



Analysis of The Inquiry held by the Health Services
Commissioner 2002, into
an Incident at The Royal Melbourne Hospital, Victoria.

October 2004

Case Study of The Inquiry into an Incident at The Royal Melbourne Hospital by the Health Services Commissioner.

Contents

INTRODUCTION	3
THE TIMETABLE OF EVENTS LEADING UP TO AND INCLUDING THE HSC INQUIRY	5
RECOMMENDATIONS	6
THE <i>HEALTH SERVICES (CONCILIATION AND REVIEW) ACT 1987</i> AND THE HEALTH SERVICES COMMISSION OF VICTORIA	7
ESTABLISHMENT OF THE INQUIRY	8
Terms of Reference	8
Establishment of a Team	8
Issues arising from within the Team	9
INQUIRY ISSUES	10
Communication	10
Media	10
Other interested parties	10
Hospital Staff	11
Independence and cooperation with other interested parties	11
Costs	12
Timeliness	12
Cooperation	12
Expert assistance	12
Terminology and general language	12
Gathering information	12
Audit	13
Disseminating material	13
Written submissions	13
ACKNOWLEDGEMENTS	13

INTRODUCTION

This analysis was prepared by Wendy Kimpton and describes the methodology and processes involved in conducting the Health Services Commission (HSC) Inquiry into the systems in place at the Royal Melbourne Hospital (RMH) after serious allegations involving some nursing staff became the subject of examinations by the Coroner and the Nurses Board of Victoria. It documents the background and management of a successful, speedy and cost efficient investigation and provides a “road map” which may be useful in assisting any relevant future inquiries into hospital-based incidents.

On 8 October 2001, RMH received an anonymous letter alleging, among other things, that two patients had died after having been given non-prescribed drugs by nurses in the Hospital's Neurology Unit. The two patients involved were a 63 year-old male who died on 27 February 2001, and an 89 year-old male who had been admitted on 31 May 2001 following a stroke at home, and who died on 28 August 2001.

In March 2002 the HSC was requested to conduct an Inquiry, by Victoria's Minister for Health, the Honourable John Thwaites, and to report to him within three months. The Draft Report of the Inquiry was completed at the end of June 2002, and drafts were provided to relevant stakeholders to meet the requirements of natural justice. The final report was presented to the Minister for Health in August 2002 and he released it to the public in the same month. The total cost of the Inquiry was \$55,000.

The HSC Inquiry Terms of Reference were systems and procedures oriented, although the final Term of Reference allowed for a broader investigation of unforeseen issues in the event that areas in need of improvement were identified.

The reputation of the HSC as an independent expert in conducting conciliatory complaints resolution assisted in developing an atmosphere from the outset that reduced fears of recrimination and blame. A pledge of full support from the RMH management and Board of Directors was important in promoting openness and honesty, negating the Commissioner's need to invoke her formal powers of investigation under the *Health Services (Conciliation and Review) Act 1987*. Melbourne Health and the Board of Directors also conducted their own inquiries, which came up with similar findings to those of the HSC.

Research into quality improvements in health settings indicates that “shaming and blaming” approaches do not promote quality changes. The promotion of quality is enhanced by open disclosure and a commitment to addressing systemic issues. The methodology of the Inquiry was informed by this reasoning and was designed to identify systems issues and to recommend ways of addressing them.

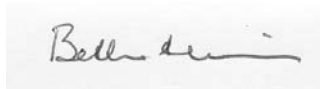
Good communication between the HSC and the other two independent examining bodies, the Coroner and the Nurses Board of Victoria, was established at the outset, and a system of joint consultation and communication assured clear demarcations were established, and maintained, to ensure minimal duplication between the respective inquiries.

The Commissioner communicated openly with the media, to keep RMH patients, their families, and the public informed throughout the Inquiry and following the release of The Report. The Commissioner made herself available for comment on radio and television, as well as being accessible to print media.

Subsequently Melbourne Health has reported to the Department of Human Services and the HSC on progress made by the Melbourne Health Improvement Plan (MHIP).

On 5 April 2004 Melbourne Health hosted a MHIP Day at which a panel of stakeholders, including the Health Services Commissioner, attended and a Stocktake Report was presented by Melbourne Health's Safety and Service Improvement Unit to present a review of progress against recommendations by independent external as well as internal stakeholders.

The Commissioner has concluded that significant progress has been made. She was particularly impressed by the enthusiasm and commitment to quality change demonstrated by Melbourne Health Staff and a visit to the Royal Melbourne Hospital confirmed significant progress has been made especially in the area of drug storage and control.

A handwritten signature in black ink, appearing to read "Beth Wilson", is centered within a light gray rectangular box.

Beth Wilson
Health Services Commissioner

THE TIMETABLE OF EVENTS LEADING UP TO AND INCLUDING THE HSC INQUIRY

19 March 2002 to 26 March 2002

Melbourne Health (MH) media release
Department of Human Services (DHS) inform HSC of media release
Reports appear in Victoria's newspapers, on radio and television
The Commissioner speaks to:

- ABC Radio
- The Board of RMH
- The Coroner
- Television and press

Informal discussions between DHS and HSC determine the Terms of Reference (TOR)
Minister appoints expert assistants
Minister recommends Investigative Consultant to assist HSC

27 March 2002

The HSC received a letter, dated 26 March 2002, from the Minister for Health, requesting formally an independent Inquiry be conducted, under section 9(l)(m) of the *Health Services (Conciliation and Review) Act 1987*, and to provide a report on the Inquiry by no later than 30 June 2002.

April 2002

Gathered information read
Alleged complaints listed
Meeting with RMH CEO and Board
Interview schedule developed and interviews arranged
Interview tools developed
Documentation audit developed
Documentation audit commenced
Review of documentation at Coroner's office
Meetings with Coroner
Preparation for Staff Seminar at RMH
Tour of RMH Neurology Unit
Meeting with ANF
Meeting with Drugs and Poisons Unit (DPU) of DHS

May 2002

Interviews continued
Documentation audit continued
Determination of benchmark standards from appropriate organisations

June 2002

Interviews completed
Documentation audit completed
Report written and disseminated to those subject to adverse comment

RECOMMENDATIONS

It is recommended that:

1. Terms of Reference need to be articulated with clarity and precision, yet also include provision for unexpected findings to be investigated and reported.
2. Terms of Reference need to be drawn up jointly in consultation between the Commissioner and the Minister's office to ensure they are attainable yet flexible and they should be included in the Minister's formal request for an Inquiry. This will allow the Inquiry to begin immediately.
3. Expert advisers need to assess carefully the commitment required to complete an Inquiry. Included in such an assessment will need to be time commitment and increasing demands as the inquiry progresses, including the likelihood of the necessity to write up those parts of the report which fall under their area of expertise. There may also be the possibility of additional time being required once the Final Draft is completed and feedback is received from stakeholders.
4. An assessment of the combined skills of the Team needs to be made prior to commencement to ensure all aspects of an inquiry can be completed by the Team members, and that the load of each can be shared. All team members need to have the necessary skills for the writing up of a report. The expert advisers and Commissioner require ample time to determine recommendations when time pressures are at their greatest.
5. At the outset of an Inquiry careful negotiations are important to ensure all Team members understand what is required of them in terms of time and work commitment.
6. Open, honest and cooperative communication between members of the Inquiry Team is essential to ensure tensions are minimised as the pressure to complete within the timeframe increases.
7. It would be ideal to alert all professional, interested parties to a forthcoming Inquiry prior to it reaching the press.
8. Where possible, it is beneficial to obtain copies of all relevant documents prior to initial media interviews.
9. It is essential that lines of communication with other interested parties are established as quickly as possible to ensure cooperation.
10. Meeting interested parties in their places of work and informing them of the proposed course of action ameliorates anxiety and promotes trust while also establishing the authority of the HSC.
11. Hospital staff need to be informed of the purpose, method and proposed reporting of the Inquiry and have the opportunity to meet with the Inquiry Team.
12. The united stance of the Inquiry Team and the hospital ensures that staff understand that quality improvements, and not blame, are sought.
13. Access to the Inquiry Team should be freely available to all hospital staff.

14. Dialogue with those conducting separate investigations is important to ensure the correct balance between independence and cooperation.
15. A balance needs to be struck between informality and compliance with the legislation and TOR to ensure openness and a quest for quality improvement rather than apportioning blame.
16. To comply with the rules of natural justice it is necessary to supply copies of the final draft report to anyone who is the subject of adverse comment.
17. It is important to determine at the outset of the Inquiry the form of evidence to be included, for example, whether written submissions will be received.
18. Interested parties on the periphery of an Inquiry may be in a position to offer unexpected but highly useful information and should be encouraged to become involved.

THE HEALTH SERVICES (CONCILIATION AND REVIEW) ACT 1987 AND THE HEALTH SERVICES COMMISSION OF VICTORIA

The *Health Services (Conciliation and Review) Act 1987* was established to ensure complaints arising from the provision of health services within Victoria, would be dealt with in a conciliatory manner by an independent body, the Health Services Commission. The current Commissioner, appointed on 1 May 1997, is a lawyer with experience in alternative dispute resolution and administrative law. The Commissioner places strong emphasis on a conciliatory approach to complaints resolution and quality improvements. This has been well received by service providers, service users and consumers. Consequently, the HSC has a cooperative and cordial relationship with all twelve of Victoria's registration boards and the Commission has become involved in quality health initiatives and policy development at state, national and international levels.

Victoria's *Health Services (Conciliation and Review) Act 1987* also makes provision for the HSC to investigate matters referred by the Minister. The legislative framework, the Commission's reputation for successful conciliation and accessibility within the community and the full cooperation of RMH meant there was no need to invoke formal powers or to be unduly legalistic. This saved time, expenses associated with legal challenges and allowed for a comprehensive, yet efficient and cost effective Inquiry. Subsequent quality improvements at RMH demonstrate that this approach was successful. In addition many other hospitals have used the recommendations of the Inquiry to audit and improve their own services.

ESTABLISHMENT OF THE INQUIRY

The legislative basis for the Inquiry provided structure and authority as well as providing protection and confidentiality. It was also important to ensure that the correct balance was struck to ensure undue technicalities did not interfere with the progress of the Inquiry.

Terms of Reference

1. Terms of Reference need to be articulated with clarity and precision, yet also include provision for unexpected findings to be investigated and reported.

The Terms of Reference were included in the Minister's formal request for an Inquiry to the Commissioner, and had been jointly drawn up and agreed upon earlier by the DHS in consultation with the Commissioner. MH management was kept informed about this. This allowed the Inquiry to begin immediately in the knowledge that the Terms of Reference were realistic yet flexible.

"The Terms of Reference are to inquire into the following matters concerning the operation of the RMH campus:
medications management, including drug stock control, administration and documentation;
incident reporting systems, particularly relating to concerns identified by any staff;
standards of documentation related to patient care;
nursing management oversight of clinical practice at ward level;
systems for staff support;
other opportunities for improvement identified during the course of the review."

2. Terms of Reference need to be drawn up in consultation between the Commissioner and the Minister's office to ensure they are attainable yet flexible and they should be included in the Minister's formal request for an Inquiry. This allows the Inquiry to begin immediately.

Establishment of a Team

Following the Minister's formal request to the Commissioner negotiations were conducted between HSC and the Department of Human Services (DHS) concerning resources. It was agreed that the Department would provide funding of \$55,000 to HSC, which would cover, inter alia, the costs of an Investigative Consultant and that DHS would negotiate separately with the two independent expert advisers. It is important for all Inquiry Team members to be advised as accurately as possible of time and work commitments required of them to allow them to set more appropriate fees given the significant amount of work they performed including extensive assistance with writing the final report. The independent advisers negotiated their fees with DHS independently. Defining their expected roles accurately would have allowed them to set appropriate fees to the DHS.

Issues pertinent to the nursing profession were expected to provide the main focus of the Inquiry. An experienced Registered Nurse with extensive knowledge and understanding of nursing issues was recommended by the DHS, as the Investigative Consultant. The appointment of a nurse with strong communication skills to this position was vital to ensure a free and frank exchange of relevant information. It saved an enormous amount of time and ensured that all those who provided information were treated respectfully and could feel "safe" without fear of recrimination.

The role of the investigative consultant was determined by the Inquiry Team and was:
to conduct interviews relevant to the Terms of Reference,
record and transcribe interviews, review procedures and protocols,
write a report of the investigation to allow the drafting of recommendations by the Commissioner and her advisers.

The two expert advisers were a medical practitioner/lawyer who held the position of Chair at a large medical institution while also working at a large law firm; and a Professor of Nursing, whose work on professional ethics, nursing and health care ethics, professional conduct, and the professional and legal status of nursing, is respected nationally and internationally.

Issues arising from within the Team

3. Expert advisers need to assess carefully the commitment required to complete the Inquiry. Included in such an assessment will need to be time commitment and increasing demands as the inquiry progresses, including the likelihood of the necessity to write up those parts of the report which fall under their area of expertise. There may also be the possibility of additional time being required once the Final Draft is completed and feedback is received from stakeholders.

4. An assessment of the combined skills of the Team needs to be made prior to commencement to ensure all aspects of the Inquiry can be completed by the Team members, and that the load of each can be shared. All Team members need to have the necessary skills for the writing up a report. The expert advisers and Commissioner require ample time to determine recommendations when time pressures are at their greatest.

5. At the outset of an Inquiry, careful negotiations are important to ensure all Team members understand what is required of them in terms of time and work commitment.

6. Open, honest and cooperative communication between members of the Inquiry Team is essential to ensure tensions are minimised as the pressure to complete within the timeframe increases.

INQUIRY ISSUES

Communication

Media

7. It would be ideal to alert all professional, interested parties to a forthcoming Inquiry prior to it reaching the press.

8. Where possible, it is beneficial to obtain copies of all relevant documents prior to initial media interviews.

The Commissioner was obliged to balance carefully the need to be open, and accessible to the media, without disseminating information causing unnecessary anxiety to the public. This can be difficult to control as it will not usually be possible to warn all relevant people prior to a press release by another organisation. In the case of the RMH situation the Hospital CEO issued a press release on 19 March 2002. The Commissioner was advised this would happen the previous night and obtained a copy, but it was not possible to obtain copies of all relevant documents, for example, RMH's Investigator's Report, prior to speaking to the media the following morning.

The media has an important role to play in bringing issues to the attention of the public. Their motivations will differ from those of the Commissioner, Government and those who are the subject of the Inquiry. Openness is essential to gain public trust but there will be pitfalls. An example of this can be seen in the following dialogue:

Herald-Sun Reporter: "Will you be recommending that all nurses be subject to random drug and alcohol testing?"

Commissioner: "I won't be in a position to know what I will be recommending until I have conducted the Inquiry."

Herald-Sun Reporter: "Well, would you be prepared to consider it?"

Commissioner: "I'll consider all submissions put to me."

This appeared as a page one story under the headline: "Nurses may be drug tested."

Other interested parties

9. It is essential that lines of communication with other interested parties are established as quickly as possible to ensure cooperation.

10. Meeting interested parties in their places of work and informing them of the proposed course of action ameliorates anxiety and promotes trust while also establishing the authority of the HSC.

On the day following the press release by the RMH, the Commissioner met with the CEO and Board of Directors at the Hospital, and separately with the Coroner and members of the Homicide Squad in the Coroner's offices. The Inquiry Team also visited the Neurology Unit in April and was given a tour by the Unit's Director. The HSC's reputation for placing a high priority on quality improvements in a non-adversarial manner was tested and reinforced at a time when there was loud public outcry, and one of Melbourne's largest public hospitals was facing severe accusations. By explaining her proposed course of action to all, levels of anger and anxiety subsided minimising the likelihood of legal challenges and the need to invoke formal powers of investigation.

Hospital Staff

11. Hospital staff need to be informed of the purpose, method and proposed reporting of an Inquiry and have the opportunity to meet with the Inquiry Team to allay fears.

The HSC Team decided to interview as many staff as possible from RMH and conducted a seminar that was chaired by the RMH CEO. All speakers emphasised that the Hospital and Board were giving full cooperation, and that staff could feel free to give information, confident that the Inquiry sought quality improvement, not blame. Telephone and email accessed information were provided, and seminar notes were posted on the Hospital intranet for staff unable to attend.

12. The united stance of the Inquiry Team and the Hospital ensured staff understood that quality improvement, and not blame, was the objective.

13. Access to the inquiry team was freely available to hospital staff.

Independence and cooperation with other interested parties

14. Dialogue with those conducting separate investigations is important to ensure the correct balance between independence and cooperation.

The allegations at the centre of the HSC Inquiry led to five separate examinations being conducted. These were:

- The HSC Inquiry
- MH's Internal Review
- MH's Board of Operations Review
- The Coroner's Inquiry
- The NBV investigation

The HSC Inquiry investigated organisational structures and systems. The HSC Team and the CEO of MH met as infrequently as possible on the understanding that should issues of urgency arise, they would be immediately addressed. RMH arranged for an administrator to be available as a contact person for HSC. He assisted in the coordination and management of large numbers of one to one and group interviews. Interviews were conducted during the day and on the night shift. Themes and issues determined independently, overlapped in each of these final reports, and acted as a method of confirming findings.

The other two examinations by the Coroner/Police and the NBV had different foci, and it was important to avoid overlap by good communication. Each was expected to take much longer than either the HSC or MH investigations, and this proved to be the case. The findings of the Hospital, Board and HSC inquiries were very similar finding the same shortcomings and emphasising the need for urgent quality improvements in their recommendations.

Costs

Timeliness

The Minister determined that the Inquiry should take three months. The cooperation and communication of all relevant stakeholders, the other examining parties, and the exchange of progress reports, ensured the focus of each inquiry was maintained, and the desired outcome reached within the timeframe. The priority placed on maintaining adherence to the timeframe forced limitations on the Inquiry, which were acknowledged and outlined in the Final Report.

Cooperation

The Hospital's cooperation and consequent smooth facilitation of interviewing, minimised disruption to the Hospital's day to day functioning while streamlining the process for the HSC, and minimising the costs to both parties.

Expert assistance

Expert assistance was volunteered and accepted. The Manager, Drugs and Poisons Unit, DHS, provided advice about the *Drugs, Poisons and Controlled Substances Act 1981*, its history and implementation. The Society of Hospital Pharmacists of Australia (SHPA), Victorian Branch, assisted with drafting of recommendations relating to pharmacy issues.

Terminology and general language

Communication across a variety of professional fields in an area in which the general public have a desire and right to know what has occurred in a large publicly funded hospital, needs to be couched in terms comprehensible to all, with an absence of jargon. While the Inquiry was conducted under the terms of the *Act*, and subject to legislative powers, the Commissioner ensured that legalese and jargon had no place in either the day to day communication process or the final Report. This was reinforced by the Investigative Consultant's use of informal language when addressing interviewees.

<p>15.A balance needs to be struck between informality and compliance with the legislation and TOR to ensure openness and a quest for quality improvement rather than apportioning blame.</p>
--

Gathering information

Existing documentation was provided as requested in the early stages of the Inquiry. This included: Mission Statements; Nursing Philosophy and Objective Statements; Corporate and Nursing Standards such as Incident Management, Medication Management, Nursing Documentation and the Nurses Code of Ethics; Procedures; Position Descriptions; and Standard Forms such as Incident Forms. This documentation was scrutinised to determine its adequacy. It was equally important to determine what documentation was absent, and what was deemed to be inadequate. Documentation for standards, for example, was poorly represented and other policies were incomplete and/or out of date.

Audit

A method for auditing of documentation was drawn up by the Investigative Consultant. RMH documented standards and policies were audited. Access to some relevant patient files had to be made at the Coroner's office where they had been quarantined for examination by the Coroner. Time constraints limited auditing to a selection of files taken over a two-week period.

Disseminating material

16. To comply with the rules of natural justice it is necessary to supply copies of the final draft report to anyone who is the subject of adverse comment.

Prior to completing and disseminating the Final Report the HSC sent Draft copies to the Minister, the DHS, the RMH Board, the RMH CEO. This process meets the requirements of natural justice and can also result in helpful suggestions and avoid mistakes.

Written submissions

Written submissions were not encouraged because of limited time, although some were received, including one from the ANF. These were accepted and considered. Patients, their families and carers could not be invited to make submissions, again because of time constraints.

17. It is important to determine at the outset of the Inquiry the form of evidence to be included, for example, whether written submissions will be received.

The Melbourne Teaching Hospitals' Drug Usage Group offered assistance in formulating recommendations presented in the Final Report. Their expertise provided background information on the constraints upon pharmacists and their lack of control of drugs on the wards. By assisting the Commissioner, these groups were able to address concerns their members had identified by moving them into the public interest.

18. Interested parties on the periphery of an Inquiry may be in a position to offer unexpected but highly useful information and should be encouraged to become involved.

ACKNOWLEDGEMENTS

The Health Services Commissioner thanks the members of the Health Services Commission Inquiry Team for their dedication and support throughout the duration of the Inquiry. In particular she thanks the Investigative Consultant Lois Kennedy, and the two expert assistants Professor Megan-Jane Johnstone and Dr. Heather Wellington both of whom fulfilled tasks beyond the expectations of their initial agreement. The Commissioner also expresses appreciation to the CEO and staff of Melbourne Health, the Coroner and relevant members of the Victorian Police Homicide Squad, the Nurses Board of Victoria, and, the Australian Nursing Federation, for their cooperation and assistance in expediting the Inquiry. Her thanks also go to the Victorian Drug Usage Advisory Committee, the Melbourne Teaching Hospitals Drug Usage Group, and the Society of Hospital Pharmacists of Australia for their expert advice on the storage and administration of drugs in hospitals.