The Hon Ryan Park MP
Minister for Health
Minister for Regional Health
Minister for the Illawarra and the South Coast

NSW GOVERNMENT

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Our Ref: COR23/22

The Hon. Michael Daley, MP
Attorney General
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Coronial inquest into the death of Maureen Anne Smith

Dear Attorney General Michael.

I write in relation to the findings and recommendations made on 21 August 2023 by Deputy State Coroner Harriet Grahame in the inquest into the death of Maureen Anne Smith.

Ms Smith died on 1 April 2018 at Armidale Rural Referral Hospital from sepsis with the antecedent cause of septic arthritis. The Deputy State Coroner found there were systemic errors in the management of Ms Smith's condition which caused her transfer between hospitals to be delayed overnight. This had the cascading effect of delaying the commencement of antibiotic treatment and resulted in Ms Smith receiving sub-optimal care.

Magistrate Grahame made a total of 7 recommendations[1], with 6 directed to NSW Health organisations. Five recommendations are supported and alternate actions are being undertaken to meet the intent of one recommendation.

Recommendation 2

The Deputy State Coroner recommended:

To Glen Innes District Hospital, Hunter New England LHD:

An audit process of appropriate nursing records should be undertaken at Glen Innes District Hospital, including the use of Standard Audit General Observation charts, fluid charts, recording of hourly rounding and recording of observations, with a view to improving these matters to attain an acceptable standard if the result of that audit were to demonstrate system issues. Such audit should be conducted at least twice yearly, for a trial period of two years and the capacity to be ongoing, in order to identify trends.

Hunter New England LHD has undertaken sepsis and vital signs audits, and a staff knowledge survey regarding sepsis. Results are being used to develop an education plan, with targeted education being delivered by Clinical Nurse Educators, results to be reviewed by the sepsis working party. The sepsis working party was established in March 2023, local sepsis champions identified and Sepsis Care standard is under review. Further, a review of the Tablelands sector Executive on call after hours policy is being undertaken with all in charge registered nurses at Glen Innes Health Service.

[1] The Deputy State Coroner directed Recommendation 1 to the Medical Council of NSW.

Monthly audits are being undertaken in the Quality Audit Reporting System (QARS) to monitor clinical documentation including intravenous fluid, fluid balance, Standard Audit General Observation, and hourly rounding charts, and identified trends are acted on. Hunter New England LHD liaised with NSW Health Pathology to embed processes for critical results to be communicated to treating clinicians in a timely manner to reduce the risk of further deterioration. The system is in place with results being routinely received by the medical officer or registered nurse in charge.

Recommendation 3
The Deputy State Coroner recommended:

To Hunter New England LHD, NSW Ambulance and HealthShare NSW:

That communications between transport agencies in relation to a patient transfer should involve the treating doctor whenever possible, but especially in relation to any potential change to the medically agreed timeframe, to avoid incorrect information concerning the diagnosis or urgency being passed on second or third hand.

Involvement of a patient's treating doctor in communications between transport agencies, whenever possible, ensures a patient's treating team liaise directly with the appropriate transport provider and that the most current clinical information is communicated. This communication should include changes in a patient's condition which can impact the medically agreed timeframe.

HealthShare NSW is rolling out a No Electronic Booking System process that requires a patient's treating team to contact NSW Ambulance directly, should a transport booking need to be moved from HealthShare NSW Patient Transport Service to NSW Ambulance. This ensures up-to-date clinical information and requirements are communicated. The initiative has significantly reduced the number of transfers sent to NSW Ambulance by the Patient Transport Service.

The No Electronic Booking System initiative was implemented in Hunter New England LHD in August 2020. HealthShare NSW implemented the initiative in 3 further LHDs, and is negotiating with LHDs across NSW, with support by the Ministry of Health as required.

When NSW Ambulance Control Centres receive a call to book an ambulance transfer of a patient, the caller should be a clinician involved and/or have knowledge of the patient. If NSW Ambulance call takers are advised a caller is not a clinician or has no knowledge of the patient, efforts will be made to speak to or obtain contact details for an appropriate person. Further, NSW Ambulance notes the role of NSW Ambulance Virtual Clinical Care Centre clinicians in clinically reviewing timeframes that are provided to NSW Ambulance during the initial transfer booking.

Recommendation 4
The Deputy State Coroner recommended:

To Hunter New England LHD and HealthShare NSW:

That an inter-hospital booking for specialist treatment cannot be made with Patient Transport Services (via any method, whether directly or via Patient Flow Unit) unless a medically agreed timeframe has been agreed between the sending and receiving staff (by doctors unless unavailable) and recorded in the Patient Transport Services system.

Medically agreed timeframes for all inter hospital transfers for specialist care will ensure transport is facilitated by the most appropriate provider and considers patient acuity, clinical requirements, and time sensitivity. The Patient Flow Portal (PFP) is currently being updated to support the changes as part of the new Adult Critical and Specialist Care Inter Hospital Transfer Policy endorsed by the Deputy Secretary for System, Sustainability and Performance Division. The PFP changes are planned to be implemented across NSW Health in March/April 2024 and as part of these changes, medically agreed timeframes will

be captured for every inter hospital transfer booking. HealthShare NSW has advised however that significant changes are required to the non-emergency transport booking system to incorporate medically agreed timeframes that will be captured in the PFP.

Recommendation 5
The Deputy State Coroner recommended:

To Hunter New England LHD and HealthShare NSW:

That the Hunter New England LHD urgently consider and address the following issues as part of the pilot Medically Agreed Timeframe Project:

a. *provide a solution for obtaining a medically agreed timeframe where the three-way phone call between the Patient Flow Unit, the referring clinician and the accepting clinician is bypassed;*
b. *provide certainty that a "force function" can be implemented in the Patient Flow Portal (PFP) and the Patient Transport Services Computer Aided Dispatch when the booking does not come through the Patient Flow Portal;*
c. *provide a mechanism to enforce the Local Health District updating changes to the medically agreed timeframe in the booking system;*
d. *clarify the trigger for the proposed escalation pathway for notifying the Local Health District when Patient Transport Services does not have capacity to conduct a transfer including whether it is an automated or a human function;*
e. *clarify whether the proposed notification system leaves time for the patient transfer to be reallocated to another service in order to meet the original medically agreed timeframe; and*
f. *remove the time estimate pre-generated by the Patient Transport Services booking system as it risks confusing the medically agreed timeframe.*

Hunter New England LHD and HealthShare NSW are working together to address issues in relation to the pilot of the Medically Agreed Timeframe project to ensure patients receive the most appropriate means of transport and timely access to care. The Ministry of Health Operational Data Store team is currently implementing changes to the PFP to support the changes as part of the new Adult Critical and Specialist Care Inter Hospital Transfer Policy endorsed by the Deputy Secretary for System, Sustainability and Performance Division. These changes include the capture of medically agreed timeframes for inter hospital transfers.

The force function in the PFP will specifically relate to making it mandatory for a clinician to select a medically agreed timeframe when requesting an Inter Hospital Transfer and/or Inter Hospital Transfer with an associated PTS booking. Additional enhancements to the PFP can be made to support the PTS booking process which can be considered as part of the PTS Reservations Model Project, which Health Share NSW is implementing. HealthShare NSW is implementing a Health Patient Transport Reservations Model to support escalation pathways and notification systems to incorporate appropriate time for patient transfer to be reallocated if needed and removal of a pre-generated time estimate from the patient transport services booking system to reduce risk of confusion. The Health Patient Transport Reservations Model is supported by resources for LHDs. A pilot began in Hunter New England LHD in October 2023. Expansion of the model to other LHDs is planned for 2024.

Recommendation 6
The Deputy State Coroner recommended:

To Hunter New England LHD:

That the Patient Flow Unit should record telephone calls in order to further improve training and performance, including to assist with accurate audits of the number of patients transferred within the relevant medically agreed timeframe.

Hunter New England ICT and the Patient Flow Unit identified a suitable call recording system that would allow all calls to be recorded and available for timely retrieval to support education and training and audit of staff performance.

Hunter New England ICT is working with an external provider to develop a program with full call centre functionality that will be compatible with a Telstra based platform to allow call recording. The Patient Flow Unit will need to change to the Telstra based platform prior to introducing the new call recording system.

Recommendation 7
The Deputy State Coroner recommended:

To NSW Ambulance:

Consider undertaking an audit of outcomes from overflow transfer requests including:

a. *whether they were triaged through the Virtual Clinical Coordination Centre;*
b. *whether NSW Ambulance undertook the transfer within 24 hours or otherwise; and*
c. *whether (and the circumstances in which) the transfer request was sent back to Patient Transport Services.*

NSW Ambulance has carefully considered auditing of outcomes from overflow transfer requests.

NSW Ambulance advises that subsequent to the passing of Ms Smith, that the Virtual Clinical Coordination Centre (VCCC) was established. The VCCC has oversight of the interhospital transfer queue, including transfers that do not require an emergency response, such as those from HealthShare NSW Patient Transport Service, whether overflow or not. An experienced VCCC clinician consults with the referring facility with the aim of identifying any clinical risk and supports the NSW Ambulance Control Centre in making dispatch decisions. The VCCC provides real-time review of patient awaiting transfer to ensure safe and timely dispatch.

I trust that this response confirms NSW Health's commitment to a process of continuous improvement and delivering safe and high-quality care to all patients of the NSW health system.

For more information, please contact Joanne Edwards, Executive Director, System Management Branch, NSW Ministry of Health at moh-systemmanagementbranch@health.nsw.gov.au.

Yours sincerely

Ryan Park MP
Minister for Health
Minister for Regional Health
Minister for the Illawarra and the South Coast

CC: NSW Coroner's Court
Encl. Coroner's report – *Inquest into the death of Maureen Anne Smith*