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PO Box 745 Indooroopilly QLD 4068 AUSTRALIA
Ph 1300 662 173 or +61 7 3378 2668
Email stenography@pacifictranscription.com.au
Web www.pacifictranscription.com.au

MEDICO-LEGAL SOCIETY OF NSW INC.

SCIENTIFIC MEETING

WEDNESDAY, 8 JUNE 2016 AT 6.15 P.M.

THE TOPIC:
CLINICAL GOVERNANCE AND PATIENT SAFETY FOR NSW HEALTH SERVICES

SPEAKERS: DR MURRAY WRIGHT
MS DEANNE TADROS

QUESTION TIME

NEUROSURGEON: You have been talking about problems from the public health perspective. I have been in the private hospital system for 10 years in Australia and am about to retire. You have not addressed the problem in the private system. I have been looking at various problems from the private aspect. There is not very good clinical governance, there is no mandated reporting and it is all a club situation. If I have a problem, I have to tell a colleague. It is all hidden and it is not taken care of. All the clinical governance is only applicable in the public system. What measures has the government taken to effectively control the private system? I have just been doing medico-legal work on one neurosurgery person who made three identical disasters and so, are we only addressing the public hospitals, while the private hospitals are exempt from this kind of disciplinary action?

MS DEANNE TADROS: The Ministry has a private health branch. Basically all private hospitals are regulated by the Private Health Facilities Act and they are licensed through the Ministry's Private Health Care Unit . As part of the licence requirements they are obliged to follow some of the Ministry's policies. For instance, though they are not required to follow our incident management system, most private hospitals do have a similar system in terms of investigating complaints. The Act also provides for the Private Facilities to establish Root Cause Analysis teams.

DR MURRAY WRIGHT: I think you make a reasonable point but to back up what Deanne is saying, I think also the private hospitals do complete their own root cause analyses and so they are signed up to aspects of the incident management system.

I should have said in my presentation that the RCA process is currently under review. As it is covered by a statute, it is quite a large process to review it. Some of our concerns have been about the quality of the investigations, given the numbers of RCAs that we have done over time.

I think the RCA process is a very robust and very good methodology when it is done by people who are appropriately trained and also have the appropriate time. The reality is the RCA process is very time and labour intensive. I think it is fair to say that some of the private hospital cases

that I see - because we do see them – show private hospitals are still on a learning curve in terms of how best to use these processes.

I think the point from Deanne's presentation is that this is still a system in evolution and it is relatively recent days. After all, those critical incidents and the subsequent inquiries that we are talking about have only been in the last 15 years. I see it as a still maturing process with further improvement to come. The engagement of the private sector is an important part of it. They are subject to the complaints process and I would also add that they are subject to an accreditation process. Accreditation processes have a very significant dimension of quality and safety compliance. Private sector services are just as subject to that as are the public sector services.

DR JONATHAN PHILLIPS, PSYCHIATRY: Murray, is watering down the RCA going to lead to lower standards? My concern is that a system exists now which is probably robust in every sense but if you are going to water it down, what is the outcome?

DR MURRAY WRIGHT: Did I say watered down, Jonathan? I have a particular interest in this, because I worry that the quality and the learnings form RCAs in my part of the world relies on a relatively small number of highly skilled and highly experienced people. To do a good RCA takes three significant meetings, a review of every scrap of clinical evidence and a number of offline interviews. The good RCA investigators are very experienced clinicians and they do have other things that they need to be doing as well.

I was involved in the very first RCA in New South Wales and so have been on the whole journey. My concern is that in mental health we do about 180 RCAs a year. The problem with RCAs is that they are at their most valuable when you have real time data and information so that you can draw conclusions from reliable information. When you think about it, this has come from airline safety where they have black boxes and all sorts of recordings and other data sources.

We use RCAs to investigate community based suicides. These are tragic incidents and we can often learn really important things by investigating them - but not through the RCA methodology. You can learn as much with a well-chosen, single, external reviewer or investigator who can go to the heart of the matter in less time and with more reliability. What we do is put them into this cumbersome process where we do not have real time data and, clinicians being clinicians,

we want to try and understand what happens, so we often interpolate. Where we have gaps in information, we often try and interpolate what happened. So we can have gaps in information of up to a week between the last time a person was seen and when the tragic event happened. The reliability of the RCA process in those cases is doubtful. This demoralises the people who are doing the investigation, because they spend all this time locked into a process only to come up with wishy-washy findings. What happens then is they get investigation fatigue so that when the right kind of case crops up such as an in-patient suicide where I think an RCA methodology is perfect, the investigators may be overworked and jaded because of a number of other inconclusive RCAs they have been involved in.

My advice has been to be more targeted about where the RCA methodology is best and leave it to the discretion of the LHDs and their clinical governance units for the ones that fall outside that. They can still use the RCA process if they think it is going to be helpful, or they can use one of the other investigation methodologies. It is not RCA or nothing. It is giving some freedom and flexibility to the local clinical governance units to make a more thoughtful decision about what is the best way to get to the heart of this matter.

MS KEELY GRAHAM: I have a question to both or either of you. Which way do you see the system going to develop further and in particular I am interested in whether there is sufficient cooperation between the various bodies? The HCCC gets a whole lot of information from investigating complaints, but then there is the Ombudsman service the coroner's office, AHPRA and the various health departments. Are they sufficiently coordinated to see trends and information that is shared with the other bodies or is that one way it can be developed further?

DR MURRAY WRIGHT: One simple way in which I think we could do better is if we closed the information feedback loop. We require services to collect a lot of information which we react to and feedback on an ad hoc basis, because they have reached a critical level. If my service has a particular incident, then we get investigated or we have an investigation and we learn from it. However does the wider system learn from it? No, not reliably. Given the size of the New South Wales jurisdiction, we have a lot of information which I think is often not reliably available to the person who would learn from it. Because we are secularised into local health districts, when we have incidents happen within a particular part, even within a

particular hospital, which would be of value for other hospitals to know about, it is not reliably done.

I am working at the moment with the Clinical Excellence Commission to try and work out a way to distil the useful information from the high level incidents and feed it back into the system in a way that it will be read. There is no point in feeding back information which never gets looked at. It has to be done in a way that is going to be engaging for the decision makers. I see it is a huge opportunity given our population of 7.5 million and, trust me, there is rich material there from which people could really learn.

MS KEELY GRAHAM: Interstate as well?

DR MURRAY WRIGHT: New South Wales is a third of the country and I think if we get it done sufficiently well for New South Wales, we would be more than happy to share that. We do have avenues such as meetings at a national level where we do share that kind of information.

MS JO MONTGOMERY, formerly QUALITY AND SAFETY BRANCH OF NSW HEALTH, now at AVANT: I am wondering what systems are in place at the moment to recognise the impact of serious adverse events on clinicians and what role do the two governance units play in supporting the vulnerable clinician who has made the error?

DR MURRAY WRIGHT: Good question. Even without being investigated, anyone who has ever worked as a clinician knows how committed the vast majority of clinicians are to patient welfare and an adverse incident, particularly an unexpected adverse incident, is devastating. I have mentioned the devastation for the families and others but it is devastating for everyone. That is why how we frame and manage the necessary investigation is crucial, because people are already feeling terrible. If you go in with a frame that says something went wrong here and we are going to find out who did it, then you are not going to help that person.

My perspective is that I want our clinicians to operate at their best possible level at all times. I want people to be able to continue to learn and to develop. I have seen this very directly, and I want them to go into the next situation which remotely resembles the one where they have had a tragic outcome and not be terrified of making decisions. After all you can do as much harm by not making a decision as you can by making a bad decision. It is not just about their welfare, it is about their capacity to front up to work the next day and to operate effectively.

It might sound weak to say education is important, but I think it is being really careful about what a just culture and what a no blame approach really means. There are limits to that and there is accountability. There is a separate and different process of support of clinicians after a tragic incident and we try and separate them out from the people who are responsible and are for investigation. There is obviously an awareness of the need to offer support and welfare to individual clinicians and every district has an EAP program. We make that very clear, and we try and manage that in a transparent way. I think it still happens that it can be quite damaging to individuals to have an adverse incident and to develop the perception, rightly or wrongly, that in some way they are being blamed for what has happened. In my experience it is very rarely the case that you can pin blame or accountability on an individual. Obviously we get to see the ones where you do, but they are, in my view, quite a minority.

MR GARY CLUBB, works for an MDO: I just want to ask a question about the service check register in NSW Health which is state-wide and transcends the boundaries of the individual districts. We have occasionally seen doctors placed on that at an early stage of the investigation of complaints. I want to ask, given what you have said about just cultures and so on, whether that is not the ultimate punishment and a great discouragement for doctors to report?

MS DEANNE TADROS: The service check register has strict criteria about when you can be placed on it. Usually you will only be placed on the service check register after an investigation or if you decline to participate in the investigation and you then leave the area of service.

MR GARY CLUBB: Once you are on it, it is very hard to get off it.

MS DEANNE TADROS: We have recently amended the service check register policy to provide for a review after a period of time to get off the service check register. Also procedural fairness requirements allow practitioners to provide their reasons before we put them on the service check register. However it does come down to a public safety issue. There are not many people on the service check register and generally they have met a set of criteria to be placed on the register.

MS FRAN DAVIS, AVANT: In my experience they are put on the service check register as the first move. So what would we

do with a local health district who has put a practitioner on the service check register without any kind of investigation, without any kind of finding, what do we do?

MS DEANNE TADROS: The service check register policy outlines a procedure that you can follow if you are placed on the service check register and you would like to have a review of that decision. However without knowing the case where someone put a practitioner on the service check register without following the policy, all I can suggest is that you follow the policy in terms of the stages of the review.

MS FRAN DAVIS: It is not our policy.

MS DEANNE TADROS: No, I know. We did recently amend the policy. I am quite happy to go back and have the policy reviewed again if you have examples of people being placed on the service check register inappropriately.

MS KEELY GRAHAM: Before we go to the Queen's Club for dinner, will you join me in thanking two excellent speakers.

MEETING CONCLUDED