Health Law Seminar
Improving patient outcomes
Clinical governance update
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Presented by:

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Recent Reports

- Australian Commission of Safety and Quality in Healthcare – Review of serious failures in reported test results for Prostate-Specific Antigen (PSA) testing of patients by SA Pathology – July 2016
- NSW Health – Bankstown-Lidcombe Hospital medical gases incident: final report prepared by the Chief Health Officer 26 August 2016
- Common themes and lessons learnt

Reported Test Results for PSA Testing by SA Pathology

- **March 2015** – SA Pathology started reporting PSA levels in patients at low levels
- **7 November 2015** – assay lots used by SA Pathology inaccurate in the range of 0.03 to 0.08 ug/L, with positive bias of 0.03 ug/L
- Usual number of undetectable PSA results decreased by 90%
- Number of patients showing detectable PSA following previously undetectable PSA increased from 49% to 89%

Reported Test Results for PSA Testing by SA Pathology

- Complaint from urologist end of **January 2016**
- Further telephone complaints made by clinicians and patients through February and March 2016
- **18 March 2016** SA Pathology writes to all urologists explaining the problem
- **March 2016** notice on SA Pathology website
- **4 April 2016** media exposure, then
- **April 2016** “look back” process commenced

Reported Test Results for PSA Testing by SA Pathology

Recommendations

- A formal apology to the patients
- New management structure, including clinical expertise to monitor and inform production of results
- Quality control procedures to meet national standards and regularly audited
- National accreditation for SA Pathology
- Implement enhanced risk management system, clinical staff to be trained in open disclosure

Bankstown-Lidcombe Hospital Medical Gas Incidents

- Incorrect gas administered to two neonates through neonatal resuscitaire in operating theatre 8
- Baby 1 born late **June 2016** – survived but unexpected poor outcome
- Baby 2 born **13 July 2016**, R.I.P
- **14 July 2016** paediatrician requested testing of gas outlets in theatre 8
- **21 July 2016** gas outlets tested – nitrous oxide emitted from O_2 outlet in theatre 8 neonatal resuscitaire

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Bankstown-Lidcombe Hospital Medical Gas Incidents

Background

- **2014** baby resuscitated, oxygen cylinder emptied
- Hospital installed piped oxygen to birthing unit
- Later decision made to install piped O_2 to neonatal resuscitaire in OT's
- **2 June 2015** approval to proceed
- **14** and **15 July 2015** installation performed, completed **16 July 2015**

Bankstown-Lidcombe Hospital Medical Gas Incidents - Response

- **13 July 2016** Coroner's referral and police investigation
- **21 July 2016** after gas outlet testing, theatre 8 closed. Rectification completed **18 August 2016**
- **22 July 2016** review of clinical notes of all births in theatre 8 completed
- **25 July 2016** commencement of testing all gas outlets across NSW Health facilities in NSW – completed **15 August 2016**
- **July 2016** RCA report into both incidents commissioned
- Independent expert report commissioned
- **26 August 2016** final report of CHO

Bankstown-Lidcombe Hospital Medical Gas Incidents

Bankstown-Lidcombe Hospital Medical Gas Incidents - Recommendations

- MOH review senior management role in clinical and corporate governance in commissioning clinical infrastructure at the hospital
- MOH promulgate a requirement for contractors to have a separation of the installer and the tester (this not currently required in Australian Standard)
- MOH write to Australian Standards to require separation of installer and tester, and clarify when anaesthetist should attend testing
- New clinical process for unexpected hypoxia - checking and changing gas supply and circuits

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Common Themes and Lessons Learned

- Mechanisms to escalate issues to senior management, staff trained on severity indicators
- Disharmony in culture can contribute to problems
- Involvement of multidisciplinary teams
- Monitor that activities performed are widely accepted as competent professional practice
- Avoid delay in dealing with an issue once raised to senior management

Common Themes and Lessons Learned

- Policies for adverse event reporting, investigation, RCA, look back and open disclosure
- Management accountability
- Use of technology to identify issues

Common Themes and Lessons Learned

Guideposts:

- Urgent investigation and response, use appropriately qualified external experts
- Notification to relevant external bodies without delay – e.g. TGA, ARPRA
- Notification to management and Board
- Implementation of policies and procedures to reduce the risk, and update as necessary
- Multidisciplinary team approach
- Media policy
- Open disclosure as relevant, including public apology as appropriate

If you would like any further information regarding this presentation, please contact:

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