Health (DOH) until 31 October 2017. An annual inspection must be performed prior to the issuing of a new licence.

The DOH Environmental Health Branch undertakes the annual inspection of DPH and prepares a report for the Chief Health Officer (CHO) prior to the issuing of a licence. The report details three Licensing Standards by which the inspection is undertaken:

Licensing Standard 1: the private hospital shall comply with all aspects of the *Private Hospitals Act* under the following criteria:

- licence to conduct a private hospital details are correct
- a register of patients in the approved form must be maintained which records specific patient details
- a register in the approved form must be maintained for scheduled substances
- a registered nurse must be on duty at all times
- the private hospital maintains a record of all births and deaths

Licensing Standard 2: the private hospital shall comply with other NT legislation, including but not limited to:

- *Medicines, Poisons and Therapeutic Goods Act 2012 and Regulations*
- *Food Act 2004*
- *Tobacco Control Act 2011*

- *Radiation Protection Act 2004*
- *Care and Protection of Children Act 2007*
- *Fire and Emergency Act 1996*

Licensing Standard 3: the private hospital is required to hold full accreditation against the National Safety and Quality Health Service Standards (the National Standards) and meets all mandatory criteria. The inspection undertaken by DOH Environment Health Branch authorised officers advises the CHO that the DPH holds accreditation. The licensing inspection does not set out to re-assess National Safety and Quality Health Service Standards.

The DPH is due for its 2017 licence inspection and review of the Licensing Standards, detailed above. Licensing inspection is scheduled for August 2017.

DPH accreditation against National Safety and Quality Health Service Standards (National Standards)
DPH is accredited against the National Standards until 28 January 2018. I have written to the Healthscope CEO on a number of occasions since the findings were handed down, seeking assurances that DPH meets the National Standards. On each occasion, Healthscope has confirmed this, and provided further information about the work being done in response to the findings.

Healthscope has brought forward the date of DPH assessment against the National Standards to the end of September 2017. This date is four months before the expiry of the current accreditation period.

New licence

DOH and Healthscope have agreed that, post satisfactory inspection, the new licence will be issued by the CHO for a period of six months until 30 April 2018. A new licence will then need to be issued. A six month licence period allows for a full consideration of DPH's compliance with the National Standards as identified at the September 2017 survey. This information will need to be considered by the CHO when determining the conditions to be placed on the issuing of a new licence.

In addition, Top End Health Service is in discussion with DPH about the Health Service's contract with DPH in response to the Findings.

In relation to the following recommendations, Dr Jo Seiler, General Manager, DPH has provided her response at Attachment A.

Recommendation 211: Darwin Private Hospital not permit high risk surgery to be undertaken where it does not have the resources to mitigate those risks.

Recommendation 212: Darwin Private Hospital implement an escalation system to provide a proper rapid team response when the rapid response criteria are met.

Recommendation 213: that should Darwin Private Hospital continue to operate at High Dependency Unit, that it be properly and appropriately resourced and in conformity with Standard 9 of the National Standards on Safety and Quality in Health Care and the Guidelines of the College of Intensive Care Medicine of Australia and New Zealand.

Yours sincerely



Professor Catherine Stoddart

23 August 2017

Attachment A – DPH response

Copy to: Mr Greg Shanahan, CEO, Department of Attorney-General and Justice

Dr Sara Watson
Director Clinical Quality and Patient Safety
Department of Health
Level 45 Health House
87 Mitchell Street
Darwin NT 0800
E: sara.watson@nt.gov.au

17 August 2017

Dear Dr Watson

RE: DARWIN PRIVATE HOSPITAL – CORONER’S FINDINGS FROM INQUEST INTO THE DEATH OF IRENE MAGRIPLIS

Thank you for the letter dated 11 August from Janet Anderson requesting that Darwin Private Hospital respond to the Department of Health a written response to the Coronial Findings from the inquest into the death of Irene Magriplis.

As a result of the findings Darwin Private has actively endeavored to meet the recommendations provided by the Coroner. Our response and the work to date are as follows:

211. That Darwin Private Hospital not permit high risk surgery to be undertaken where it does not have the resources to mitigate those risks.

The Chief Medical Officer for Healthscope, Dr Michael Coglin has liaised with the General Surgeons Australia and the Royal Australasian College of Surgeons. We are in the process of engaging two General Surgeons nominated by these professional bodies and review the surgical casemix at Darwin Private Hospital and report on the scope of general surgery undertaken at the Hospital and the ability of the Hospital to support surgery of this complexity. The surgeons nominated will be expert general surgeons with a practice largely grounded in hospitals comparable with DPH. The independence of these surgeons, their expertise and their recommendations will provide the Hospital with a comprehensive response to this recommendation by the Coroner. This work remains ongoing.

212. That Darwin Private Hospital implement an escalation system to provide a proper rapid response team when the rapid response criteria are met

Darwin Private Hospital has reviewed its current escalation system to manage patient deterioration. The revised escalation system is now aligned to that used by Royal Darwin Hospital. The following changes have now been put in place:

i. Observation Chart

The Adult Observation Chart now used at Darwin Private was adapted by the chart used at Royal Darwin Hospital; the clinical parameters for clinical deterioration are now consistent between both hospitals. Please see attachment 1a and 1b. Standard General Adult Observation Chart



ii. Hospital Escalation Protocol

In line with the track and trigger parameters in the observation chart the Darwin Private Hospital escalation protocol was reviewed accordingly. The triggers for escalation are now aligned with Royal Darwin Hospital. The actions for clinical review; rapid response and code blue have all been revised. Please see attachment 2. Adult Escalation Flow Chart

iii. RMO Escalation of Care Responsibilities

The introduction for an RMO Escalation of Care flow chart has been introduced in line with the Escalation Protocol. This flow chart outlines the role of the RMO in patient deterioration and their responsibility during a clinical review; rapid response and code blue. Please see attachment 3. Deteriorating Patient – RMO Flowchart

iv. Patient and Carer Escalation

Darwin Private has also reviewed the patient and carer escalation process. This process encourages both the patients, families and carers to participate in the escalation of care to our staff. Please see attachment 4. Patient and Carer Escalation.

v. Policy: Clinical Deterioration, Recognising and Responding to

Given the changes that have been implemented at Darwin Private a review of the policy for clinical deterioration and patient escalation was reviewed. The policy includes the escalation protocol, clinical criteria, response activation, review and audit process. Please see attachment 5. Policy 2.06 Clinical Deterioration, Recognising and Responding to.

Darwin Private Hospital has actively liaised with key stakeholders of Royal Darwin Hospital and internal Visiting Medical Specialists to ensure that the escalation system to manage patient deterioration is aligned between both Hospitals. This will ensure that the escalation protocol, clinical criteria, response activation, review and audit are consistent.

213. That should Darwin Private Hospital continue to operate a High Dependency Unit that it be properly and appropriately resourced and in conformity with Standard 9 of the NSQHS and the Guidelines of the College of Intensive Care Medicine of Australia and New Zealand

In April 2017 the High Dependency Unit was externally reviewed by the Director of Intensive Care and Nurse Unit Manager of Ashford Hospital, Adelaide. It was noted that the Unit provides an environment for closer nursing observation (ratios and training) with primary responsibility for the patient remaining with the admitting medical specialist. It is an area with physical environs, equipment and nurse staffing levels to enable greater nursing intervention and monitoring compared to the ward area. Therefore, the Unit functioned as a "Special Observation Unit" rather than a "High Dependency Unit". As such the Unit has been re-named as a Special Observation Unit (SOU). Therefore, policies and responsibilities have been redeveloped as part of this change. Please see the following:

Attachment 6: Policy 9.03 SOU-Referral, Admission and Discharge Process

Attachment 7: Policy 9.04 SOU-Unplanned transfer to

Attachment 8: RMO Ward Responsibilities

Attachment 9: RMO Position Description & Orientation

Attachment 10: Patient Information Special Observation Unit



214. That the Department of Health and the Top End Health Service consider these findings and recommendations in their dealings with licensing of Darwin Private Hospital.

This recommendation is not applicable to Darwin Private Hospital.

Darwin Private has actively reviewed its clinical systems for patient deterioration in line with the recommendations of the coroner. It will proactively continue to review and implement changes of best practice to ensure the highest quality and patient care is provided.

If you would like any more information please feel free to contact me.

Yours Sincerely,



Dr Jo Seiler
General Manager



08 8920 6011



08 8920 6008



Rocklands Drive
Tiwi, NT 0810



P.O. Box 42571
Casuarina, NT 0811



[illegible][illegible]

Name		Signature		Date		Remarks	
1	John Doe	John Doe	John Doe	10/10/10	10/10/10	10/10/10	10/10/10
2	Jane Smith	Jane Smith	Jane Smith	10/10/10	10/10/10	10/10/10	10/10/10
3	Bob Johnson	Bob Johnson	Bob Johnson	10/10/10	10/10/10	10/10/10	10/10/10
4	Alice Brown	Alice Brown	Alice Brown	10/10/10	10/10/10	10/10/10	10/10/10
5	Charlie White	Charlie White	Charlie White	10/10/10	10/10/10	10/10/10	10/10/10
6	Diana Green	Diana Green	Diana Green	10/10/10	10/10/10	10/10/10	10/10/10
7	Frank Black	Frank Black	Frank Black	10/10/10	10/10/10	10/10/10	10/10/10
8	Grace King	Grace King	Grace King	10/10/10	10/10/10	10/10/10	10/10/10
9	Henry Lee	Henry Lee	Henry Lee	10/10/10	10/10/10	10/10/10	10/10/10
10	Ivy Scott	Ivy Scott	Ivy Scott	10/10/10	10/10/10	10/10/10	10/10/10
11	Jack Adams	Jack Adams	Jack Adams	10/10/10	10/10/10	10/10/10	10/10/10
12	Karen Baker	Karen Baker	Karen Baker	10/10/10	10/10/10	10/10/10	10/10/10
13	Liam Clark	Liam Clark	Liam Clark	10/10/10	10/10/10	10/10/10	10/10/10
14	Mia Evans	Mia Evans	Mia Evans	10/10/10	10/10/10	10/10/10	10/10/10
15	Noah Foster	Noah Foster	Noah Foster	10/10/10	10/10/10	10/10/10	10/10/10
16	Olivia Gibson	Olivia Gibson	Olivia Gibson	10/10/10	10/10/10	10/10/10	10/10/10
17	Peter Hall	Peter Hall	Peter Hall	10/10/10	10/10/10	10/10/10	10/10/10
18	Quinn Harris	Quinn Harris	Quinn Harris	10/10/10	10/10/10	10/10/10	10/10/10
19	Rachel King	Rachel King	Rachel King	10/10/10	10/10/10	10/10/10	10/10/10
20	Samuel Lee	Samuel Lee	Samuel Lee	10/10/10	10/10/10	10/10/10	10/10/10
21	Tina Miller	Tina Miller	Tina Miller	10/10/10	10/10/10	10/10/10	10/10/10
22	Uma Moore	Uma Moore	Uma Moore	10/10/10	10/10/10	10/10/10	10/10/10
23	Victor Nelson	Victor Nelson	Victor Nelson	10/10/10	10/10/10	10/10/10	10/10/10
24	Wendy Ortiz	Wendy Ortiz	Wendy Ortiz	10/10/10	10/10/10	10/10/10	10/10/10
25	Xavier Perez	Xavier Perez	Xavier Perez	10/10/10	10/10/10	10/10/10	10/10/10
26	Yara Quinn	Yara Quinn	Yara Quinn	10/10/10	10/10/10	10/10/10	10/10/10
27	Zoe Reed	Zoe Reed	Zoe Reed	10/10/10	10/10/10	10/10/10	10/10/10
28	Adam Smith	Adam Smith	Adam Smith	10/10/10	10/10/10	10/10/10	10/10/10
29	Bella Taylor	Bella Taylor	Bella Taylor	10/10/10	10/10/10	10/10/10	10/10/10
30	Chris White	Chris White	Chris White	10/10/10	10/10/10	10/10/10	10/10/10
31	Diana Young	Diana Young	Diana Young	10/10/10	10/10/10	10/10/10	10/10/10
32	Frank Adams	Frank Adams	Frank Adams	10/10/10	10/10/10	10/10/10	10/10/10
33	Grace Baker	Grace Baker	Grace Baker	10/10/10	10/10/10	10/10/10	10/10/10
34	Henry Clark	Henry Clark	Henry Clark	10/10/10	10/10/10	10/10/10	10/10/10
35	Ivy Evans	Ivy Evans	Ivy Evans	10/10/10	10/10/10	10/10/10	10/10/10
36	Jack Foster	Jack Foster	Jack Foster	10/10/10	10/10/10	10/10/10	10/10/10
37	Karen Gibson	Karen Gibson	Karen Gibson	10/10/10	10/10/10	10/10/10	10/10/10
38	Liam Hall	Liam Hall	Liam Hall	10/10/10	10/10/10	10/10/10	10/10/10
39	Mia Harris	Mia Harris	Mia Harris	10/10/10	10/10/10	10/10/10	10/10/10
40	Noah King	Noah King	Noah King	10/10/10	10/10/10	10/10/10	10/10/10
41	Olivia Lee	Olivia Lee	Olivia Lee	10/10/10	10/10/10	10/10/10	10/10/10
42	Peter Miller	Peter Miller	Peter Miller	10/10/10	10/10/10	10/10/10	10/10/10

HOSPITAL ESCALATION PROTOCOL

Attach 2

One or more observations
fall within the yellow area
or staff concerned

One or more observations
fall within the red area
or staff, patient or carer
concern

All Cardiac and Respiratory
Arrests
One or more observations
fall within the purple area

CLINICAL REVIEW

RAPID RESPONSE

CODE BLUE

- Call & STATE to T/L & NUM/AHC:
"I need a CLINICAL REVIEW"
- Repeat & record observations within 60min use clinical review stickers in notes
- NUM/AHC & T/L to discuss with RMO in consultation with VMO

- Remain with patient and press Nurse Assist Button
- T/L/NUM to dial: 6333 (triggers response to RMO, DON/ACH) STATE "I need a RAPID RESPONSE on [Ward] / [Bed Number]"
- Emergency Response Data collection chart commenced
- T/L/NUM to call VMO immediately
- Repeat observations at least every 30 minutes
- Riskman

- Activate Code Blue Alarm (Alarm sounds throughout 1st floor of hospital)
- Dial 7*** and state "CODE BLUE - Darwin Private Hospital [Ward] / [Bed Number]"
- Stay with the patient
- Commence emergency management until RDH Code Blue Team arrives
- Emergency Response Data Collection Chart commenced
- Riskman

If patient continues to:
- deteriorate,
- clinical review has not been attended within 30 minutes or
- observations fall within the red area on the observation chart

Initiate Rapid Response as per criteria

If patient suffers Cardiac or Respiratory Arrest

If no review within 15mins
or the patient further deteriorates
or patient suffers a
Cardiac or Respiratory Arrest
Initiate Code Blue as per
DPH Code Blue Protocol

INDIVIDUAL ALTERATIONS TO RESPONSE CRITERIA CAN BE DOCUMENTED BY VMO ON OBSERVATION CHART OR IN MEDICAL RECORD

Darwin Private Hospital Resource

Section:	2. Clinical	Ref. No.:	2.24
Title:	Deteriorating Patient – RMO Flowchart	Issue Date:	Aug 2017
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DPH RMO Escalation of Care Responsibilities

- Review all patients in the Special Observation Unit - at least 3 times per shift.
- Discuss patient and concerns with the treating VMO and document events and outcomes clearly in the Medical Record after all reviews.
- Attend and assist the nursing staff in clinical emergencies and assist the RDH Code Blue team with Rapid Responses and Code Blue calls.
- Assist with transfers to and from DPH SOU, RDH CCU or RDH ICU
- Escalation Criteria responsibilities as outlined below for
CLINICAL REVIEW, RAPID RESPONSE AND CODE BLUE
- Make timely and clear documentation of the concerns, the discussion with the VMO, the treatment plan and outcome of treatment initiated in the medical record.

Clinical Review

- Observation within the yellow zone or if staff have concerns with a patient which do not fit the Clinical Review Criteria.
- The T/L, NUM or the AHC will contact the RMO and state "I need a clinical review on (Ward) / (Bed Number)
- The RMO must respond and review the patient within 30 minutes.
- Discuss the concerns and management with the NUM, TL or AHC in direct consultation with the VMO.
- A Clinical Review Sticker will be placed in the medical record when the RMO documents the incident:

Rapid Response

- Observation within the red zone or the staff have concerns with a patient which do not fit the Rapid Response Criteria.
- The primary nurse will activate the Nurse/AHC button in the patient room and stay with the patient.
- The T/L/NUM/AHC will dial **6333** and state "I need a Rapid Response on (Ward) / (Bed number)
- The T/L/NUM or AHC will contact the RMO and state "I need a Rapid Response on (Ward) / (Bed number) and will activate the VMO immediately.
- The RMO must respond as soon as possible and must respond within 5 minutes.
- If the RMO does not respond within 10 minutes or if the patient continues to deteriorate the T/L/NUM/AHC will initiate a CODE BLUE.
- The RMO will discuss the concerns with the VMO, the TL, NUM, DON or AHC and assist in the initiation of appropriate patient management.

Code Blue

- Observation within the purple zone or cardio-pulmonary arrest.
- The nursing staff will activate the emergency or "Code Blue" alarm in the patient room.
- The primary nurse will initiate appropriate emergency management.
- A call to **7***** will be made to activate the RDH "Code Blue" team.
- The alarm will sound throughout the entire floor of the hospital and the location of the code blue will be displayed on all monitors.
- The RMO MUST attend immediately along with the TL from each unit and the DON/AHC.
- The RMO will assess the situation and call the VMO immediately (if not already in attendance). The VMO must attend.
- The RMO will assist with management until the RDH "Code Blue" team arrives and continue assistance as required.
- The RMO will assist with retrieval to higher care if appropriate.



Patient & Carer Escalation

Are you worried...?

You are part of the care team!

Darwin Private Hospital encourages patients, families and carers to participate in patient care and we recognise you as a valuable member of the team.

1

Talk to a nurse or a doctor about your concerns

If you are not satisfied with the response

2

Talk to a nurse in charge of the shift

If you are not satisfied with the response

3

Contact the Director of Nursing 89206015 or After Hours Coordinator 89206021

If you are not satisfied with the response

ASSIST

If you and/or your carer believe that your medical condition has deteriorated and you need to see a Nurse and/or Doctor **URGENTLY**, press the **YELLOW ASSIST** button on the panel behind your bed.

Signs of deterioration may lead to serious adverse clinical events. Please alert our staff and assist them to detect changes you or others have noticed.

After all, no one knows you better than yourself, family and friends.

We rely on you, friends and loved ones to inform us if you are not feeling well or experiencing unusual pain or discomfort. Please **ALWAYS** tell a member of staff if you are feeling unwell or if you feel your condition has changed in any way.

Our staff support patient and carer involvement. You know how you feel and your loved ones know how you usually behave so if anything changes, we encourage you to raise your concerns with staff.



Manual:	Darwin Private Hospital Policy Manual	Ref. No.:	2.06 (Prev 9.05)
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Title:	Clinical Deterioration, Recognising and Responding to	Page:	1 of 10
HS Policy	Clinical Deterioration, Recognising and Responding to. 8.45		

PURPOSE

The Darwin Private Hospital addendum **MUST** be read in conjunction with the Corporate Healthscope Policy 8.45, Clinical Deterioration, Recognising and responding to

The purpose of this policy is to provide a standardised approach to escalating clinical deterioration aligning Darwin Private Hospital with Royal Darwin Hospital. This enables prompt and effective escalation to minimise the occurrence of adverse events such as cardiac arrest, unplanned intra hospital transfer to ICU and unexpected deaths.

SCOPE

This policy applies to all Registered Nurses, Enrolled Nurses, Resident Medical Officers (RMO) and Visiting Medical Officers (VMO) accredited to work at Darwin Private Hospital. It refers to all adult patients in acute and non-acute settings at DPH.

POLICY

The Darwin Private Hospital policy on Clinical Deterioration, recognising and responding to is:

- Care is patient centered and appropriate to the needs and wishes of the individual.
- Advanced Personal Plans and Medical Orders for Life Sustaining Treatment will be considered prior to escalation of care.
- A clinical review, rapid response or code blue can be initiated by either the patient, carer (PACE), nursing staff, RMO or VMO
- DPH's Escalation Protocol is in effect 24 hrs a day to respond to signs of clinical deterioration.
- Escalation criteria apply to all patient care areas at all times.
- DPH have access to appropriately qualified, skilled and experienced staff to allow escalation processes to be fulfilled.
- Primary responsibility for the care of the patient lies with the primary Visiting Medical Officer (VMO).
- Minimum observations are documented in the medical record and patient care plans.
- Any modifications to observations for patients is to be completed by the VMO on the Observation Chart.
- Handover processes Includes clear communication of monitoring plans and frequency of observations and further orders as directed by VMO.
- Communication between VMO, RMO and Nursing cannot be via mobile text messaging
- Communication tools approved by The Australian Commission of Safety and Quality in Health Care (ACSQHC) are used when communicating about a deteriorating patient. For DPH the communication tool used for all patients, at each line of communication is: ISOBAR.

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- The Medical Advisory Committee and High Level Executive committees of DPH and RDH receive feedback on the effectiveness and outcomes of the Escalation Systems which are in place and endorsed by DPH.
- Privacy principles are adhered to at all times.

DEFINITION

Trigger is a predetermined point where a routine measurement or observation will meet the criteria for activation of escalation protocols. Triggers may include but are not limited to:

- Vital Signs trigger as indication on observation charts
- Threatened airway
- Respiratory or Cardiac Arrest
- Chest Pain
- Worried/concerned
- Family/ Carer request
- Increased or unexplained confusion/ delirium
- Unexplained altered neurology/ loss of consciousness
- Seizure
- Decreased Sensation/ limb strength
- Uncontrolled pain
- Haemorrhage
- Persistent Oliguria
- Unexpectedly high wound drainage volume
- Unexpectedly high fluid Imbalance
- Expression of suicidal Ideation or suicide (attempted or successful)

Review (Clinical or Rapid Response) is classified at all times to be a physical assessment of the patient by the Senior Nurse, RMO and/or VMO.

PROCEDURE

Any modifications to observations for patients is to be completed by the VMO on the Observation Chart. If at any time the Primary Nurse feels they are not receiving the response required for their patient from either the T/L, AHC or RMO, they can subsequently contact the VMO directly using ISOBAR to communicate their concerns. This includes stating the type of response they are asking for.

1. Patient and Carer Escalation (PACE)

It is acknowledged by DPH that often the patient's carer or relative may notice a change in their loved one when visiting or the patient themselves are concerned over their condition.

Flyers educating patients and their relatives should be displayed behind each bed and in communal areas of the hospital explaining the Patient/ Carer/ Relative escalation process.

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PACE Steps

1. Talk to the nurse or doctor, if concerns not addressed
2. Talk to the NUM Jacana, if concerns not addressed
3. Contact the DoN or After Hours Coordinator

PRESS ASSIST Button if patient or carer believe that the medical condition has deteriorated and **URGENT** response is required.

2. CLINICAL REVIEW

Criteria:

- Triggered by any observation in a yellow area
- You are worried about the patient but they don't fit the criteria.

Action – Primary Nurse:

- The Team Leader and NUM/AHC of the shift to be informed, primary nurse to state **"I need a Clinical Review on [Ward] / [Bed Number]"**.
- Review the patient to ensure the following are managed appropriately
 - o O₂ requirements,
 - o pain,
 - o fever,
 - o fluids,
 - o blood loss
 - o distress.
- Repeat & Record Observations within 60 minutes.
- If patient continues to deteriorate or a clinical review has not occurred within 30 mins or observations fall within the red area on the observation chart – Initiate Rapid Response as per criteria.
- If the observations fall within the purple area on the observation chart – initiate Code Blue as per criteria.
- Clinical Review sticker to be placed in the patient notes as a prefix to documenting the event.

Action – Team Leader NUM/AHC

- Team Leader and NUM/ AHC to discuss with RMO in consultation with the VMO.

Action – RMO/VMO

- Must respond and review the patient within 30 minutes
- Discuss the concerns and management with the TL, NUM or AHC in direct consultation with the VMO.
- Document the following in the patient medical record at the time of review
 - o Concerns
 - o Treatment plan (with VMO consultation)
 - o Outcome of treatment

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3. RAPID RESPONSE

Criteria:

- Triggered by any observations that fall in the red area
- New or unrelenting chest pain
- New or unrelenting shortness of breath
- Increased or unexpected fluid or blood loss You are worried about the patient but they don't fit the criteria

Actions – Primary Nurse

- Remain with patient and press "Nurse Assist" button.
- Record Observations **AT LEAST** once every 30 mins on Emergency Response Data Collection (HMR 7) on side of resus trolley.
- Complete riskman at end of incident

Actions – TL/NUM

- The Team Leader/ NUM to dial: "6333" and state "I need a Rapid Response on [Ward] / [Bed Number]".
- The Team Leader/ NUM to call VMO immediately.
- The Team Leader/ NUM (or AHC after hours) to assess the patient if a delay in RMO attendance.
- If no review within 30min or the patient deteriorates further or patient suffers a cardiac/ respiratory arrest call a CODE BLUE as per protocol.

Actions – RMO/VMO

- RMO must respond and review the patient within 15 minutes
- Discuss the concerns and management with the TL, NUM or AHC in direct consultation with the VMO.
- Document the following in the patient medical record at the time of review
 - Concerns
 - Treatment plan (with VMO consultation)
 - Outcome of treatment
- VMO and NUM /AHC discussion to determine if SOU transfer is required – as per DPH Policy 9.04 SOU Unplanned transfer.

Actions SOU Patient – VMO

- If patient in Special Observation Unit, VMO must attend within 60 minutes
 - If unable to attend AND patient condition has not improved, a CODE BLUE will be called.

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4. CODE BLUE

Criteria:

- Triggered by an observation in the purple area
- Respiratory or Cardiac Arrest
- Airway threat
- Sudden fall in level of consciousness
- New drop in O2 saturations less than 90%
- Seizure – prolonged > than 5 minutes, or repeated
- You are worried about the patient but they don't fit the criteria
- A rapid response has been called but the patient has not been reviewed within the 30 min time frame.

Actions – Primary Nurse

- Activate CODE BLUE alarm (Red Button in patient rooms and nurses station)
- Commence resuscitation until RDH Code Blue Team arrives – DRABCD
- Record Observations **AT LEAST** once every 5mins on Emergency Response Data Collection Form (HMR 7) on side of resus trolley.
- Riskman incident report

Actions – First Responder

- Dial 7*** (initial response) to trigger the Code Blue Team from RDH and state "Code Blue; Darwin Private Hospital, [ward/room]"
- Notify VMO

Actions – DPH Code Blue Team Members (as listed below)

- Transport resus trolley to room
- Assist with resuscitation efforts
- Documentation
- Family support / contact NOK

Actions – RMO

- Immediately respond to Code Blue alarm
- Assess situation and contact VMO
- Assist in patient management until RDH Code Blue team arrives and as required.
- Assist patient transfer to higher care if required.
- Document the following in the patient medical record at the time of review
 - o Concerns
 - o Treatment plan (with VMO consultation)
 - o Outcome of treatment

Actions – VMO

- Immediately respond to Code Blue call
- Assist in patient management until RDH Code Blue team arrives and as required.
- Document the following in the patient medical record at the time of review
 - o Concerns
 - o Treatment plan
 - o Outcome of treatment

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5. INCIDENT CONTROL

In the event of a Code Blue, the VMO (or RMO) assumes control until the RDH Code Blue team arrives in all adult and paediatric responses.

DPH Code Blue attendance

- RDH Code Blue Team
- T/L each unit
- DON/AHC
- RMO - to phone VMO if not present.
- VMO
- Anaesthetist (as available)
- PSA – to act as runner

6. TRANSFER TO RDH

In circumstances where a patient undergoes an unplanned transfer to Royal Darwin Hospital due to clinical deterioration:

- The patient's NOK is to be notified as soon as possible
- The Director of Nursing is to be notified by phone
- A riskman entry is to be completed.
- The NUM of the unit where incident occurred will liaise with RDH daily about the patient's condition, diagnosis, treatment and outcome – this is to be entered into the riskman as a journal entry.
- If the patient is deceased post transfer:
 - I. Enquiries as to cause of death are to be made with the receiving hospital/ primary treating medical specialist.
 - II. A copy of the death certificate/ report to coroner is obtained from the receiving hospital where possible.
 - III. The death is to be classified as a sentinel event and a Critical Systems Review undertaken.
 - IV. The case is to be undertaken as a review by the hospital Morbidity and Mortality Committee.

7. RESUSCITATION TROLLEYS

- The resuscitation trolleys in the clinical areas have a standardised layout and equipment in alignment with RDH. This is to enable all staff from any area/ site, to access the contents of the trolley rapidly given all Code Blue events are multisite staffing.
 - See below for resuscitation trolley set-up
- It is essential that nil other equipment is added to minimise clutter of non-standard, essential items.
- Each ward is responsible for maintaining its resuscitation trolley and equipment, including AEDs.
- Equipment is not to be secured with rubber bands as this can damage the sterile integrity of the packaging.

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8. REPORTING AND MONITORING

- DPH utilises Clinical Review Stickers in patient notes.
- The Emergency Response Data Collection Form (HMR 7) is to be initiated when a Rapid Response or Code Blue is called. All observations and documentation are to be made on this form.
- Riskman is used for capturing and auditing all "Rapid Response" and "Code Blue" events. This enables identification of clinical variables which may affect outcomes and identify areas for improvement. It is an expectation that post any Rapid Response or Code Blue a Riskman is completed by the Primary Nurse or Team Leader. An outline of the Evaluation and Auditing process can be located in HSP policy 8.45 Clinical Deterioration, Recognising and Responding to document.
- All Rapid Response and Code Blue incidents are to be reviewed at the Clinical Deterioration Committee and tabled at the Patient Care Review Committee.
- Staff debrief to occur for all Code Blue calls

IDENTIFIED RISK (S) AND RISK ASSESSMENTS

Clinical deterioration is not recognized and responding in a appropriate manner placing the patient at risk of harm

High

Likelihood is possible with major consequences

KEY PERFORMANCE INDICATORS

Riskman reports reflect compliance with Darwin Private's Rapid Response Protocol.
 Medical Record Audits reflect accurate documentation and compliance to both policy

REFERENCES

HSP Policy 2.54 Suicide (Threatened, Attempted or Completed) of an Inpatient in a Non- Mental Health
 HSP Policy 8.18 Clinical Handover – Departmental and Intra-Unit
 HSP Policy 8.45 Clinical Deterioration, Recognising and Responding to document
 DPH Policy 9.04 - SOU, Unplanned Transfer To
 National Consensus Statement: Essential Elements for recognising and responding to Clinical Deterioration:
 Australian Commission on Safety and Quality in Health Care
 NT Government/ NT Health: Rapid Response Team RDH Procedure
 NT Government MR070.01 Adult (> 12 years) Observation Chart

Author: Project Officer, HDU Review

REVIEW HISTORY

Date	Reviewed by	Event – ie new policy, minor revision, major changes
Sept 2014		New policy
Aug 2017	DON	Policy updated to new template, renumbered, re-named and moved to Clinical, updated as per External review recommendations

REVIEW / CONSULTATION

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General Manager	Director of Nursing	Quality Manager
VMO		

	Consequence				
Likelihood	Insignificant	Minor (2)	Moderate (3)	Major (4)	Catastrophic
Almost certain	Medium	High	Extreme	Extreme	Extreme
Likely (4)	Medium	Medium	High	Extreme	Extreme
Possible (3)	Low	Medium	Medium	High	Extreme
Unlikely (2)	Low	Low	Medium	Medium	High
Rare (1)	Low	Low	Low	Medium	Medium

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Resuscitation Trolley Set-up - Adult

Top of Trolley

Disposable Adult size resuscitator bag attached to O2 tubing (in sealed bag)
 Oxygen tubing x 2 with tubing connector
 Masks – 1 of each size 3, 4, 5, and 6
 HME filter (Airway Filter)
 Oral airway 1 of each sizes 70mm, 80mm, 90mm, and 100mm
 Scissors/ Neuro torch/ Sticky tape dispenser
 Sharps Container
 Protective eyewear x 4
 SAED Defibrillator with Adult Defibrillator pads x1

Drawer1 – Syringes

Syringes – 10 of each 20ml, 10ml, 5ml, 3ml
 Needles – 10 of each 18g, 19g, 23g, 21g, 25g
 ABG syringe x2
 Additive labels x6
 Alcohol Swabs x10
 0.9% Sodium chloride 10mls x 10

Drawer 2- IV Equipment

IV cannulas (Safety style) -6 each of 14g, 16g, 18g, 20g, 22g
 IV starter pack x2
 Gauze x2
 IV cannula loop extension x4
 Stoppers x 4 (blue cap)
 Three way tap x 1
 Micropore tape x1

Drawer 3 – Drugs

Adult resuscitation Drug pack supplied by Pharmacy containing:

- Adrenaline 1:10,000 x 3 ampules
- Glucose 50% 50ml x1
- Calcium gluconate 10ml x 5

Drawer 4 – Airway Equipment

Y suction catheters – 2 x10g, 2 x 12g, 2 x 14g
 Yanker Sucker x 1
 O2 face mask x1
 Oxygen Nipple (connector) and oxygen tubing
 NRBM O2 mask x1

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Resuscitation Trolley Set-up - Adult

<u>Drawer 5 – Equipment</u>	<u>Side of Trolley</u>
0.9% Sodium chloride 1000mls x2	Procedure gloves – variety of sizes
IV giving sets x2	Stethoscope x 1
Incontinent sheets (blueys) x2	Clipboard with Emergency Response Data
IV pressure bag (1000ml)	Collection Forms/debrief sheets
Spare resuscitator x 1	Tourniquet x2
Spare defibrillator pads x 2	ARC ALS flowchart and BLS flowcharts (Resource 2.83)
Spare defibrillation battery x1	Oxygen cylinder
	Portable suction device with tubing
	IV pole

Checking the Resuscitation Trolley

Sign and date checklist

Daily

Top of resus trolley
 AED
 Oxygen and Suction
 Security Tag
 Documented use by dates

Monthly and after Tag broken

As per daily checks
 Each draw - complete check

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Manual:	Darwin Private Hospital Policy Manual	Ref. No.:	9.03
Section:	Special Observation Unit (SOU)	Issue Date:	Aug 2017
Title:	SOU – Referral, Admission and Discharge Process	Page:	1 of 6
HS Policy			

PURPOSE

This document informs staff on a standardised Referral, Admission and Discharge system for Darwin Private Hospital into their Special Observation Unit (SOU). This policy will ensure safe and appropriate admission and discharge into SOU in order to support patients with higher acuity needs and to minimise the occurrence of adverse clinical events through wrongful allocation of level of care.

SCOPE

This policy applies to all Registered Nurses, Enrolled Nurses, Resident Medical Officers (RMO) and Visiting Medical Officers (VMO) accredited to work at Darwin Private Hospital.

POLICY

Darwin Private Hospital's policy on Referral, Admission and Discharge into SOU is:

- **All SOU admissions must be referred and accepted by a VMO**
- **All patients must have comprehensive treatment plans and goals documented.**
- **All planned admissions must be pre-booked with the Jacana NUM and notated on webPAS .**
- **For the provision of higher level observation, treatment and monitoring of medical and surgical patients**
- **Exclusion criteria for SOU includes but is not limited to**
 - Patient has an active NFR form, unless reversible cause identified.
 - Greater than one organ system compromised.
 - Patient requires ventilation support or is likely to require ventilator support.
 - Haemodynamically unstable.
 - GCS<9 or unknown cause for rapid CNS deterioration.
 - Infective patient that requires negative pressure isolation.
 - Acute Myocardial Infarction or acute compromised arrhythmia.
 - Status Epilepticus.
 - Patients requiring Inotropic support
- **Unplanned admissions with multi-organ involvement and unstable are not suitable for SOU and MUST be transferred to RDH ICU.**
- **Post-operative observations will include ½ hourly for 4 hours, then hourly unless otherwise documented by the VMO.**
- **Clinical handover is to be given using ISOBAR between all medical and nursing staff throughout the management, transfer or discharge of the patient. This includes a full check of any invasive lines, drains, medications and documentation.**
- **Communication between VMO, RMO and Nursing cannot be via mobile text messaging**
- **Staffing will be 1:2 nurse patient ratio**
- **The SOU Registered Nurse has been orientated to the SOU, provided an SOU orientation booklet and completed the SOU competencies.**
- **The secondary nurse can be an Enrolled nurse working under direct supervision of the primary nurse and has completed the SOU competencies and orientation to the SOU.**

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Ref. No.: 9.03
Issue Date: Aug 2017

Title: SOU – Referral, Admission and Discharge Process
 HS Policy

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- Safety checks will be conducted at each shift change / new admission and will include checking alarm parameters. ALL settings outside the standard parameters must be documented by the VMO.
- Monitoring equipment alarms are not to be turned off and immediate review of the patient and monitoring equipment to occur prior to PAUSING any alarms.
- Strict Fluid Balance is to be documented with any abnormalities of excess, or insufficient fluid loss to be immediately reported to the VMO.
- Patients will be reviewed twice daily by the VMO
- If the patient is being treated by multiple specialists, the primary VMO must document the order of communication/escalation to enable the RMO and Nursing staff to escalate appropriately.
- All patients in SOU will have a documented review by the Jacana NUM/TL each shift.
- In the absence of the VMO, the RMO is to be notified of any patient concerns, escalation processes or to review treatment orders, pathology and radiology. The RMO is to handover any abnormalities or concerns to the VMO.
- The SOU is not to be used as ward overflow, nor is the SOU nurse to be allocated patients on the ward.
- All efforts are to be made to ensure privacy and dignity of the SOU patient is upheld.
- NOK to be notified if an unplanned admission into SOU occurs.
- Prior to transfer to the ward, a final documented assessment is to occur including vital signs.
- Patients should be admitted into SOU for no more than 48 hours. If their condition is not improving the VMO MUST review and consider potential transfer to higher level care.
- The decision to discharge a patient from SOU lies with the VMO.
- All patients discharged home directly from SOU will have an electronic discharge summary completed.

DEFINITION / BACKGROUND

Requirement for SOU is predominately by acuity as opposed to being for specific conditions. These patients require a higher level of observation, treatment, monitoring, frequent interventions and/ or therapies not available or suitable for the medical or surgical ward.

Typical conditions / problems which are appropriate for SOU care and exclusion criteria are listed below. This is not an exhaustive list and is intended as a guide only. Ultimately the appropriateness should be determined by the VMO assessment, in discussion with the AHC and NUM.

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PROCEDURE

1. PLANNED SURGICAL REFERRAL PROCEDURE

- At the time of booking the elective patient, the requirement for admission to SOU is to be indicated by the VMO on their consent form or booking form.
- The admitting VMO shall maintain primary responsibility for the patient admitted into SOU at all times, however specialist VMO's may be involved in the patients care.
- If the patient is being treated by multiple specialists, the primary VMO must document the order of communication/escalation to enable RMO and Nursing staff to escalate appropriately.
- This information is to be entered on WebPAS and identified on the theatre list.
- The anaesthetist must review the patient prior to their surgical procedure and in consultation with the VMO identify any specific monitoring criteria, treatment plans, goals and/ or any modifications to the "between the flags" vital signs.
- The Jacana NUM should be made aware of the admission via email who will then confirm the admission booking and ensure appropriate staffing is organised.

2. UNPLANNED REFERRALS

- In the event of an unplanned admission, please refer to DPH Policy 9.04 SOU - unplanned transfer to.

ALL PATIENTS ADMITTED TO SOU ARE TO BE REVIEWED BY THE VMO TWICE DAILY

3. ADMISSION CRITERIA

CARDIAC

- Any new haemodynamically STABLE arrhythmia eg: RAF, SVT, BBB, Bradycardia, post PPM Insertion.
- Mild CCF (Killip Class II) without shock or requiring CPAP/BIPAP
- Moderately symptomatic hypotension without compromise +/- BP arterial monitoring.
- Moderately symptomatic hypertension requiring acute therapy and cardiac monitoring.
- Hypovolaemia requiring fluid resuscitation, without shock.
- Sepsis, without shock.

PULMONARY

- Haemodynamically stable patients requiring NRB or High Flow NP to maintain O2 saturations >90%.
- Acute asthma requiring interventions hourly.
- Allergic reaction with mild upper airway obstruction requiring oral or nebulised treatment only with mild-mod increased WOB.

NEURO

- Patients with a GCS >9 (acute deterioration) with nil other complications.

Authorised:	Jo Seiler	Authorised:	Pauline Amorim
Designation:	General Manager	Designation:	Director of Nursing
Signature:		Signature:	

Manual: Darwin Private Hospital Policy Manual
Section: Special Observation Unit (SOU)

Ref. No.: 9.03
Issue Date: Aug 2017

Title: SOU – Referral, Admission and Discharge Process
HS Policy

Page: 4 of 6

- Prolonged (>20min) frequent seizures requiring intervention (with a confirmed diagnosis).

OTHER

- Impaired renal/ electrolyte/ metabolic function requiring active treatment and monitoring due to risk of deterioration.

SURGICAL

- Post-surgery – haemodynamically stable, however requires fluid resuscitation (blood, colloid) post significant blood loss.
- Post-surgery – requires increased monitoring/ frequency of observations for first 24 hrs.
- Morbidly obese patients managed with narcotics (oral or PCA) post-surgery for first 24 hrs.
- Post-surgery patients with extreme uncontrolled pain.

4. EXCLUSION CRITERIA

- Patient has an active NFR form, unless reversible cause identified.
- Greater than one organ system compromised.
- Patient requires ventilation support or is likely to require ventilator support.
- Haemodynamically unstable.
- GCS<9 or unknown cause for rapid CNS deterioration.
- Infective patient that requires negative pressure isolation.
- Acute Myocardial Infarction or acute compromised arrhythmia.
- Status Epilepticus.
- Patients requiring inotropic support.

5. DISCHARGE CRITERIA

- The patient's physiologic status has stabilised and the need for increased monitoring is deemed no longer necessary by the VMO.
- The patient is suitable for admission onto the ward.
- The patient is suitable for discharge home.
- If the patient's physiological status is deemed by the VMO to have deteriorated and an active documented NFR order has been put in place after discussion with the patient and/ or their family.
- If a patient's physiological status declines and requires a higher level of care in a Critical Care Unit.

6. DISCHARGE PROCESS

- VMO to assess the patient prior to discharge.
- VMO to discuss discharge with SOU nurse, ward NUM/Team Leader or AHC for appropriate SOU to Ward transfer in terms of staffing and suitability. Patient to be included in this discussion
- Discharge to ward plan with reportable parameters documented, frequency of observations, drug chart completed, pathology/ radiology slips completed and 24 hrs of fluid orders charted by VMO (or RMO on behalf of the VMO).
- SOU nurse to complete a final assessment including vital signs. Ward nurse to complete this assessment alongside the SOU nurse with ISOBAR handover occurring, checking of all invasive lines and drains and documentation together prior to transfer.
- Ward to ward transfer form HMR 3.4

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Manual:	Darwin Private Hospital Policy Manual	Ref. No.:	9.03
Section:	Special Observation Unit (SOU)	Issue Date:	Aug 2017
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HS Policy			

- SOU nurse to aim to discharge patient out of SOU by 1000 to the ward, this includes preparing all administration/ documentation ready for the VMO when they come in to reassess their patient in the morning.
- Discharge patient details off webPAS and patient monitor.
- Check all patient administration is completed and filed.
- No discharges to occur overnight.
- Wipe down all monitor leads, BP cuffs and monitors.
- PCA pump returned to Recovery.
- Complete patient data collection sheet.

7. CLOSURE OF SOU BETWEEN DISCHARGES AND ADMISSIONS – RESPONSIBILITY OF RN ON DUTY

NURSING STAFF

- Notify Housekeeping staff of SOU closure.
- Check to see when next booked patient is due for admission.
- Handover resus checklist responsibility to Jacana NUM/TL
- Safety checks and restocking (don't over stock)
 - resus trolley
 - Administration draws and documentation.
 - IV/ pathology trolley.
 - IV pumps are plugged in for recharging and
 - Oxygen, suction and air vials behind beds to ensure functional.
 - Baskets behind beds
 - Nurse's station.
 - Check number of telemetry units in drawer against stock out, ensure all batteries are on charge.
 - PPE - gowns/ masks / gloves.
 - Transfer bag is appropriately stocked and ready for use.
- Handover to Jacana T/L when all aspects of SOU have been checked and stocked and SOU closed.

HOUSEKEEPING STAFF

- Check all bins emptied and bathroom clear of pans/ urinals and linen.
- Follow daily cleaning schedule for closed unit

IDENTIFIED RISK (S) AND RISK ASSESSMENTS

Management of the unwell patient could be at risk if the Special Observation Unit is not well managed.

Risk Rating: HIGH

Likelihood is possible and the consequence could be major

REFERENCES

Authorised:	Jo Seiler	Authorised:	Pauline Amorim
Designation:	General Manager	Designation:	Director of Nursing
Signature:		Signature:	

Manual:	Darwin Private Hospital Policy Manual	Ref. No.:	9.03
Section:	Special Observation Unit (SOU)	Issue Date:	Aug 2017
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HS Policy			

Review of Healthscope Darwin Private Hospital (DPH) High Dependency Unit (HDU) Gap analysis
 26/04/2016 – 27/04/2017

Guidelines for Admission to HDU: Starship Children's Hospital Paediatric Care Unit : printed of internet
 30 May (2017)

Admission to ACHA Critical Care Units Policy March 2017

NSW Government: Health South Eastern Sydney Local Health District: ICU/HDU Adult Admission
 Criteria (2012)

Australian Commission on Safety and Quality in Health Care's "National Safety and Quality Health
 Service (NSQHS) Standards" (2010)

Guidelines on Standards for Special Observations Units for Training in Intensive Care Medicine (2013)

Author: Project Officer, HDU Review

RELATED POLICIES

HSP Policy 2.48 Deaths, In- Hospital – Review of
 HSP Policy 2.50 Discharge of a Patient
 HSP policy 4.10 Mandatory Training
 HSP Policy 8.13 Advanced Life Support
 HSP policy 8.18 Clinical Handover – Departmental and Intra-Unit
 HSP Policy 8.42 Basic Life Support
 HSP policy 8.45 Clinical Deterioration, Recognising and Responding to

DPH Policy 9.04 SOU, Unplanned transfer to

REVIEW HISTORY

Date	Reviewed by	Event – ie new policy, minor revision, major changes
Aug 2017		New policy

REVIEW / CONSULTATION

General Manager	Director of Nursing	Quality Manager
-----------------	---------------------	-----------------

	Consequence				
Likelihood	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic
Almost certain	Medium	High	Extreme	Extreme	Extreme
Likely (4)	Medium	Medium	High	Extreme	Extreme
Possible (3)	Low	Medium	Medium	High	Extreme
Unlikely (2)	Low	Low	Medium	Medium	High
Rare (1)	Low	Low	Low	Medium	Medium

Authorised:	Jo Seller	Authorised:	Pauline Amorim
Designation:	General Manager	Designation:	Director of Nursing
Signature:		Signature:	

Manual: Darwin Private Hospital Policy Manual
Section: Special Observation Unit (SOU)

Ref. No.: 9.04 (prev 1.10)
Issue Date: Aug 2017
Page: 1 of 2

Title: SOU – Unplanned transfer to

PURPOSE

The purpose of this policy is to provide a standardized approach to the transfer of a patient to the Darwin Private Hospital (DPH) Special Observation Unit from any other department within the hospital to ensure the appropriate management of all patients within an appropriate timeframe.

SCOPE

This policy applies to all Registered Nurses, Enrolled Nurses, Allied Health Professionals and Visiting Medical Officers (VMO) accredited to work at Darwin Private Hospital. It applies to all patients in acute and non-acute settings and includes adults, adolescents and children

POLICY

Darwin Private Hospital's policy on unplanned transfer of a patient to the Special Observation Unit (SOU) is:

- The decision to transfer a patient to the SOU from any other department within the hospital rests with the admitting or treating VMO.
- The transferring ward will ensure the patient's next of kin (NOK) is kept informed of the change of condition, transfer, and expected treatment.
- The requirement for an SOU bed is communicated and coordinated through the DPH Access manager or the After Hours Coordinator (AHC).
- The DPH Access Manager or the AHC communicates the requirement for patient admission to the SOU to the Jacana Nurse Unit Manager (NUM) or the Team Leader of Jacana Ward.
- If the SOU is open and a bed is available, the Jacana NUM or Team Leader will relay the information to the HDU staff member who will prepare for the patient's admission.
- If an SOU bed is not available (4 patients currently in SOU) and none of the current patients have been cleared for transfer out of the unit, the DPH Access manager or AHC will inform the VMO and a suitable bed within the Royal Darwin Hospital Critical Care Unit may be sought.
- If the SOU is not open at the time, the Jacana NUM or Team Leader will immediately allocate the nominated SOU appropriate staff member on duty at the time on Jacana ward to open the SOU and prepare for the patient's admission.
- The NUM or Team Leader on Jacana ward will then re-allocate the Jacana ward patient load and liaise with the DPH Access Manager or the AHC on duty to replace the staff member if required.
- When patients accommodated within SOU have been cleared for transfer out of the unit by the admitting VMO, the transfer of that patient must be facilitated within a reasonable timeframe. No unreasonable delays should occur.
- Transfer of patients into and out of the SOU occurs in a coordinated and timely manner to ensure the clinical and physical safety of the patient.
- An SOU competent staff member will be rostered for all shifts on the Jacana Ward roster to ensure that the SOU can be opened if required at any time.

Authorised:	Jo Seiler	Authorised:	Pauline Amorim
Designation:	General Manager	Designation:	Director of Nursing
Signature:		Signature:	

Manual: Darwin Private Hospital Policy Manual
Section: Special Observation Unit (SOU)

Ref. No.: 9.04 (prev 1.10)
Issue Date: Aug 2017
Page: 2 of 2

Title: SOU – Unplanned transfer to

DEFINITION / BACKGROUND

The Darwin Private Hospital Special Observation Unit is a 4 bed facility located within the Jacana Ward consisting of 4 monitored beds, one of which is a private room. It has the capacity to provide care for both complicated and complex surgical and medical admissions and patients requiring cardiac monitoring.

PROCEDURE

- The admitting VMO will determine the requirement for patient admission to the DPH SOU.
- The admitting VMO will liaise with NUM Jacana, the Access manager or the After Hours Coordinator of the intention to admit the patient to the DPH SOU.
- The access manager or the after- hours coordinator will liaise with the Jacana Nurse Unit Manager or Team Leader who will facilitate the staffing required to provide appropriate patient care.
- The Nurse Unit Manager or the team leader on Jacana will notify the RMO of the impending admission.
- The patient will be accepted into the DPH SOU in an appropriate timeframe.
- The VMO will be contacted by the Jacana NUM or the staff allocated to the DPH SOU at the time and informed of the patients arrival.

IDENTIFIED RISK (S) AND RISK ASSESSMENTS

Poor management of the Special Observation Unit may result in increased risk of harm to the patient	Risk Rating: MEDIUM <i>Likelihood is possible and the possible consequence could be high</i>
-----------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------

KEY PERFORMANCE INDICATORS

RiskMan – patient incidents

REFERENCES

Author: Pauline Amorim, Director of Nursing

RELATED POLICIES

HSP 8.18 Clinical Handover – Departmental and Intra-Unit

HSP 8.45 Clinical Deterioration, Recognising and Responding to

REVIEW HISTORY

Date	Reviewed by	Event – ie new policy, minor revision, major changes
Dec 2016		New Policy
Aug 2017	QM	Policy name changed, moved to SOU section.

REVIEW / CONSULTATION

General Manager	Director of Nursing	Quality Manager
Hospital Access Manager	NUM Jacana	After Hours Coordinators

Authorised:	Jo Seiler	Authorised:	Pauline Amorim
Designation:	General Manager	Designation:	Director of Nursing
Signature:		Signature:	



Darwin
PRIVATE HOSPITAL

DPH RMO WARD RESPONSIBILITIES



RMO Clinical Responsibilities

Attach 8

As this rotation is through the Division of Medicine at RDH you are primarily responsible for, and the majority of your time will be spent with, the medical patients on behalf of the General Physicians and the Cardiologists.

The care of the surgical patients rests with the Specialist Surgeons at all times. You may be asked to assist with these patients in the event of problems or changes in patient condition but the ultimate responsibility sits with the Specialist Surgeon and consequently they must be notified in the first instance of any problems arising with their patients.

- Routine review of all SOU patients both medical and surgical at least three times per shift and review of DPH ward medical in-patients under the supervision of the admitting/treating Specialist Physician or Cardiologist.
- Clinical review of patients both medical and surgical, at the request of the VMO or the Team Leader of the wards and SOU as required.
- Discuss patients or any concerns with the treating Specialist, both Medical and Surgical, after review and document events, treatment plans and outcomes clearly and timely.
- Attending and assisting in clinical emergencies and assisting the DPH Nursing Staff and the RDH Resuscitation team when called. Assist with RDH retrieval to higher care if required.
- Admission of new medical patients under the supervision of the admitting Physician or Cardiologist and as time permits, admission of surgical patients admitted via RDH or VMO rooms under the supervision of the VMO. The DPH RMO is not responsible for the admission of elective patients admitted via the DPH operating theatre.
- Attend ward rounds with Specialist Physicians and Cardiologists daily. It is not the responsibility of the DPH RMO to attend surgical rounds with the Surgical Specialists but these rounds are seen as a learning opportunity to be taken when time and workload permits.
- Assist nursing staff with difficult cannulations as required. It is not the role of the DPH RMO to attend to all cannulations. The DPH nursing staff are encouraged to complete competency in cannulation and phlebotomy and these tasks are the responsibility of the nursing staff in the first instance. Other procedures such as male catheterization may be requested only in the event that a nurse who has gained competency in this procedure is not available.
- Ordering and follow up of pathology and radiology results as requested by the Specialists.

RMO Administrative Responsibilities

- Clear and timely documentation in medical record of routine reviews, clinical reviews, rapid responses and code blues as per RMO escalation of care flowchart.
- Transfer notes in the medical record and summary for patients requiring transfer to RDH ICU, HDU or CCU, or DPH SOU. Routine transfer summaries are considered the Specialists responsibility.
- Medication orders as requested by Specialist Physician or Surgeon. DPH uses a National Inpatient Medication Chart.

Exclusions

- The DPH RMOs are not expected to participate in Operating Theatre activity
- DPH RMOs are not required to review obstetric or paediatric patients except for assisting in medical emergencies.
- The DPH RMO is not required to become involved in the care of the RDH patients accommodated within the DPH wards (Bed Buys) except in the event of a medical emergency. These patients are RDH patients and are the responsibility of the admitting medical or surgical team.
- The DPH RMO is not required to do routing clerking of elective admissions.
- The DPH RMO is not required to complete routine discharge summaries.

Nursing Staff Responsibilities

- Notify the RMO by telephone when a patient has been admitted to the ward and needs to be admitted by the RMO. Please don't just write it on the whiteboard.
- Never write urgent things on the RMO Job whiteboard. Ring the RMO.
- Always let your team leader know that you are contacting the RMO and the reason for the call.
- Treat the RMO with respect at all times.



Darwin
PRIVATE HOSPITAL

RMO

POSITION DESCRIPTION & ORIENTATION

Aug 2017 / 1.10

RMO rotation from RDH to DPH was established in early 2010 via the Division of Medicine. *Attach 9*

In 2014, with expansion of DPH with HDC/CCU, there was a need to further expand the RMO cover provided within DPH to ensure 24 hour coverage of the wards seven days a week.

Four full time positions were established with the DPH based RMO working 12 hours shifts on a rotating roster. The DPH RMOs provide general medical cover for both medical and surgical patients admitted to DPH under the supervision of the admitting Specialist.

These positions provide a unique learning and training opportunity to work in the private sector and interact directly with DPH Specialists.

Hospital Overview

Darwin Private Hospital is a 108 bed facility consisting of:

Jacana Ward:

- 44 bed acute medical/surgical unit and includes the 4 beds allocated as the Special Observation Unit (SOU).
- Surgical admissions primarily elective post-operative.
- Medical admissions primarily via Consultants rooms or transferred from RDH.
- Cardiology admissions. Cardiac patients often transferred from RDH CCU for telemetry monitoring on the ward.

Key Personnel: Nurse Unit Manager
Clinical Nurse, Level 2

Special Observations Unit:

- 4 Beds consisting of a three bed room with an adjacent private room which sits within Jacana ward.
- Surgical admissions directly from Operating Theatre as a result of clinical deterioration in current in-patients from all units.
- Medical admissions from deteriorating current in-patients, directly from RDH and from VMO rooms.
- Cardiac patients requiring monitoring from DPH Cath Lab, VMO rooms, RDH CCU and other areas of RDH.

Key Personnel: Nurse Unit Manager

Corella

- 31 bed Sub-acute medical and Rehabilitation unit.
- Sub-acute medical admissions.
- Rehabilitation admissions primarily from Jacana Ward post general or orthopaedic surgery, post-acute medical illness and from RDH.

Key Personnel: Nurse Unit Manager
Clinical Nurse, Level 2

Jabiru

- 20 bed Obstetric and Gynaecology unit
- 4 Bed Paediatric Unit
- 6 bed Special Care Nursery Level 2B

Key Personnel: Jabiru Nurse Unit Manager, Paediatric Nurse Unit Manager, Birth Suite Nurse Unit Manager



Darwin
PRIVATE HOSPITAL

RMO

POSITION DESCRIPTION & ORIENTATION

General Manager: Dr Jo Seiler

Director of Nursing: Pauline Amorim

Facility Educator: Sally King

Term Supervisor: Dr Nadarajah Kangaharan

Clinical Responsibilities

As this rotation is through the Division of Medicine at RDH you are primarily responsible for, and the majority of your time will be spent with, the medical patients on behalf of the General Physicians and the Cardiologists. The care of the surgical patients rests with the Specialist Surgeons at all times. You may be asked to assist with these patients in the event of problems or changes in patient condition but the ultimate responsibility sits with the Specialist Surgeon and consequently they must be notified in the first instance of any problems arising with their patients.

- Routine review of all SOU patients both medical and surgical at least three times per shift and review of DPH ward medical in-patients under the supervision of the admitting/treating Specialist Physician or Cardiologist.
- Clinical review of patients both medical and surgical, at the request of the VMO or the Team Leader of the wards and SOU as required.
- Discuss patients or any concerns with the treating Specialist, both Medical and Surgical, after review and document events, treatment plans and outcomes clearly and timely.
- Attending and assisting in clinical emergencies and assisting the DPH Nursing Staff and the RDH Resuscitation team when called. Assist with RDH retrieval to higher care if required.
- Admission of new medical patients under the supervision of the admitting Physician or Cardiologist and as time permits, admission of surgical patients admitted via RDH or VMO rooms under the supervision of the VMO. The DPH RMO is not responsible for the admission of elective patients admitted via the DPH operating theatre.
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- Ordering and follow up of pathology and radiology results as requested by the Specialists.

Administrative Responsibilities

- Clear and timely documentation in medical record of routine reviews, clinical reviews, rapid responses and code blues as per RMO escalation of care flowchart.
- Transfer notes in the medical record and summary for patients requiring transfer to RDH ICU, HDU or CCU, or DPH SOU. Routine transfer summaries are considered the Specialists responsibility.
- Medication orders as requested by Specialist Physician or Surgeon. DPH uses a National Inpatient Medication Chart.



Darwin
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RMO

POSITION DESCRIPTION & ORIENTATION

Exclusions

- The DPH RMOs are not expected to participate in Operating Theatre activity
- DPH RMOs are not required to review obstetric or paediatric patients except for assisting in medical emergencies.
- The DPH RMO is not required to become involved in the care of the RDH patients accommodated within the DPH wards (Bed Buys) except in the event of a medical emergency. These patients are RDH patients and are the responsibility of the admitting medical or surgical team.
- The DPH RMO is not required to do routing clerking of elective admissions.
- The DPH RMO is not required to complete routine discharge summaries.

Lines of Responsibility

RMO (PGY 2/3)

1. DMS or Delegate RDH (i.e JMO coordinator RDH)
2. Medical Co-Director, Division of Medicine, RDH)
3. Director of Medical Services DPH
4. General Manager DPH
5. DPH Consultants/VMOs
6. Clinical /Term Supervisor

Lines of Communication

RMO

1. Specialist in charge of the patient concerned
2. Term/Clinical Supervisor
3. Medical Co-Director, Division of Medicine
4. DMS or delegate – JMO coordinator RDH
5. DMS – Darwin Private Hospital

RMO is encouraged to be involved in

1. JMO teaching sessions
2. Clinical handover meetings
3. Audits
4. Research Projects
5. Optional activities during time off which can include outreach clinics or specialist clinics

Educational Resources

1. Library
2. Textbooks
3. Journals and Division of Medicine Journal meeting
4. Formal teaching
5. RMO/Registrar tutorials
6. Division of Medicine grand rounds
7. Radiology meeting

Business Tools

1. Mobile phone
2. Computer
3. Allocated office space
4. Room with a sofa bed

Patient and Carer Escalation of Care

Darwin Private Hospital encourages patients, families and carers to participate in patient care and we recognise you as a valuable member of the team

If you are a family member are concerned

1. Talk to your nurse or doctor about your concerns

If you are not satisfied with the result

2. Talk to the Nurse Unit Manager for Jacana

If you are not satisfied with the result

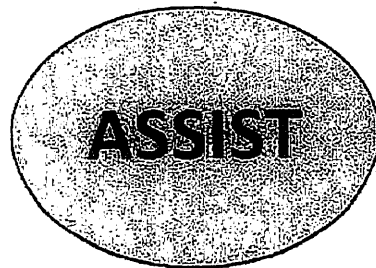
3. Contact the

Director of Nursing on 89206015 or
After Hours Coordinator on 89206021

If you and/or you carer believe that your medical condition has deteriorated and you need to see a

Nurse and/or Doctor URGENTLY

Press the YELLOW ASSIST button on the panel behind your bed



We endeavor to provide an excellent service at all times, but should you have any concerns please speak with the Nurse Unit Manager Jacana on 89206254.

If this does not resolve your concern, please contact the

Quality Manager on 89206040

Aug 2017 / 2.23

Attach 10



Darwin Private Hospital
Special Observation Unit



Patient Information

Special Observation Unit

Introduction

The Special Observation Unit (SOU) is a four bed unit located in Jacana Ward of Darwin Private Hospital. This information is provided for both planned and unplanned admissions into the unit.

The SOU has been established to care for patients who generally need a higher level of monitoring and management of their condition but are expected to improve with a short stay in SOU.

The Unit

Patients who require an higher level of monitoring are admitted to the Special Observation Unit. This may be a planned admission due to medical reasons or because of the type of surgery, or it may occur as an unexpected part of your admission.

The SOU is staffed by specialist nursing staff and a Resident Medical Officer (RMO), however your care will continue to be managed by your Specialist Doctor.

Contact Numbers

SOU—89206009

Jacana / SOU Nurse Unit Manager 89206254

After Hours Coordinator—89206021

Director of Nursing—89206015

Relatives and friends may want to check on a patient's progress. We are unable to discuss this over the phone other than to the recognised Next of Kin. It would be helpful if one person only telephones the unit for a daily update and informs others concerned.

If there is a change to a patient's condition, the next of kin will automatically be advised, unless otherwise requested.

Visiting the Unit

Only two visitors are able to visit each patient at any one time.

Visiting hours are generally

3—8 pm daily

We do make exceptions for newly admitted or unwell patients.

Please speak to a member of staff before entering the unit. You may have to wait a while before you are able to enter. You will be asked to clean your hands with gel or soap and water before entering and when leaving SOU.

Children under the age of 12 are generally not encouraged to visit, however allowances can be made. Children cannot be in the unit without an adult.

Please respect all patient's rights to privacy. Visitors are usually asked to wait outside the unit whilst nursing care, physiotherapy or medical examinations take place. We apologise if you are kept waiting for any periods of time.

Infection Prevention

We try to reduce the risk of infections being spread by ensuring all staff, patients and visitors clean their hands

- On entering the unit
- Before and after touching the patient, or patient equipment
- On leaving the unit

Personal Items

Space around each bed is limited, so please only bring personal toiletries with you.

Flowers are not permitted in the SOU due to limited space and increased risk of infection. Large volumes of water close to medical equipment is also an electrical safety risk.