



ROYAL MELBOURNE HOSPITAL INQUIRY REPORT

August 2002

Report by the Health Services Commissioner to the Minister for Health,
the Hon. John Thwaites MP under Section 9(1)(m) of the Health
Services (Conciliation and Review) Act 1987

TABLE OF CONTENTS

1 EXECUTIVE SUMMARY.....	1
2 RECOMMENDATIONS.....	5
3 BACKGROUND TO THE INQUIRY	12
3.1 Introduction	12
3.2 Terms of Reference	12
3.3 The Inquiry Panel.....	12
3.4 Methodology	13
3.5 Limitations of the Inquiry	14
4 FRAMEWORK FOR THIS REPORT	16
5 CONTEXTUAL BACKGROUND	17
5.1 Structural Change Affecting RMH	17
5.2 Corporate Leadership	18
5.3 Nursing Leadership	19
5.4 Organisational Structure and Systems.....	20
5.5 Approaches to Health Care Safety and Quality.....	25
5.6 Clinical Relationships	30
6 MEDICATIONS MANAGEMENT, INCLUDING DRUG STOCK CONTROL, ADMINISTRATION AND DOCUMENTATION.....	31
6.1 Background	31
6.2 Medication Management.....	32
6.3 Medication Misuse.....	35
6.4 Medication Errors.....	37
7 INCIDENT REPORTING SYSTEMS, PARTICULARLY RELATING TO CONCERNS IDENTIFIED BY ANY STAFF	38
7.1 Background	38
7.2 Adverse Events.....	39
7.3 Staff Complaints.....	41
7.4 Management of Incidents Involving Staff.....	42
7.5 Patient Complaints	42
7.6 Patient/Consumer Satisfaction	44
8 STANDARDS OF DOCUMENTATION RELATED TO PATIENT CARE.....	45
8.1 Background	45
8.2 Documentation Audit	45
9 NURSING MANAGEMENT AND OVERSEEING OF CLINICAL PRACTICE AT WARD LEVEL	49
9.1 Background	49
9.2 Monitoring and Evaluating Clinical Practice	50
9.3 Clinical Standards and Competencies	51
9.4 Nurse Unit Manager Supervisory Capacity.....	51
9.5 Nurse Staffing	53
9.6 Educational and Research Resources and Programs	54
9.7 Nursing Practice and Policy Development	55
9.8 Resolving Ethical Issues.....	56
10 SYSTEMS FOR STAFF SUPPORT	59
10.1 Introduction	59
10.2 Staff Support Services.....	60
10.3 Aggression Management.....	62
10.4 Communication	64
11 CONCLUSION	65
11.1 Appendix 1	66
11.2 References	67

1 EXECUTIVE SUMMARY

This Report presents the findings and recommendations of an Inquiry referred to the Health Services Commissioner (HSC) by the Minister for Health, The Hon. John Thwaites on 26 March 2002. The Inquiry followed serious allegations involving some nursing staff at the Royal Melbourne Hospital (RMH) that are the subject of investigation by the Coroner and Victoria Police.

The Inquiry was greatly assisted by Lois Kennedy who conducted most of the investigations, Dr Heather Wellington and Professor Megan-Jane Johnstone.

The HSC received full cooperation of the CEO, the Board of Directors, the management and staff of RMH and the Department of Human Services so it was not necessary to invoke formal powers.

The Inquiry was conducted to examine systems issues impacting on the quality of patient care at RMH. During the Inquiry nursing profession issues emerged as being particularly affected by management and infrastructure problems. Although the nursing profession is the main focus of this Report the issues have implications throughout RMH and for other comparable hospitals.

The Terms of Reference required HSC to investigate and advise on a range of specific issues relating to management and delivery of patient care at RMH (medications management, incident reporting systems, standards of documentation related to patient care, nursing management and overseeing of clinical practice at ward level, and systems for staff support). The HSC was also required to advise on other opportunities for improvement identified during the course of the Inquiry and to make recommendations to ensure quality improvements in systems and procedures in metropolitan health services and public hospitals in Victoria.

The methodology included structured individual and group interviews with management and staff, an audit of documentation in medical records, site visits and consultation with experts. Limitations on the Inquiry included the short time frame of three months, lack of industry benchmarks to enable comparisons to be made and lack of corporate memory because of many management and staff changes. Time did not allow interviews to be conducted with patients and their families or carers, nor for there to be a comprehensive call for written submissions.

Issues identified included inadequacy of past organisational structures, lack of continuity of senior management and changes in the professional role of nursing and their impact on the delivery of patient care.

Structural Changes Affecting RMH

In common with all metropolitan public hospitals RMH has experienced major structural changes since 1995. A review of the changes in the first half of 2000 found the networks had become too large, and there had been an undue emphasis on commercial viability at the expense of considerations such as the quality of patient care. A new structure was implemented in July 2000.

The Inquiry found the structural changes from 1995 until 2000 had an adverse impact on staff morale and standards. They coincided with complexities experienced by all metropolitan hospitals including the financial implications of scientific and technological changes, increased public scrutiny, increasing demands for services, long waiting lists, higher patient acuity and shorter length of stay, widespread nursing shortages and increasing use of casual staff.

Corporate Leadership

From 1995 until 2000 RMH experienced considerable leadership instability, which was the source of much critical comment by staff. Staff considered there to have been a lack of accountability, a failure to include staff in decision making, a lack of vision and too much focus on fiscal matters. This resulted in mistrust of management, poor staff morale and a drop in standards of care for patients. Staff also expressed more confidence in current leadership but positive results of new initiatives have still to filter throughout the organisation.

Nursing Leadership

Between 1995 and 2000 there were five Directors of Nursing with very heavy workloads. This intensified when nursing middle management positions were reduced dramatically. Nursing leadership was unable to make the necessary structural adjustments to provide adequate support and mentoring to the large nursing workforce. More recent changes have improved this situation as a new team, selected specifically to address these problems, has been established and positive initiatives have begun to be implemented. It is still too soon to assess how successful this has been but the Inquiry identified a genuine commitment on the part of the management team to re-establish structures to ensure staff are well supported to provide good patient care.

Organisational Structure and Systems

RMH organisational goals, values and mission have not been well articulated. Implementation of positive changes has begun in the last twelve months with the development of a fully integrated and systematic approach to patient care including the implementation of a consultative framework to achieve changes in staff development, research and education programmes, promotion of ethical behaviour, and patient focussed care and teamwork. A strategic plan has been completed and recently approved by the Board.

Standards, Policies and Procedures

RMH staff continue to feel the effects of past poor systems and consider current systems of monitoring and evaluation to be inadequate. New policies and procedures now exist but are not well understood beyond management level. RMH does not have a documented nursing philosophy or nursing objectives.

Corporate and Clinical Governance

Clinical governance is a relatively new concept in health care and the necessary structures and processes are still evolving at many hospitals. RMH is no exception and, until the new organisational structure was implemented early in 2002, clinical divisions were under resourced in terms of administrative and supervisory capacity. RMH has a range of quality programs in place but these are not well integrated.

Medications Management

In contemporary health care settings the potential for medication error or misuse is significant. In Australia medication errors are estimated to cost \$350 million each year. The Australian Council for Safety and Quality in Health Care has identified medication safety as a priority area and is progressing national strategies to address them.

The Inquiry was advised there had been a decline in the rigour of medication control at RMH which has recently begun to be addressed by management. Nursing policies and procedures relating to drug administration and control at RMH have been under review since mid 2001. Staff are currently working with a dual system of old and new policies which is causing confusion and needs to be addressed. Preceding the recent allegations of misconduct at RMH there was no Hospital-wide monitoring of compliance with medication policies and procedures, and there was confusion about responsibility for monitoring drugs and compliance with legislative requirements. The most appropriate position of responsibility for this role is the Director of Pharmacy.

Incident reporting

RMH has a Clinical Risk Management Committee, which would benefit from the inclusion of nurse clinicians. RMH has not established systems for collecting data on sentinel events and for undertaking limited adverse occurrence screening even though the Department of Human Services requires public hospitals to do so. Staff consider that many incidents, including serious ones, are not reported. There is a lack of consistency throughout RMH on what incidents should be reported. Staff receive little or no feedback about incident reports.

Complaints

In the recent past many staff decided there was little point in making complaints, as they were not listened to and their complaints were not acted on by management. Patient complaints are handled better as RMH has a full-time complaints liaison officer who is involved in training of staff as well as providing support for patients, their families and carers. She does not have adequate administrative support.

Standards of Documentation

Clear and accurate records of all aspects of patient care are important to ensure safety, quality and continuity of care. RMH is still in the process of establishing systems and processes to ensure accountability for medical records across all clinical areas. The Inquiry conducted a limited medical record audit which revealed poor standards of documentation. This needs to be addressed urgently.

Nursing Issues

There is currently a global shortage of nurses that is having a significant and negative effect on health care. RMH has not been immune from this and has been obliged to employ a high number of casual staff. More recently funding has been made available to increase the availability of permanent nursing staff and this has begun to have a positive impact.

At RMH nurse educator numbers were reduced dramatically between 1995 and 2000. Over the past two years the situation has improved with nurse educator numbers growing from three to 20. Their main role is to support newly graduated nurses but the professional needs of other nursing staff are not yet being met. Nursing staff indicated that RMH does not have formal mechanisms for nurses to raise ethical issues, receive feedback or gain immediate advice and support when dealing with ethical problems encountered in their work.

Systems for Staff Support

Resource constraints during the latter part of the 1990's at RMH had a serious adverse impact on nursing support services. High workloads, exposure to stressful situations, poor roster and shiftwork arrangements, combined with a reduction in staff support positions, contributed to low staff morale and a drop in standards. More recently budgets have been improved to redress these problems but full recovery will take time.

Nurses are just as susceptible to emotional and physical hazards in the workplace as any other group. Nurses with impairments, whether through illness, substance or drug abuse, require assistance and this has not been forthcoming until very recently at RMH. The establishment of a health program for nurses based on the Victorian Doctors' Health program would be of assistance.

The need to promote programs designed to value, support and develop the skills of nurses within a quality framework has been recognised at RMH. Management acknowledges past deficiencies and has begun to develop new structures to address them.

In hospitals complex interactions occur between diverse professional groups and highly vulnerable, often traumatised, patients and families. Situations of conflict can occur. It is the responsibility of the organisation to have processes in place to reduce these risks and to resolve conflict as quickly as possible. RMH had an aggression management committee but this has not been operational for some time. Clear and consistent policies need to be developed to ensure aggression, whatever its source, is reduced and addressed.

2 RECOMMENDATIONS

It is recommended that:

- 1. RMH continues to cultivate trust in management by maintaining consistent and transparent management practices, communicating RMH vision and encouraging participation from all staff in decision-making.**
- 2. RMH decreases organisational reliance on corporate memory by documenting, communicating and evaluating leadership decisions and their outcomes.**
- 3. RMH establishes processes for ongoing monitoring of the outcomes of organisational change.**
- 4. A further independent follow up review into the effectiveness of organisational change at the RMH is conducted in 12 months' time.**
- 5. Nursing leadership in Australia is promoted in collaboration with peak nursing organisations, so that nurses feel part of a professional and supportive network that has State and National affiliations.**
- 6. RMH management ensures that the strategic plan clearly articulates the organisation's goals, values and mission.**
- 7. RMH management makes explicit its planning and service delivery objectives and these are disseminated to all employees when they have been ratified.**
- 8. RMH management develops and communicates corporate objectives annually, to enable divisions to integrate operational plans with corporate objectives.**
- 9. RMH demonstrates that it values the knowledge and expertise of nurse clinicians by involving representative clinical nurses on RMH committees, including strategic planning and policy-making committees.**
- 10. RMH clearly defines the expected outcomes of the new structure and evaluates progress against the stated outcomes.**
- 11. RMH ensures the membership, progress and outcomes of all committees are evaluated on an annual basis.**
- 12. RMH ensures all standards, policies and procedures are developed according to best practice approaches.**
- 13. RMH ensures all standards, policies and procedures are accessible to staff and training is provided to ensure staff understand, and compliance is monitored.**

14. **RMH ensures all nursing standards, policies and procedures are available on the Intranet by March 2003.**
15. **RMH nursing leadership engages all nurses in the development of a nursing philosophy that incorporates the art and science of nursing as practised at RMH, and communicates it to existing and new nursing staff.**
16. **The Department of Human Services liaises with academic and professional nursing stakeholders to determine opportunities for health care organisations to share expertise and approaches to the development of nursing standards, policies and procedures. Such standards, policies and procedures would:**
 - **guide the quality of, and allow evaluation of, nursing practice throughout Victoria;**
 - **be evidence based and outcome focussed;**
 - **be responsive to practice development;**
 - **be compatible with requirements for ACHS accreditation; and**
 - **uphold the ANCI *National Competency Standards for the Registered Nurse, Code of Professional Conduct for Nurses in Australia* and *Code of Ethics for Nurses in Australia*.**
17. **RMH finalises a Quality Management Plan that integrates with Melbourne Health's strategic directions and meets the quality requirements of external accrediting bodies and the Department of Human Services.**
18. **RMH appoints an individual (however designated) with the knowledge and expertise to co-ordinate all aspects of quality and accreditation.**
19. **RMH documents a clinical governance policy and a framework for reporting that supports the Board and senior management in fulfilling their responsibilities to monitor and address issues relating to safety and quality of care.**
20. **RMH allocates resources to educate and support staff to fulfil their responsibility to monitor, evaluate and continually improve the services they provide.**
21. **RMH provides specific education to staff in relation to monitoring clinical practice.**
22. **RMH establishes a system to recognise and celebrate individual and group quality achievements.**
23. **RMH integrates ACHS accreditation standards into relevant Hospital structures, thus ensuring industry standards are met, outcomes are monitored and disruptive peaks and troughs of activity are avoided.**

24. **RMH further investigates relationships between medical and nursing staff and implements strategies to improve doctor/nurse communication and interaction related to patient care.**
25. **RMH reviews the design of its individual patient medication storage system to ensure that risks of medication error are minimised and access to individual patient medication storage containers is appropriately restricted, documented and audited.**
26. **Responsibility for monitoring and addressing compliance with legislation, Regulations and policy is clearly assigned within RMH to the Director of Pharmacy.**
27. **RMH reviews procedures governing ‘loaning’ of drugs between wards and obtaining non-imprest items after hours.**
28. **RMH reviews medication storage facilities within the Intensive Care Unit and the Emergency Unit and ensures the availability of adequate and accessible storage facilities to ensure that staff and patient safety is not compromised.**
29. **RMH develops urgently a ‘zero tolerance’ policy on the theft and misuse of drugs by staff, and considers allowing, within that policy, controlled and monitored access to ‘chemist line’ items. (see also Recommendation 66).**
30. **Processes continue to be developed and monitored to ensure medications are stored appropriately and securely to prevent unauthorised access.**
31. **Drug stocks are audited regularly, on a systematic and random basis, to ensure compliance with drug storage and administration requirements, and clear reporting and response procedures are developed.**
32. **The Melbourne Teaching Hospitals’ Drug Usage Group be asked to assist hospitals by developing model policies, procedures and guidelines for medication security and control.**
33. **The Department of Human Services reviews the effectiveness of the current ‘co-regulatory’ approach to the management of drugs, poisons and controlled substances in hospitals.**
34. **RMH Medication Risk Committee develops comprehensive feedback mechanisms to all Divisions of RMH to enable staff to learn from Hospital errors and implement pro-active preventative strategies that link into quality programs.**

35. **The Department of Human Services seeks advice from the Victorian Quality Council and the Melbourne Teaching Hospitals Drug Usage Group on the potential for the introduction of a standardised medication chart for all Victorian hospitals to decrease the incidence of medication error.**
36. **RMH includes clinical nurse representatives on the Clinical Risk Management Committee.**
37. **RMH develops a Hospital-wide program for meeting Department of Human Services requirements for reporting sentinel events and limited adverse occurrence screening.**
38. **RMH revises its policy and reporting pro forma for adverse events to ensure:**
 - **reporting lines are unambiguous**
 - **timelines for all levels of action are clearly stated;**
 - **there is a clear and effective feedback loop;**
 - **key performance indicators are practical and relevant;**
 - **policy changes related to adverse events are captured appropriately and implemented through the quality improvement program.**
39. **RMH adopts a systems approach to clinical risk management, in accordance with established best practice.**
40. **RMH ensures the provision of appropriate educational programs on clinical risk management for all staff.**
41. **RMH includes education on clinical risk management in orientation programs for all new staff.**
42. **RMH formalises a process for the management of staff complaints and staff feedback, to ensure all complaints are registered and actioned, and feedback is provided.**
43. **The formal complaints process includes provision for further review of serious complaints where the staff member is dissatisfied with the outcome of the initial management of the complaint.**
44. **Complaints and feedback processes are linked with local quality improvement programs.**
45. **RMH ensures staff are familiar with the provisions of the *Whistleblower Protection Act* 2001 (Vic.) and processes are in place for its implementation.**
46. **RMH ensures that the Complaints Liaison Officer receives appropriate administrative support.**

47. **Senior management at RMH continues to support the work of the Complaints Liaison Officer by assisting in the training of all staff, including senior medical staff, about the importance of good complaints handling.**
48. **RMH management adopts the new complaints management proposal to allow individual Divisions to be responsible for complaints investigation and resolution and systems changes in their own areas, with oversight by the Complaints Liaison Officer.**
49. **RMH nurse managers establish accountabilities for individual staff members to assess the quality of the service they provide.**
50. **RMH develops a standard for handling medical records.**
51. **RMH nursing leadership develops a rationale for information to be included in nursing documentation and provides relevant education to all clinical staff.**
52. **RMH develops outcome standards for documentation relating to:**
 - **nursing assessment**
 - **planning care**
 - **implementation of care**
 - **outcome/evaluation of care.**
53. **RMH works with all stakeholders to design improvements to the Medical Record Progress Notes which would assist in alerting staff when patient follow up action is required.**
54. **RMH develops a process for regularly monitoring the quality of medical record documentation.**
55. **RMH provides education and guidance for all staff on the need for, and benefits of, effective performance review and development processes.**
56. **Comprehensive and outcome oriented best practice standards and mandatory registered nurse competencies pertinent to generalist and speciality areas of practice are developed and/or adopted by RMH and assessed on a regular basis.**
57. **RMH participates in State and National initiatives aimed at the development and implementation of best practice standards for clinical nursing practise.**
58. **RMH reviews the administrative workload of Nurse Unit Managers and Associate Nurse Unit Managers to ensure an appropriate level of clinical supervision and support is maintained.**

59. **RMH reviews the level of supervisory support available to nursing staff working night duty.**
60. **Infrastructure support for nurse educators is reviewed and, where deficient, developed to ensure nurse educators can function effectively in their role.**
61. **The effectiveness of the CPR competency training is evaluated systematically.**
62. **RMH considers introducing additional mandatory education or competency testing in priority areas identified by clinical staff and nurse educators, e.g. administering medications, administering patient controlled analgesia (PCA) and epidural management, documentation, and aggression management.**
63. **RMH considers the development of a 'Nursing Practice Development' program as a means of fostering expertise in evidence based nursing care.**
64. **RMH develops formal mechanisms for nurses to raise ethical issues, receive feedback or gain immediate advice and support when dealing with ethical problems encountered during the course of their work.**
65. **Key stakeholders such as the Nurses Board of Victoria and peak nursing organisations be involved in a Government sponsored advisory group to explore the feasibility of developing a health support program for nurses in Victoria similar to the Victorian Doctors' Health Program.**
66. **RMH develop services to ensure staff experiencing illness at work have access to on-site healthcare. (see also Recommendation 29).**
67. **RMH Human Resources Service assesses as a matter of priority organisational culture and satisfaction levels of non-management staff and develops strategies to address adverse cultural and morale issues.**
68. **RMH Human Resources Service develops a standard for staff orientation for implementation at the Departmental level. All programs should be documented formally and monitored for effectiveness.**
69. **RMH re-establishes the Aggression Management Committee to address current issues of aggression whatever their source.**
70. **RMH considers the feasibility of rostering the Psychiatry Registrar and/or appropriately trained psychiatric nurses on duty or on call during the night.**

- 71. RMH management continues to monitor nursing relationships to ensure nurses, particularly junior nurses, feel confident of the respect of their peers.**
- 72. RMH management devises strategies for listening actively to staff issues, and provide opportunities for staff feedback.**
- 73. RMH establishes shared accountabilities for communication and establishes a process for educating staff and monitoring the effectiveness of communication across the organisation.**

3 BACKGROUND TO THE INQUIRY

3.1 Introduction

In March 2002 serious allegations of misconduct involving nursing staff at the Royal Melbourne Hospital (RMH) Campus of Melbourne Health were made public. The allegations are the subject of investigation by the Coroner and Victoria Police. The Nurses Board of Victoria has suspended the registration of two nurses and advises it has deferred all investigations about the alleged misconduct pending the outcome of the Coroner's investigation. The Executive and Board of Melbourne Health have each conducted separate investigations into issues associated with the allegations.

On 26 March 2002 the Minister for Health, The Hon. John Thwaites, MP asked the Health Services Commissioner (HSC) to conduct an independent inquiry.

3.2 Terms of Reference

The Terms of Reference are to inquire into the following matters concerning the operation of the RMH campus:

1. medications management, including drug stock control, administration and documentation;
2. incident reporting systems, particularly relating to concerns identified by any staff;
3. standards of documentation related to patient care;
4. nursing management oversight of clinical practice at ward level;
5. systems for staff support; and
6. other opportunities for improvement identified during the course of the review.

The Minister also asked the HSC to make recommendations to ensure quality improvements in systems and procedures in Victorian metropolitan health services and public hospitals.

The time frame for the Inquiry was three months.

3.3 The Inquiry Panel

The *Health Services (Conciliation and Review) Act 1987 (Vic)* section 9(1)(m) allows the HSC to inquire into matters referred by the Minister.

The HSC, Beth Wilson, conducted the Inquiry assisted by Lois Kennedy, a Registered Nurse experienced in nursing administration, quality management, hospital accreditation and development of nursing standards.

Dr. Heather Wellington and Professor Megan-Jane Johnstone were appointed as advisors to the HSC. Heather Wellington is a medical practitioner with a background in health care management, governance, policy and law. Megan-Jane Johnstone is Professor of Nursing and Director of Research in the Department of Nursing and Midwifery, RMIT University, and is noted for her work on professional ethics and professional conduct.

3.4 Methodology

3.4.1 Engagement with RMH Management and Staff

The HSC arranged an initial meeting with the Chair of the Board of Directors and the Chief Executive Officer (CEO) of Melbourne Health. The Melbourne Health representatives made it clear the Inquiry had their full support, and made resources available to the HSC.

The HSC, and the investigative consultant, held a seminar at RMH on Tuesday, 11 April 2002 to advise staff of the purpose, method and proposed reporting of the Inquiry. The HSC's presentation was made available on the hospital 'intranet' to inform staff who were unable to attend.

Although the inquiry was held under s.9(1)(m) of the *Health Services (Conciliation and Review) Act* 1987 the willingness of RMH executive and staff to participate in the Inquiry meant it was not necessary for the HSC to use the powers of investigation available to her under the Act.

3.4.2 Review of RMH Formal Structures

A review of RMH administrative structures and systems was undertaken including organisational design, strategic directions, policies, procedures, position descriptions, incident reporting processes, employment and other relevant statistics, the most recent accreditation report and the Melbourne Health Annual Reports.

3.4.3 Structured Individual Interviews

A series of structured, individual interviews was held with 33 key RMH personnel (see Appendix 1). Interviews were transcribed, and transcripts were returned to the interviewees to validate their responses prior to analysis. Informal interviews were conducted with a former Director of Medical Services and a Director of Nursing Services who had left RMH within the previous five years, and the current Director of Pharmacy.

The willingness of RMH personnel to discuss freely issues of concern and to comment on a range of subjects related to management, clinical governance and RMH's quality systems was particularly helpful to the Inquiry.

3.4.4 Structured Group Interviews

Five group interviews were conducted with approximately 60 nurses registered in divisions 1 and 2 of the Register of the Nurses' Board of Victoria. These interviews yielded a representative range of opinions from staff responsible for patient care at the Hospital.

3.4.5 Review of Documentation in the Medical Records

An audit was conducted of the records of 60 complete patient admission episodes. Medical records were selected according to a formula designed by the RMH Health Information Manager and were examined using an audit tool formulated with reference to RMH policy standards.

3.4.6 Written Submission from the Australian Nursing Federation

The HSC's Inquiry Team met with the Australian Nursing Federation (ANF) to inform it of the Inquiry and the approach to be taken. Subsequently a submission from the ANF was received and noted.

3.4.7 Guided Tour of Neuroscience Unit

An inspection of the Neuroscience Unit at the RMH was undertaken as part of the Inquiry. RMH managers conducted the tour and provided information relating to the work environment, work practices and local quality improvement activities.

3.4.8 Consultation with Experts

Expert opinion was obtained from:

- the Manager, Drug and Poisons Unit of the Department of Human Services - in relation to legislative requirements for medication management, and recommendations for improvement of handling and storage of medications;
- the President of the Health Services Review Council;
- the Chief Executive of the Nurses Board of Victoria; and
- members of the Society of Hospital Pharmacists of Australia, Victorian Branch.

3.5 Limitations of the Inquiry

1. The time frame for conducting the Inquiry was three months, which was sufficient to obtain the information required to address the Terms of Reference, but not to compare relevant structures and processes at RMH with those of similar metropolitan hospitals.
2. There is a lack of industry benchmarking to enable comparison of essential elements of effective hospital management, including methods and outcomes of clinical governance, incident reporting standards and rates, documentation and implementation of policies and procedures and recruitment and retention rates.

3. While there was considerable consistency of themes from interviews conducted with RMH and Melbourne Health personnel, there were some limitations in obtaining comprehensive information. The majority of management personnel interviewed had been appointed recently to their positions and expressed significant concerns about the management structures they inherited. Research for the Inquiry did not, however, extend to formal interviews with past senior managers.
4. The time frame precluded a comprehensive, quantifiable content audit of the medical records that would have statistical validity. The findings were, however, consistent throughout the medical records examined and were also consistent with the opinion of the majority of RMH personnel interviewed.
5. No interviews were conducted with patients, families or carers.
6. Time and resources did not permit a call for written submissions.

4 FRAMEWORK FOR THIS REPORT

The Inquiry was conducted to examine systems issues impacting on the quality of patient care at RMH. During the Inquiry, nursing profession issues emerged as being particularly affected by management and infrastructure issues. Although the nursing profession is the focus of this Report, the findings have implications throughout RMH and other comparable hospitals.

The Terms of Reference for this Inquiry required the HSC to investigate and advise on a range of specific issues relating to the management and delivery of patient care at the RMH (e.g. medications management, incident reporting systems, standards of documentation related to patient care, nursing management and overseeing of clinical practice at ward level and systems for staff support). In addition, the HSC was provided with a broad term of reference to ‘advise on other opportunities for improvement identified during the course of the review’, and was asked to make recommendations to ensure quality improvements in systems and procedures in Victorian metropolitan health services and public hospitals. RMH staff consistently commented at interview on the inadequacy of past RMH organisational structures and systems, lack of continuity of senior management and changes in the professional role of nursing, and their impact on the delivery of patient care. Considerable confidence and optimism was, however, expressed about current organisational structures and leadership.

The issues identified by staff relating to organisational structure, leadership and systems are discussed in Section 5 of this Report, providing a contextual background for the remainder of the Report. Section 5 explores, in the context of contemporary knowledge about health care safety, quality and clinical governance, the structural and systemic issues identified by RMH clinical and management staff as directly impacting on the delivery of high quality patient care. The specific issues identified in the Terms of Reference of the Inquiry are addressed in Sections 6 to 10:

- Section 6 Medications management, including drug stock control, administration and documentation;
- Section 7 Incident reporting systems, particularly relating to concerns identified by any staff;
- Section 8 Standards of documentation related to patient care;
- Section 9 Nursing management oversight of clinical practice at ward level; and
- Section 10 Systems for staff support.

5 CONTEXTUAL BACKGROUND

5.1 Structural Change Affecting RMH

RMH is a major teaching public hospital. Its services include adult tertiary care, general and specialist medical and surgery services, trauma and mental health care. It has a strong research program and serves a rapidly increasing and ageing population. Approximately 13% of the people living in the region served by RMH are over the age of 65 with 51% of patients from non-English speaking backgrounds. The area served by RMH is primarily Northern and Western regions of metropolitan Melbourne with some services provided in regional Victoria.

RMH, like all Victorian metropolitan public hospitals, has experienced considerable structural change over the past decade. Following a 1995 review by the Metropolitan Hospitals Planning Board, Melbourne's 35 previously independent public hospitals were aggregated into seven Health Care Networks. RMH became a campus of the Western Health Care Network in August 1995. On 3 November 1997 the North Western Health Care Network, of which RMH became a member campus, was created following amalgamation of the North Eastern Health Care Network and the Western Health Care Network.

The Health Care Networks, overseen by Boards of Directors, were intended to achieve improvements in patient care through new governance arrangements, the promotion of 'hub and spoke' models of care, transfer of services closer to where people lived, and monitoring of quality, accessibility, and efficiency of health care services.

The outcome of these major structural changes to the metropolitan health care system was evaluated in a Ministerial Review of Health Care Networks, which was presented to the Minister for Health in May 2000. The Review Panel reported that the Health Care Networks, in particular the North Western and Inner and Eastern Health Care Networks, had become too large and there had been an undue emphasis on 'commercial' viability at the expense of considerations such as the quality of patient care.

In July 2000 a new metropolitan health system structure was implemented. Twelve Metropolitan Health Services were formed, with RMH becoming a campus of Melbourne Health. Melbourne Health also incorporates the Melbourne Extended Care and Rehabilitation Service.

During this period a number of intrinsic and extrinsic factors added to the complexity experienced by all health care organisations. These included:

- increasing sophistication of medical science and technology with associated ethical and financial implications;
- increasing public scrutiny and demands for accountability as consumers became more informed of health care options;
- increasing demand for services and longer waiting lists;
- higher patient acuity related to shorter length of stay;

- widespread nursing shortages with increasing use of casual staff; and
- increasing awareness of the complex health care needs of diverse communities.

Thus, in recent years, RMH has been challenged significantly by major structural change as well as changes in the way in which health care is delivered and the community's expectations of large public health care organisations.

5.2 Corporate Leadership

Throughout this period of structural and environmental change, there has been considerable leadership instability at RMH and the former Networks, of which it was a member campus. The current CEO of Melbourne Health was appointed in January 2001. From 1996-2002 there has been a total of four CEOs of the Network/Health Service and three General Managers of RMH. Many other management changes have taken place to the extent that most of the current senior managers at RMH have been in their positions for less than two years.

Leadership instability was the source of substantial critical comment by RMH staff. Staff perceptions of the immediate past differed, with some describing a period of stagnation where activity had virtually ceased and others recalling a frantic cycle of reactive changes that they considered uninformed, and which resulted in the eventual return to what had been rejected in the past. Many staff also suggested that:

- there had been a generalised lack of accountability with changes not followed up or evaluated;
- staff participation in decision making had been neither sought nor valued;
- there was an increasing mistrust of management as staff experienced the effects of the loss of corporate memory and lack of continuity of management decisions;
- there was an absence of clear management mission and values, and an increasing focus on fiscal outcomes;
- changes were made without logic or rationale, and without sufficient justification; and
- there was an over emphasis on change for its own sake, with a resulting neglect of service delivery.

The leadership instability at RMH has been detrimental to staff morale and organisational functioning. Staff confidence in the leadership of the organisation has been seriously eroded. There is evidence, however, that Melbourne Health has made a commitment to maintain transparent processes and better governance and management practices to ensure lasting solutions.

The new leadership team is committed to achieving stability and maintaining effective management practices and senior staff have confirmed their support for current leadership directions. Senior managers interviewed were unanimous in recognizing that quality improvements were occurring and expressed their support and appreciation. Junior managers were hesitant, preferring to adopt a 'wait and see' attitude.

Recommendations:

- 1. That RMH continues to cultivate trust in management by maintaining consistent and transparent management practices, communicating RMH vision and encouraging participation from all staff in decision-making.**
- 2. That RMH decreases organisational reliance on corporate memory by documenting, communicating and evaluating leadership decisions and their outcomes.**

5.3 Nursing Leadership

A long period of stable leadership in nursing at RMH ended in 1995. During the following seven years there were five Directors of Nursing who inherited structures that were ill equipped to function effectively within the changing organisation. In 2001, for a period of eleven months, one of the Operations Directors had the added responsibility of the position of Acting Director of Nursing. Combining these positions created an unmanageable workload.

Instability of leadership was intensified when nursing middle management positions were reduced dramatically, with Operations Directors decreasing in number from nine in 1996 to two in 1999. It was not until 2002 that the deficit caused by the loss of such important positions was offset by the new structure.

Senior nursing and medical staff indicated that nursing leaders became disempowered during the many changes and could not make the structural adjustments necessary to provide adequate support and mentoring to the large nursing workforce. RMH currently has 925 equivalent full-time nursing positions, which involves 1474 individual nurses. There was consistent criticism from nursing personnel interviewed that they were not consulted and not listened to during this period of change, and when they reported problems they were ignored. Nurse clinicians stated they felt totally excluded from decision-making.

The promotional pathway to nurse unit management at RMH was based primarily on clinical experience. Management experience and knowledge of management and behavioural theory was not considered essential. Management expectations of the nurse unit managers were high, even though they had little academic training for their role. Nurse unit managers and associate nurse managers were expected to assume a considerable administrative workload with little support. For some, particularly new nurse managers, the responsibility to manage critical inter-relationship and conflict problems in a climate of constant change, declining resources and consequent loss of morale, was a heavy burden.

RMH has recently implemented new strategies and programs to support nurse managers. A middle management educational program commenced in February 2002. A new nursing leadership team has been selected carefully but has been operational only for the past few months. The team, led by a new Director of Nursing, appears to understand the current problems and has demonstrated a commitment to work to resolve them. Most of the middle managers interviewed appreciated the additional support they are receiving, and felt optimistic that a new level of responsibility and accountability has been established.

It is too soon to assess whether the new initiatives will be sufficient to address the problems that have been identified. A past failure by the organisation to implement adequate formal structures, clarify expectations and guide actions of nurses at all levels, contributed to deficiencies in leadership for nursing. Recent reforms to the organisational structure and processes have been received with optimism by staff and should enable the organisation to move forward. Ongoing internal systematic evaluation of the effectiveness of these changes should be undertaken and it would also be beneficial for a further independent follow up review to be undertaken after 12 months.

Recommendations:

- 3. That RMH establishes processes for ongoing monitoring of the outcomes of organisational change.**
- 4. A further independent follow up review into the effectiveness of organisational change at the RMH is conducted in 12 months' time.**

Across the health care system, many nurses believe that traditional supportive professional frameworks have been abandoned.¹ The importance of professional nursing role models to lift nursing morale and re-establish professional pride needs to be addressed at a system-wide level. The Department of Human Services Nurse Policy Branch has carried out considerable work over the past year, to provide a focal point for communication and professional leadership for nurses. Peak nursing organisations (e.g. the International Council of Nurses, the Royal College of Nursing Australia, the Australian Nursing Federation, and the Australian Council of Nursing Incorporated) also recognise the importance of leadership.

Recommendation:

- 5. Nursing leadership in Australia is promoted in collaboration with peak nursing organisations, so that nurses feel part of a professional and supportive network that has State and National affiliations.**

5.4 Organisational Structure and Systems

5.4.1 Strategic Planning and Organisational Design

In complex organisations such as RMH, formal structures should be analogous to signposts, directing individuals with a diversity of attitudes, lifestyles, goals and standards toward legitimate, quality based corporate and cultural objectives.

¹ LH Aiken, SP Clarke, DM Slaone, & JA Sochalski, 'Nurses' reports on hospital care in five countries', *Health Affairs* vol. 20(3), 2001, pp. 43-53; M Johnstone, 'Poor working conditions and the capacity of nurses to provide moral care', *Contemporary Nurse*, vol. 12(1), 2002, pp.7-15; Department of Human Services, *Nurse recruitment & retention committee final report*, May 2001

Peter Senge a well-known management theorist, has pointed out:

One is hard pressed to think of any organisation that has sustained some measure of greatness in the absence of goals, values and missions that become deeply shared throughout the organisation.²

RMH is recognised as one of Australia's leading tertiary referral centres, and, through its association with the University of Melbourne, has a reputation for excellence in education and research. Some senior administrators stated, however, that a culture of elitism exists which has been conducive to an attitude of complacency and lack of accountability. Although there is individual and team-based commitment to excellence in-patient care at RMH, organisational goals, values and mission have not been well articulated.

Over the past 12 months, RMH has been working to a planning framework that supports the RMH mission and targets organisational redesign. The aim is to develop a fully integrated and systematic approach to patient care. Key processes include the implementation of a consultative framework to achieve planned changes including staff development, research and education programs and services. Ethical behaviour, patient focus and accountability, are stated priorities for personnel working together as a team.

Management teams have been established to provide relevant leadership at the Divisional level. Such teams are committed to being fully informed about local and corporate issues in order to be competent, to feed information up and down the organisational structure and influence policy. Divisions now have a comprehensive infrastructure that includes financial and human resource management expertise.

In addition to the existing working framework, a comprehensive strategic plan has been completed and ratified by the Board in July 2002. It is important that this document is made available to all staff as soon as possible. Managers at all levels need to understand the corporate structure and have access to an organisation-wide strategic plan to assist them to link Divisional plans and objectives with RMH plans and objectives and ensure the organisation has a shared approach to achieving excellence in patient care, education and research.

Recommendations:

- 6. RMH management ensures that the strategic plan clearly articulates the organisation's goals, values and mission.**
- 7. RMH management makes explicit its planning and service delivery objectives and these are disseminated to all employees when they have been ratified.**
- 8. RMH management develops and communicates corporate objectives annually, to enable Divisions to integrate operational plans with corporate objectives.**

² PM Senge, *The Fifth Discipline*, 1990, p.9

The perception that the organisation is now moving in the right direction is widely held by managers. As one manager stated:

We have an operational matrix – there are standards about Melbourne Health. There is certainly an air, coming from the CEO, of trying to care for each other, what is and what is not appropriate behaviour. This is very good, and not just lip service, but we have a long way to go.

Consensus of opinion among senior managers is that the new structure is the best they have experienced within RMH. They consider it well planned and resourced, providing good access to the CEO and line management. A number of nurses, however, remain critical of the failure of RMH management to include them in decision-making. They consider management to be overly medically oriented, and that nursing expertise is neither sought nor valued.

A continuing criticism is that Divisional structures have an isolating effect and do not enable full advantage to be taken of collective knowledge and expertise, lead to unnecessary duplication of effort, and fail to present a shared view of organisational issues. One comment made was:

The sheer size of RMH causes problems in terms of a lack of continuity and coherence. Patients move across divisions but Divisions tend to behave and operate as isolated units with the priority on economic management. This means patient-centred care is not central as it should be. Instead, the focus tends to be on managing resources within a Division.

It is important that RMH management communicates expected outcomes of the new structure to all staff and ensures that relevant key performance indicators are in place to monitor its progress.

Recommendations:

- 9. RMH demonstrates that it values the knowledge and expertise of nurse clinicians by involving representative clinical nurses on RMH committees, including strategic planning and policy-making committees.**
- 10. RMH clearly defines the expected outcomes of the new structure and evaluates progress against the stated outcomes.**

5.4.2 RMH Committee Structure

RMH committees are part of the Melbourne Health corporate structure. Committees may be either advisory, operationally active, or a combination of both. All committees have an important role in planning, decision-making and effective functioning of the organisation. Evaluating the effectiveness of RMH committees was outside the scope of this Inquiry, however it was considered by some staff that committee membership was inappropriate and outcomes were variable.

Ensuring that committees monitor their results annually against their terms of reference is important in demonstrating accountability.

Recommendation:

- 11. RMH ensures that the membership, progress and outcomes of all committees are evaluated on an annual basis.**

5.4.3 Standards, Policies and Procedures

Clearly stated and accessible standards, policies and procedures are an important way in which organisations guide and articulate their expectations of staff in all aspects of their work, both corporate and professional. Nationally and internationally, current best practice approaches to safety and quality in health care emphasise the importance of a team-based approach to patient care. Standards, policies and procedures relating to clinical care are, therefore, increasingly multidisciplinary in their orientation.

The effectiveness of policies and procedures depends upon a number of factors including:

- a shared understanding of the reasons for development and relevance of the policies and procedures to the organisation;
- participation of relevant stakeholders at the developmental stage;
- clarity of purpose;
- absence of ambiguity;
- education of, and communication with staff;
- accessibility of the documentation;
- early monitoring to ensure that the policy is understood and has been implemented; and
- follow up and evaluation of content.

RMH staff were critical of current approaches to the development and implementation of organisation-wide policies and procedures. They continue to feel the effects of past poor systems and processes, and also consider that current systems of monitoring and evaluation remain deficient.

It was generally agreed that appropriate organisation-wide policies and procedures now exist. These are accessible, at least to senior staff via the ‘intranet’, and have been updated after a period of neglect. Senior staff were almost unanimous in their opinion, however, that corporate structure, policies, procedures and committee structures currently would not be well understood beyond management level and that an effective monitoring system is yet to be implemented. A process is in place to facilitate distribution and auditing of organisational-wide policies and procedures, which will be available on the ‘intranet’ within the year.

Standards, policies and procedures specific to each health care profession also are necessary to guide the professions in key areas of patient care. These standards, policies and procedures guide staff on required practices and provide a measure against which performance can be assessed. In particular, the nursing workforce in all hospitals should be guided by a documented philosophy and objectives, as well as standards, policies and procedures that define expected professional attitudes, processes and outcomes of patient care. These documents should be developed through a participatory approach and need to be reviewed regularly to ensure they remain compatible with current research.

An RMH Committee to review nursing policy and procedure was reconvened in October 2000 after a lapse of twelve months. The task of the Committee was to integrate up to eight policy and procedure manuals that had contributed to duplication, inconsistency and confusion. In August 2001 the new manual was distributed throughout the organisation. The new manual was, however, incomplete, therefore the existing manual could not be withdrawn. Staff were informed that policies in the new manual superseded those in the old, however, the new manual was not cross indexed and proved to be unwieldy for staff wishing to refer to policy. This is being addressed currently.

RMH does not have a documented nursing philosophy or nursing objectives. Although professional standards exist in the form of Australian Nursing Council Incorporated (ANCI) competency, conduct, and ethical standards, they are not included in the RMH clinical policies and procedures manual and are not promoted by management, but remain the responsibility of individual nurse professionals.

This lack of a nursing philosophy and objectives may reflect a conscious decision on the part of management to integrate all services under a multidisciplinary corporate framework. Senior nursing staff at RMH believe, however, that organisational and professional expectations of care should be manifested in the form of a documented philosophy and best practice standards.

Currently, hospitals develop their professional standards, policies and procedures in isolation from each other. Although the content may be similar, the construction and semantics are diverse. Standards are developed by nurses with varying skills and knowledge, which do not always extend to expertise in writing standards.

Recommendations:

- 12. RMH ensures all standards, policies and procedures are developed according to best practice approaches.**
- 13. RMH ensures all standards, policies and procedures are accessible to staff, and training is provided to ensure staff understand, and compliance is monitored.**
- 14. RMH ensures all nursing standards, policies and procedures are available on the Intranet by March 2003.**

- 15. RMH nursing leadership engages all nurses in the development of a nursing philosophy that incorporates the art and science of nursing as practised at RMH, and communicates it to existing and new nursing staff.**
- 16. The Department of Human Services liaises with academic and professional nursing stakeholders to determine opportunities for health care organisations to share expertise and approaches to the development of nursing standards, policies and procedures. Such standards, policies and procedures would:**
 - guide the quality of, and allow evaluation of, nursing practice throughout Victoria;**
 - be evidence based and outcome focussed;**
 - be responsive to practice development;**
 - be compatible with requirements for ACHS accreditation; and**
 - uphold the ANCI *National Competency Standards for the Registered Nurse, Code of Professional Conduct for Nurses in Australia* and *Code of Ethics for Nurses in Australia*.**

5.5 Approaches to Health Care Safety and Quality

5.5.1 Corporate and Clinical Governance

The term ‘governance’ refers to the collective and individual responsibilities of directors to provide strategic leadership that accords with the agreed directions of the organisation, and to ensure appropriate controls are in place to foster efficient and effective operation.

An effective board of governance will delegate managerial responsibility to the CEO and will ensure that appropriate accountability arrangements are in place to monitor and control the CEO’s performance.

In recent years, the community has shown an increasing interest in, and concern about, the safety and quality of health care. The community looks to health care directors and senior managers to ensure appropriate structures, processes and monitoring systems are in place. This interest and concern has been stimulated by a series of well-publicised system failures, including those of the Bristol paediatric cardiac surgical unit in the United Kingdom National Health Service and the King Edward Memorial Hospital in Western Australia.

The concept of clinical governance has been developed to describe the responsibilities of directors for the safety and quality of clinical services in health care organisations. Definitions for this term vary, but the following is considered to describe adequately the concept:

Clinical governance refers to the responsibility of Directors to ensure that appropriate structures, processes and monitoring systems are in place to assure and promote, according to best practice standards, the safety and quality of health care services. The role can be seen as analogous to the Director’s role in leading, monitoring and controlling the organisation’s general strategic and financial performance.

The engagement and support of clinical staff in these processes is crucial to effective clinical governance.

The concept of clinical governance is reflected in the *Health Services Act 1988 (Vic)*, which incorporates, within the overall responsibilities of health service boards responsibilities for monitoring and addressing the quality of health care.

5.5.2 Approaches to Clinical Governance and Quality Improvement at RMH

Clinical governance is a relatively new concept in health care, and the necessary structures and processes are still evolving at many hospitals. RMH is no exception. Until the new organisational structure was implemented early in 2002, clinical divisions appear to have been under-resourced in terms of administrative and supervisory capacity. While all available evidence would suggest that a very good standard of care is provided at RMH, clinical personnel interviewed reported feeling the effects of a number of long term constraints, both fiscal and cultural.

The recent implementation of a new organisational structure, and an increase in resources, places RMH in a position to develop and implement adequate formal structures for clinical governance. This is, however, in the early stages and considerable effort is still required to ensure best practice clinical governance at RMH.

RMH defines quality as:

- understanding what your customers require;
- specifying philosophy and scope of service;
- doing the right thing in the right way, first time, every time;
- using the right people;
- with the right outcomes; and
- with minimum adverse consequences.³

The stated aim of the CEO of Melbourne Health is to ensure a practical and effective quality system and framework is in place. RMH is in the process of restructuring its Quality Committees to develop appropriate strategies and plan their implementation. The task is a major one, as the focus for Melbourne Health over the past year has been in the redesign of services and establishment of a comprehensive infrastructure. There is now a clear corporate priority to ensure that quality management systems are appropriately structured and operating. In August 2001, a consultant was appointed to review the quality program. This review had been discussed with the Board of Directors from December 2001 and the new quality structure was presented to the Board in May 2002.

³ Melbourne Health, *Annual Quality of Care Report*, 2001, p.3

The current situation in relation to Corporate Quality Structures, which form an essential component of clinical governance structures, is:

- the Strategic Plan and Objectives (from which the quality plan will be developed) have yet to be ratified and circulated to staff;
- there is a draft Melbourne Health quality plan dated 2000-2001. There are current policies and procedures relating to quality management;
- there is no formal policy statement or documented reporting framework for clinical governance;
- there is no evidence of a formal quality education program or clinical quality support structure;
- there is no formal strategy in place to ensure quality requirements of external bodies (such as the Department of Human Services and the Australian Council on HealthCare Standards) are met;
- Melbourne Health undertakes a positive corporate quality activity by comparing service statistics with a benchmarking group of hospitals from Australia and New Zealand.

Although, at an organisational level, quality programs are not well integrated, RMH has a range of quality programs in place in all areas, including clinical areas. Examples of work undertaken are:

- monitoring waiting times, delays and cancellations in services;
- participating in the Department of Human Services Patient Satisfaction Survey;
- monitoring mortality and morbidity;
- clinical practice reviews are carried out at divisional and ward levels; and
- multidisciplinary process improvement teams are employed to review and redesign projects to reduce risk and waste and remove system blocks. These teams were supported by the Quality Manager, but have not been active recently.

Melbourne Health receives State Government funding under the 'Designing Care' program to assist in the development of initiatives to improve patient access and outcomes. Funding grants have also been awarded to RMH for a number of additional projects.

In January 2001 the incumbent quality manager was seconded to another role. The quality manager's position at RMH then remained unfilled for 15 months from January 2000 to March 2001. During that period a quality manager with the former North Western Health Care Network, was made available to RMH for two to three days per week and she provided part time quality support at the North Western Health Care Network and the RMH. She was appointed to RMH in March 2001 but resigned in May 2002, leaving the Hospital again without a quality manager.

Staff were critical of the perceived lack of organisational direction in quality processes:

Quality is carried out in an environment where the Hospital has not put any direct funding into [quality] infrastructure – capital equipment or secretarial staff. Areas have been doing it without support. That means that all of the specialty units have their own version of it and different software and mechanisms – a hotchpotch of systems has been developed. There has to be some expertise in actually having people who are capable of looking after this system with respect to accuracy, privacy, security etc. That is lacking at the moment.

Medical staff have a divisional reporting system for quality activities. This is not the case in nursing where quality improvement is the sole responsibility of the Nurse Unit Manager and clinical nurses. Some clinical areas have a definite quality focus, depending largely upon the knowledge and understanding of the Nurse Unit Manager. In areas where there is a multidisciplinary approach to improving services, some nurses expressed concern that it was left to the nurses to do the work with other staff not ‘pulling their weight’. In non-specialty areas, interview responses suggested that some nurse clinicians did not have a clear understanding of the way in which nurses should demonstrate accountability for clinical care.

RMH management recognises the need to market the positive and practical nature of quality activities and has a variety of mechanisms for rewarding staff achievement. A formal system of recognition and reward for individuals and groups who achieve significant quality improvements would provide not only positive staff reinforcement, but also inform Hospital personnel of the nature and scope of quality activities carried out within the organisation.

Recommendations:

- 17. RMH finalises a Quality Management Plan that integrates with Melbourne Health’s strategic directions and meets the quality requirements of external accrediting bodies and the Department of Human Services.**
- 18. RMH appoints an individual (however designated) with the knowledge and expertise to co-ordinate all aspects of quality and accreditation.**
- 19. RMH documents a clinical governance policy and a framework for reporting that supports the Board and senior management in fulfilling their responsibilities to monitor and address issues relating to safety and quality of care.**
- 20. RMH allocates resources to educate and support staff to fulfil their responsibility to monitor, evaluate and continually improve the services they provide.**
- 21. RMH provides specific education to staff in relation to monitoring clinical practice.**
- 22. RMH establishes a system to recognise and celebrate individual and group quality achievements.**

5.5.3 Accreditation by the Australian Council on Healthcare Standards

Accreditation is:

.....a formal process by which a recognised body, usually a non-governmental organisation, assesses and recognises that a health care organisation meets applicable pre-determined and published standards. Accreditation standards are usually regarded as optimal and achievable, and are designed to encourage continuous improvement efforts within accredited organisations. An accreditation decision about a specific health care organisation is made following a periodic on-site evaluation by a team of peer reviewers, typically conducted every two to three years. Accreditation is often a voluntary process in which organisations choose to participate, rather than one required by law and regulation.⁴

The Australian Council on Healthcare Standards (ACHS) is a national body that develops standards and provides accreditation services to public and private health care facilities nationally. In their last full organisational survey, RMH was not granted the full accreditation period available, but granted provisional accreditation for a period of 18 months to undergo a further periodic review in 2001.

The provisional accreditation identified two high priority recommendations that:

- deficiencies that existed with the Hospital's pharmacy sterile production suite be upgraded to comply with the Australian Standards;
- Biomedical Engineering (BME) develop an adequate risk management system to ensure there is regular preventative maintenance and servicing and adequate policy and procedures in place to address responsibilities of ward staff and staff in BME service for all electro-medical equipment and cardiac or body protected areas in the Hospital.

These issues were addressed prior to the periodic review in 2001 and staff involved were commended for their efforts by the ACHS surveyors and as a consequence RMH was, in May 2001, granted full accreditation status. RMH is due for a further organisation-wide survey for accreditation in 2003.

A number other recommendations related to policy shortcomings and staff knowledge of policy and procedures. For example:

- the Hospital undertake some sampling of compliance by staff with some selected policies/procedures to act as a guide to the effectiveness of mechanism designed to ensure adherence or observance of these policies/procedures;
- RMH continue to evaluate the effectiveness of and compliance with policies that relate directly to patient/consumer care;
- the use of Hospital policies in planning care be periodically estimated.

⁴ Australian Council of Healthcare Standards use the definition in AL Rooney & PR van Ostenberg, Licensure, Accreditation and Certification: Approaches to Health Services Quality. *Quality Assurance Project*, 1999

Accreditation is designed to be an evolutionary process that involves all staff members, and is aimed at improving services continuously. It is not uncommon, however, for organisations to approach accreditation as an episodic responsibility requiring intensive effort prior to an accreditation survey to ensure compliance. Staff reported that this tended to occur at RMH, with the deployment of staff to ensure structures and outcomes are in place, with little or no subsequent maintenance or resourcing. One staff member reported:

The Hospital has a mad rush every time accreditation is on. It is not appropriate. It should be in place all the time.

From an organisational perspective, a ‘stop, start’ approach to accreditation becomes an administrative problem that yields little lasting benefit for the considerable effort expended. At a national level, the Australian Council for Safety and Quality of Health Care is considering the general issue of the effectiveness of accreditation, and has signalled its intention to convene a working party to address this issue.

Recommendation:

- 23. RMH integrates ACHS accreditation standards into relevant Hospital structures, thus ensuring industry standards are met, outcomes are monitored and disruptive peaks and troughs of activity are avoided.**

5.6 Clinical Relationships

Effective interpersonal/professional relationships between staff are critical to safe, high quality patient care. Relationships between medical and nursing staff at RMH were generally considered to be productive. There were, however, some examples provided where staff relationships had deteriorated over the years, and this was considered a barrier to effective patient care. For example, the Inquiry was advised that in some wards and units there was reluctance by some nursing staff to accompany doctors on ward/unit rounds. Respondents to the Inquiry considered this to be in need of immediate attention.

While some respondents were concerned about what they perceived as a ‘divide’ between medical and nursing staff and wanted to improve the situation, they could not make any specific suggestions on what could be done. Further investigation and evaluation by RMH management is warranted.

Recommendation:

- 24. RMH further investigates relationships between medical and nursing staff and implements strategies to improve doctor/nurse communication and interaction related to patient care.**

Within the clinical domain, team meetings were perceived generally to be effective and continue to provide the opportunity for all staff to interact. Nurses were satisfied with their level of communication with Nurse Unit Managers and Associate Nurse Unit Managers. As one respondent commented:

In my ward there are resources available and if you do need something there are usually people to ask. I don't feel I am going to be left alone. There is always a person there.

6 MEDICATIONS MANAGEMENT, INCLUDING DRUG STOCK CONTROL, ADMINISTRATION AND DOCUMENTATION

6.1 Background

In contemporary health care settings, the potential for error in the administration, or misuse, of medication is significant. In Australia, medication error is estimated to be the cause of 80,000 hospital admissions at a cost of approximately \$350 million each year.⁵

It is acknowledged that:

*Most adverse events relating to medication error do not occur as a result of a single mistake by a particular individual, but because of a fault in the health care system that does not allow the error to be recognised.*⁶

Nationally and internationally it is known that:

- error rates associated with medication administration are higher where ward stock supply systems are used. The Australian Society of Hospital Pharmacists recommends the use of individual patient-based drug distribution methods to reduce error rates;
- clinical decision support systems, including aids such as guidelines, protocols, drug information and advisory services and computerised decision support systems, have been shown to improve patient safety. Computerised decision support systems are being considered and are in the developmental phase in Australia;
- the provision of clinical pharmacist support on hospital wards reduces adverse drug events.

At a national level, the Australian Council for Safety and Quality in Health Care has identified medication safety as a priority area and is progressing the development of national strategies to reduce adverse medication events. The National Strategy for the Quality Use of Medicines, a major component of Australia's National Medicines Policy, has outlined a framework for improving use of medicines in Australia. Strategies considered necessary to improve medication safety and use include:

- the development of appropriate policies and protocols to support quality use of medicines;
- mechanisms to facilitate and co-ordinate activities with other groups and organisations;

⁵ Australian Council for Safety and Quality in Health Care, *Improving Medication Safety; Report of a Medication Safety Workshop* July 2001, Australian Council for Safety and Quality in Health Care, *Improving Medication Safety; Report of a Medication Safety Workshop* July 2001, p.10, see also Australian Council for Safety and Quality in Health Care, *Second National Report on patient Safety Improving Medication Safety*, July 2002

⁶ Australian Council for Safety and Quality in Health Care, *Improving Medication Safety; Report of a Medication Safety Workshop* July 2001, p2.

- access to appropriate information to support best practice;
- access to education and training to support best practice;
- access to services and interventions that support quality use of medicines; and
- routine evaluation of activity to ensure quality use of medicines is being achieved.

In Victorian hospitals, the purchase, management and administration of drugs and poisons is regulated by the *Drugs, Poisons and Controlled Substances Act 1981 (Vic)* and the *Drugs, Poisons and Controlled Substances Regulations 1995 (Vic)*. The legislation and regulations require and enable:

- licensing of those who can make and sell drugs and poisons;
- allocation of permits to industry users to purchase the drugs and poisons they need to conduct their business;
- issuing of permits for the provision of health services;
- authorisation of people with certain qualifications (for example, doctors, pharmacists, veterinary surgeons, dentists and nurses) to possess, use and/or administer drugs for specific purposes.

A co-regulatory approach exists between the Drugs and Poisons Unit, Department of Human Services, Victoria and all organisations holding a licence or a permit under the *Drugs, Poisons and Controlled Substances Act 1981 (Vic)*. Part of this approach involves all licence and permit holders being required to maintain a Poisons Control Plan.

6.2 Medication Management

As required by the relevant legislation, RMH has a Poisons Control Plan that is approved by the Department of Human Services, with the Director of Pharmacy nominated as the 'Responsible Person' to maintain and ensure compliance with the Plan. The Plan is supported by Hospital policies and procedures.

The legislation requires different security and administration procedures for drugs in different Schedules. Schedule 4 drugs are drugs that require a prescription. The Regulations require them to be stored in a lockable storage facility. Schedule 8 drugs are those that have the potential for addiction. The Regulations specify the type of storage facility in which they must be kept (i.e. a separate storage facility must be provided for Schedule 8 and 9 poisons and drugs of dependence). The Regulations also specify security arrangements and strict record keeping requirements for Schedule 8 drugs. Consistent with best practice, the RMH Pharmacy Department provides a clinical pharmacist service on RMH wards.

Nursing policy and procedures relating to drug administration and control at RMH have been under review since mid 2001. At the time of the Inquiry, nurses were working with a dual system of old and new policies pending the outcome of the policy review. This situation was causing confusion, particularly among new and casual staff members, and needs to be addressed.

In some recently refurbished clinical units at RMH, a system of individual patient medication storage has been implemented. This storage takes the form of locked drawers situated in furniture adjacent to the patient's bedside. Nurses who have been assigned the care of those patients hold keys to those drawers. Security of keys has been an issue of concern. Prior to the Inquiry there was no provision in place for checking the distribution, holding and returning of keys.

While the use of individual patient drug administration systems is known to reduce error, some disadvantages have been noted since this system was introduced at RMH. Problems have occurred with a failure to ensure that drawers have been cleared of all drugs following patient discharge. In addition, some patients have been discharged with incorrect medication, particularly out-of-hours. These problems are under review by the RMH pharmacy department. Unless the potential for error can be reduced through system design, and access can be controlled, documented and audited, the suitability of this individual patient medication storage system should be reconsidered.

Preceding the recent allegations of misconduct at the RMH, there had been no Hospital-wide monitoring of compliance in clinical areas with medication policies and procedures. The Inquiry was advised that it was unclear whether nursing staff or pharmacy staff were responsible for monitoring and addressing issues relating to compliance with Hospital policies and procedures. Responsibility for monitoring and addressing issues of compliance with legislative and organisational requirements for the management of medication at the RMH should be delegated clearly within the organisation. The most appropriate position of responsibility for this role is the Director of Pharmacy.

Staff advised the Inquiry that, in some areas, there had been a decline in the rigour of medication control at RMH. Examples, most of which have now been addressed by management, were provided to the Inquiry:

- drugs awaiting return to pharmacy were sometimes not stored in locked facilities but left in open ward areas;
- established nursing practice requires that 'the key [of the drug cupboard] is always to be in the possession of the most senior nurse on the ward at any time and must not be left where others have access to it'⁷. It is also RMH policy that keys are to be kept on the person of the nurse in charge. The Inquiry was advised, however, that keys to the dangerous drug cupboard and the drug cupboard were kept together and were not always appropriately located. For example, occasions when drug cupboard keys had been left lying on the bench or in a drawer in the unit were reported;
- there was no system of tracking lost keys to locked patient medication drawers;
- frequency of checking procedures for drugs of addiction did not always meet the procedural standard of checking at the commencement of each shift;

⁷ M Wallace, *Health Care and the Law*, 3rd edn, 2001, p.303

- ‘Hospital in the Home’ dangerous drugs were transported in an unlocked container; and
- procedures governing ‘loaning’ of drugs between wards and obtaining non-impresst items after hours were considered by staff to be inadequate.

The following issues were identified by respondents as being of continuing concern:

- nursing staff consider replacement of impresst drugs by technicians has reduced efficiency;
- specialist areas such as the Intensive Care Unit and Emergency Department that require speedy access to life saving drugs store them in unlocked facilities. In Intensive Care the Inquiry was advised that the doors are frequently impossible to close because of the amount of stock held in the unit; and
- nurses in division 2 of the Register of the Nurses Board of Victoria administering drugs, despite drug administration currently being outside their scope of practice.

Recently, there have been demonstrable improvements in medication management systems at RMH including:

- the supply of medications to clinical areas is well supported by documentation. Separate requisition forms are supplied for restricted, non-restricted substances and drugs of addiction;
- impresst review and changes (June 1999) state that restricted impresst items should be reviewed regularly (for example, every three months) by the ward pharmacist and that restricted items should not be placed in a ward where inappropriate use due to easy access might occur;
- an RMH policy (January 2001) states that the pharmacist will be responsible to check the contents of the impresst cupboard once a month to ensure correct and appropriate stock is held on the ward;
- the inpatient medical record clearly sets out the conditions of nurse-initiated medication; and
- drug administration guidelines are available to all staff via the ‘Intranet’.

Recommendations:

- 25. RMH reviews the design of its individual patient medication storage system to ensure that risks of medication error are minimised and access to individual patient medication storage containers is appropriately restricted, documented and audited.**
- 26. Responsibility for monitoring and addressing compliance with legislation, Regulations and policy is clearly assigned within RMH to the Director of Pharmacy.**

- 27. RMH reviews procedures governing ‘loaning’ of drugs between wards and obtaining non-imprest items after hours.**
- 28. RMH reviews medication storage facilities within the Intensive Care Unit and the Emergency Unit and ensures the availability of adequate and accessible storage facilities to ensure that staff and patient safety is not compromised.**

6.3 Medication Misuse

In busy hospitals where patient care requires that drugs are readily accessible, a balance needs to be achieved between:

- security of drugs;
- accessibility of drugs; and
- accountability of health care professionals for complying with laws, policies and procedures governing the secure storage and administration of drugs.

The enormous volume of Schedule 4 drugs handled in a hospital environment means it is not practicable for every transaction to be verified retrospectively and reconciled to an individual patient. In addition, the effectiveness of the current controls relating to Schedule 8 drugs (drugs of addiction) could be diminished if all non-addictive prescription drugs were similarly controlled (i.e. checked and signed for and stock balances frequently audited).

While Schedule 4 drugs are less susceptible to abuse than Schedule 8 drugs, a number have the potential to be misused by staff. These include benzodiazepines (for example, Valium), Ketamine (an intravenous drug used for pain relief) and Panadeine Forte (which contains codeine). The legislation and regulations require that Schedule 4 drugs are kept in locked storage, but the stringent record keeping and auditing requirements of Schedule 8 drugs do not apply. Some respondents to the Inquiry indicated they were aware of, and seriously concerned about, isolated instances of theft and misuse of Schedule 4 drugs.

Control of some Schedule 4 drugs such as those mentioned above could be improved. For example, benzodiazepines and drugs containing codeine should be stored centrally in cabinets with limited and audited access. Checking and administration procedures for these drugs should facilitate reconciliation of dispensation to individual patients. Regular auditing, both systematic and random, of the usage of these drugs, including reconciliation of their use to individual patients, should be undertaken.

The Inquiry considers that all hospitals and health service facilities should have an explicit ‘zero tolerance’ policy towards the theft or misuse of drugs. This should include ‘chemist line’ items (for example, paracetamol) that are routinely available in hospital departments, as well as drugs that require a prescription. It is not unreasonable, however, for health care professionals to have controlled and limited access to a small number of ‘chemist line’ items for minor ailments. Hospital policies and procedures could reasonably allow for controlled access to a limited range of commonly used ‘over the counter’ medications.

As these are issues that affect all hospitals, it would be appropriate for the Melbourne Teaching Hospitals' Drug Usage Group to consider the development of model policies, procedures and guidelines to assist hospitals with effective medication control.

At a Directors of Pharmacy conference auspiced by the Society of Hospital Pharmacists of Australia, Victorian Branch in August 2002 the view was strongly expressed to HSC that review of the *Drugs, Poisons and Controlled Substances Regulations 1995* is required. There have been concerns that the 1995 amendments took 'de-regulation' too far and led to a lowering of standards. They referred to the 'back to basics' principles on drug control and security:

Sometimes, basic rules can be construed by busy hospital staff as clerical time wasting. Therefore, education must link patient safety and medication outcomes to the basic principles of best practice in drug storage and control. The consequences of poor practice (unlocked medication drawers, unlabelled drugs, unused medication being stored insecurely, untidy medication storage areas, drugs easily mixed up etc.) need to be clearly elucidated. Similarly, double checking certain drugs before administration, receipt and usage of drugs of dependence, oversight of all drug use and storage facilities and expiry date checking procedures, are fundamental activities that underpin the safety of the system for medicines use.

Future new functions such as automated drug distribution devices or electronic prescribing with decision support and nurse administration systems will not reduce the need to ensure that the basics are correct.⁸

Recommendations:

- 29. RMH develops urgently a 'zero tolerance' policy on the theft and misuse of drugs by staff, and considers allowing, within that policy, controlled and monitored access to 'chemist line' items. (see also Recommendation 66).**
- 30. Processes continue to be developed and monitored to ensure that medications are stored appropriately and securely to prevent unauthorised access.**
- 31. Drug stocks are audited regularly, on a systematic and random basis, to ensure compliance with drug storage and administration requirements, and clear reporting and response procedures are developed.**
- 32. The Melbourne Teaching Hospitals' Drug Usage Group be asked to assist hospitals by developing model policies, procedures and guidelines for medication security and control.**
- 33. The Department of Human Services reviews the effectiveness of the current 'co-regulatory' approach to the management of drugs, poisons and controlled substances in hospitals.**

⁸ Letter from The Society of Hospital Pharmacists of Australia to Beth Wilson, Health Services Commissioner, dated 30 July 2002

6.4 Medication Errors

It is RMH policy that medication errors are documented and reported immediately to the senior administrative nurse on duty. Incidents should be reported to the Medication Risk Committee, which takes responsibility for following up and implementing preventative action such as education or documentation. An example of the work of the Committee occurred when the usage of Ketamine increased without adequate explanation. It is now stored with Drugs of Addiction and infusions are prepared in the Pharmacy unit.

In response to a perception of under reporting of medication errors, an anonymous reporting system has been established. It has been operational since March 2002 and the number of medication errors reported has increased substantially. An increase in reported errors should not be viewed as a negative outcome in these circumstances. Rather, it indicates an increased willingness by staff to report and analyse the causes of adverse events.

The method and system of feeding information back to the divisions and other relevant areas, such as nursing educators, is still to be determined by the Pharmacy Department. This is considered by the Inquiry panel to be an important step in completing the quality loop.

Recommendation:

- 34. RMH Medication Risk Committee develops comprehensive feedback mechanisms to all Divisions of RMH to enable staff to learn from Hospital errors and implement pro-active preventative strategies that link into quality programs.**

RMH clinical nurses suggested to the Inquiry that a universal medication chart for all Victorian hospitals would decrease the incidence of medication error. This suggestion has not been evaluated specifically as part of the Inquiry but could be considered further by representatives of Victorian hospital pharmacies and the Victorian Quality Council.

Recommendation:

- 35. The Department of Human Services seeks advice from the Victorian Quality Council and the Melbourne Teaching Hospitals Drug Usage Group on the potential for the introduction of a standardised medication chart for all Victorian hospitals to decrease the incidence of medication error.**

7 INCIDENT REPORTING SYSTEMS, PARTICULARLY RELATING TO CONCERNS IDENTIFIED BY ANY STAFF

7.1 Background

Nationally and internationally, it is now well recognised that the complexity of modern health care creates significant risks for patients. The Australian health care system provides a very high standard of care. As with all modern health care systems, however, many opportunities exist to improve the safety and quality of care.

The Australian Council for Safety and Quality in Health Care has identified safety as the 'leading edge' of health care quality. Health care professionals and the organisations within which they work need to review and learn from their experiences, and be prepared to change the ways in which things are done so the care they provide is always of the highest standard. Adverse events and near misses that have the potential to harm patients, occur in all health care organisations. By investigating adverse events and near misses within a clinical risk management framework, opportunities can be identified to improve the design and operation of the systems within which health care is delivered.

- An 'adverse event' is:

'An unintended injury or complication which results in disability, death or prolonged hospital stay and is caused by health care management rather than the patient's disease.'⁹

- A 'near miss' is:

'An unexpected or unplanned event in relation to patient care that does not result in patient harm.'¹⁰

- 'Clinical risk management' is:

'An approach to improving quality in health care, which places special emphasis on identifying circumstances which put patients at risk of harm, and then acting to prevent or control those risks. The aim is to both improve quality of care for patients and to reduce the costs of such risks for health care providers.'¹¹

RMH has a Clinical Risk Management Committee, chaired by the Acting Executive Director of Medical Services, that reports directly to the CEO. Committee members are predominantly senior medical managers within Melbourne Health, together with Directors of Nursing, Allied Health and Pharmacy, and a representative of the Victorian Quality Council.

⁹ Effectiveness Unit, Quality Branch, Department of Human Services, *Evaluation of clinical risk management program: tender brief*. Tender No. T1694, 1999 (cited in Department of Human Services, *Improving patient safety in Victorian Hospitals*, 2000, p.vi)

¹⁰ Department of Human Services, *Improving patient safety in Victorian Hospitals*, 2000 p. vi

¹¹ K Walshe, and M Dineen, *Clinical risk management; making a difference?* 1998, p.5.

Nurse clinicians are not, however, represented in the membership of this Committee. Staff identified this as a deficiency. There would be mutual benefits in appointing nurse clinicians to the Clinical Risk Management Committee.

Recommendation:

- 36. RMH includes clinical nurse representatives on the Clinical Risk Management Committee.**

7.2 Adverse Events

The Victorian Department of Human Services requires hospitals to collect and analyse specific data to identify systems or practice problems in clinical care:

- ‘sentinel events’ – events that may occur independent of a patient’s condition, have adverse outcomes for patients and may be preventable. A root cause analysis pro forma is included in the Department of Human Services package which is to be completed by the Hospital and returned to Department of Human Services; and
- ‘limited adverse occurrence screening’ – medical records are screened for adverse events using screening criteria.

At the time of the Inquiry, RMH had not established the systems and processes for collecting data on sentinel events and for undertaking limited adverse occurrence screening.

Recommendation:

- 37. RMH develops a Hospital-wide program for meeting Department of Human Services requirements for reporting sentinel events and limited adverse occurrence screening.**

Metropolitan hospitals are also required by the Department to have a system for reporting, analysing and responding to adverse events and ‘near misses’.

RMH Clinical Risk Management Committee receives and actions reports from a number of working groups, committees and clinical divisions. There were 751 adverse events reported during the period October 2001 to March 2002. Of these, 59% related to patient falls, 21% to medication errors and 19% to ‘other’ events. This distribution is broadly consistent with national and international experience.

The Intensive Care Unit of RMH participates in a national incident reporting program, the Australian Incident Monitoring System (AIMS), which provides anonymity to those who report adverse events. The benefit of such a program is that hospitals receive benchmark data on which to assess their own performance. Staff from the Intensive Care Unit indicated they were satisfied with the AIMS programs.

Staff considered the 'adverse' incident reporting system could function more effectively at RMH:

- a new policy for reporting adverse events was completed in March 2002. Staff who commented on this agreed the policy and the reporting form could be improved. Clinical staff expressed concern about the pre-emptive statement on the document that presumed the cause was a failure to provide adequate nursing care, whereas the incident may have been caused by other processes;
- a number of middle managers and clinicians advised that many incidents are not reported, even when serious. In addition, they said there was a lack of consistency between clinical areas in what was expected to be reported; and
- staff noted that extremely limited or no feedback was received on the organisational analysis of, and response to, adverse events. Lack of feedback has had a detrimental effect on RMH staff relationships and morale.

It is well documented that adverse event reporting systems are highly unlikely to capture all adverse events and near misses. However, organisations that avoid a 'blame and shame' response are likely to encourage reporting, thereby increasing organisational opportunities for learning. Some staff considered that in the past RMH has demonstrated a culture of blame that has discouraged reporting.

At the March 2002 meeting of the Clinical Risk Management Committee, feedback to staff was discussed and it was agreed that this is a necessary component of an effective clinical risk management system. A feedback system is now being implemented, but at the time of the Inquiry clinical staff had not yet experienced its effects.

Critical to the effectiveness of clinical risk management strategies is the educational preparation and involvement of relevant staff. Support for staff at all levels is necessary and should include:

- involvement of respected clinical staff with a proportion of their paid hours dedicated to the program;
- staff education about the aims and objectives of the program;
- the provision of information about the program to new staff at the commencement of their employment; and
- involvement of key clinical staff in the analysis of events and provision of feedback to those involved in incidents, as well as appropriate support for those staff involved in incidents.¹²

¹² Acute Health Division, Department of Human Services, *Clinical Risk Management Strategy*, 2001, p.4

Recommendations:

38. **RMH revises its policy and reporting pro forma for adverse events to ensure:**
 - **reporting lines are unambiguous**
 - **timelines for all levels of action are clearly stated;**
 - **there is a clear and effective feedback loop;**
 - **key performance indicators are practical and relevant;**
 - **policy changes related to adverse events are captured appropriately and implemented through the quality improvement program.**
39. **RMH adopts a systems approach to clinical risk management, in accordance with established best practice.**
40. **RMH ensures the provision of appropriate educational programs on clinical risk management for all staff.**
41. **RMH includes education on clinical risk management in orientation programs for all new staff.**

7.3 Staff Complaints

Staff complaints and feedback are an important means of monitoring and identifying areas in need of improvement. RMH has an informal system of dealing with staff complaints and feedback. Such systems place the responsibility on the immediate line manager to recognise the importance of the complaint, to deal with it effectively to the stage of resolution, and to provide feedback to the staff member making the complaint.

In busy clinical areas, where prioritising administrative tasks is often necessary, the value of staff feedback/complaints is often overlooked. Several nurse clinicians advised they felt there was no point complaining, as they were ‘not listened to’ and ‘nothing ever changed’.

Staff wishing to report serious complaints now receive protection under the new *Whistleblower Protection Act 2001* (Vic.), which came into effect in January 2002.

It is important staff understand their rights and responsibilities in relation to making complaints, and alternative pathways are made available to them when they are dissatisfied with the management of serious complaints.

Recommendations:

42. **RMH formalises a process for the management of staff complaints and staff feedback, to ensure all complaints are registered and actioned, and feedback is provided.**
43. **The formal complaints process includes provision for further review of serious complaints where the staff member is dissatisfied with the outcome of the initial management of the complaint.**

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| <p>44. Complaints and feedback processes are linked with local quality improvement programs.</p> <p>45. RMH ensures staff are familiar with the provisions of the <i>Whistleblower Protection Act 2001 (Vic.)</i> and processes are in place for its implementation.</p> |
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7.4 Management of Incidents Involving Staff

Incidents and accidents involving staff members are subject to legislative control. The HR Department at RMH has established procedures to ensure legislative requirements are met, and the welfare of staff members protected. RMH staff incident/accident procedures require staff involved in an incident, accident or near miss, (or their supervisor if the staff member is incapacitated) to complete immediately a staff incident report. The report is forwarded to the work environment consultant by the end of the shift.

Following receipt of the report, all staff incidents are investigated and followed up at the local level and by the work environment consultant. A database of staff incidents is maintained for the purposes of quality improvement. Staff interviewed considered the current procedures provide effective management of staff incidents and accidents.

7.5 Patient Complaints

Patient complaints are an important source of information and they provide opportunities for quality improvements. They allow hospitals to hear what patients, their families and carers think about the services provided. Most people who make complaints want to know what went wrong and why, and they want to ensure the same thing does not happen to others. In other words, they want their complaint to make a difference by resulting in a quality change.

RMH employs a full time Complaints Liaison Officer to manage complaints and provide feedback to the CEO and Board. She considers she has strong support from the CEO and senior management. She is a member of, and reports to, the Clinical Risk Committee on a monthly basis. Substantial and serious complaints and complaint trends are brought to the attention of the Committee and usually are acted upon. The Complaints Liaison Officer also reports on a monthly basis directly to her manager who is the Acting Executive Director of Medical Services. Complaints data are reported to the HSC and become part of a Victoria wide database which is published in the HSC Annual Report.

In the financial year 2001-2002 RMH received and resolved 473 complaints. Of these, less than 1% were serious and less than 1% are deemed by RMH to require a policy change. Formal complaints relate predominantly to access to services, communication problems, care issues particularly related to elderly patients, and cancellation of surgery. There are, of course, complaints made locally that can be resolved quickly and do not come to the attention of the Complaints Liaison officer.

The Complaints Liaison Officer occasionally takes on a preventative role when Divisions ask for more assistance with patients or relatives who have a problem. The role of the Complaints Liaison Officer is a very busy one and, because the officer needs to respond immediately to 'crises', this means much of her time is taken up being reactive rather than proactive or reflective. Some administrative support would ease this situation and allow the Complaints Liaison Officer to engage in work which uses complaints information to improve the quality of services. This could include for example the use of root causes analyses to determine how complaints information can be used constructively in an atmosphere free from blame.

Recommendation:

- 46. RMH ensures that the Complaints Liaison Officer receives appropriate administrative support.**

The Complaints Liaison Officer at RMH is involved in education of all new staff at orientation on a monthly basis. Training about the importance of complaints is also provided for new Hospital Medical Officers and there is an active Community Advisory Committee to which the Complaints Liaison Officer has input. This is an important part of the role and should continue to be encouraged and supported by management.

In most of our hospitals there is some resistance to the work of complaints officers from staff who view complaints negatively. In the experience of the HSC, this is a problem with some senior medical staff. Changing these attitudes can only be achieved through strong leadership from the top. Even though only 1% of complaints are deemed to be serious, every complaint is important to the individual who goes to the trouble of making the complaint.

Recommendation:

- 47. Senior management at RMH continues to support the work of the Complaints Liaison Officer by assisting in the training of all staff, including senior medical staff, about the importance of good complaints handling.**

Currently there is no formal process at RMH to link patient complaints with quality improvement. The Complaints Liaison Officer does not have formal representation or input into the Quality Committee. When a complaint has been dealt with, the Complaints Liaison Officer does not receive any follow up information from Divisions in relation to policy and procedural changes that may have resulted from the complaint. The absence of a complete feedback loop for quality processes is a problem for the complaints processes, as it is throughout the Hospital.

A new process for complaints management was completed and approved prior to January 2001. The process requires major educational and cultural change throughout the Hospital, and has not yet been adopted. The proposed complaints management process would mean that individual Divisions in the Hospital would be accountable by taking responsibility for complaints investigation and resolution and system changes within their own areas, with the whole process being overseen by the Complaints Liaison Officer to ensure statutory timelines in the legislation relevant to the HSC and reporting requirements are met.

Recommendation:

- 48. RMH management adopts the new complaints management proposal to allow individual Divisions to be responsible for complaints investigation and resolution and systems changes in their own areas, with oversight by the Complaints Liaison Officer.**

7.6 Patient/Consumer Satisfaction

A key performance indicator for clinical practice is that of patient satisfaction levels. RMH participates in the Hospital-wide Department of Human Services patient satisfaction surveys. In addition, some ward/unit areas conduct their own local patient satisfaction surveys. While these surveys provide a broad perspective on patient satisfaction indicators, some staff indicated that, in their opinion, there is not a culture of consumer feedback at RMH, nor knowledge of what is specifically required to improve patient/consumer satisfaction.

RMH employs a clinical nurse consultant who has direct dealings with families. In the opinion of several nursing staff, the culture of relying on the clinical nurse consultant has diminished the skill of clinicians to deal with family issues. As one respondent commented:

The employment of a nurse consultant has changed the role of the bedside nurse, and we have become bad at getting involved with families. The clinical nurse consultant deals with that. Four years ago when we did not have that luxury we were the ones who were consulted.

A simple test of accountability to assess quality of care would be for each staff member to document the level of satisfaction of patients in their care in the medical record on each shift.

Recommendation:

- 49. RMH nurse managers establish accountabilities for individual staff members to assess the quality of the service they provide.**

8 STANDARDS OF DOCUMENTATION RELATED TO PATIENT CARE

8.1 Background

In hospitals vital aspects of patient care are carried out by a number of staff within the nursing, medical and allied health disciplines. Clear and accurate documentation of all aspects of a patient's care is important to ensure safety, quality and continuity of care. It facilitates assessment, diagnosis, planning, implementation, and evaluation of patient care. It is a fundamental means by which information is passed between health care providers and a record of patient care and associated health outcomes is maintained.

The Australian Standard for documentation states:

*A record should correctly reflect what was communicated or decided or what action was taken. It should be able to support the needs of the business to which it relates and be used for accountability purposes.*¹³

Health care organisations should have in place clear policies about the required content of medical records, and the effectiveness of these policies should be monitored regularly. These policies are usually supervised by a senior specialist Health Information Manager.

There is a history of change of Health Information Managers at RMH. The current manager was appointed in February 2002, and is establishing systems and processes to ensure accountability for medical records across all clinical areas. There is a procedure manual, (dated 2001), for documentation in medical records. However, there are no criteria for management and handling of medical records. The Health Information Manager is not aware of any recent content audits of medical records, but expressed a commitment to conducting such audits in the future.

8.2 Documentation Audit

8.2.1 Background

To assess the standard of documentation in the medical records, an audit of 60 medical records of patients discharged over a two-week period in February 2002 was conducted. These records were selected and supplied to the Inquiry by the Health Information Manager.

The audit specifically focused on the following essential components of documentation:

- patient assessment;
- planning of care;
- implementation of care; and
- evaluation of care.

¹³ Australian Standard, ISO 15489.1:2002, Records Management – General, p.7

Although all documentation within the medical record was included, the primary purpose of the audit was to assess the quality of nursing documentation, which was evaluated against standards in the medical records procedure manual, dated 2001.

General findings of the documentation audit indicated the need for significant improvement:

- there was little uniformity in what was included in the record, and many components are not covered by documentation standards. This issue may not be specific to RMH.
- medical records (also called progress notes) were not well integrated. Medical, nursing and allied health staff had made sequential entries. There were, however, large gaps in the progress notes caused by the introduction of an additional documentation tool designed to plan and document the entire sequence of medical and nursing care. This tool is given various titles and for the purpose of this Inquiry will be titled the 'clinical pathway' (this will be considered further under the separate subheading 'Planning of Care' below);
- the wards in which patients were located were not identified in the progress notes;
- signatures were often illegible, although the notes were usually legible. In a few cases the name of the writer was printed, as required by procedural standards. The designation of the writer was often omitted;
- on three occasions alerts were not appropriately documented for patients, who had a reported allergy to a medication. While reports of medication allergies can be unreliable and their clinical significance varies, patients with confirmed, serious medication allergies can be compromised seriously if these are not appropriately documented (RMH was advised of this immediately, to enable remedial action to be taken);
- progress notes were difficult to follow. Irrelevant and redundant information was included frequently and duplication of information occurred regularly, thus blurring the salience of essential information; and
- a number of entries were not dated.

8.2.2 Patient Assessment

Nursing assessment is important as it forms the basis for care planning and measuring patient progress. There is no Hospital-wide standard for nursing assessment. The documentation audit found that:

- documentation of nursing assessment was frequently inadequate, relating only to presenting symptoms. The exception occurred in specialist areas where thorough nursing assessments occurred;

- documented assessment of elective surgical patients is of a higher standard because they undergo pre-admission screening that provides assessment data from which care is planned;
- discharge planning was evident on most records, and the Discharge Risk Assessment form was usually completed but not always; and
- medical assessment was usually clear and comprehensive, although not always dated.

8.2.3 Planning of Care

Again, there is no Hospital-wide standard for planning of care. A variety of methods and tools were used to plan and document patient care, the two most common of which are explained below:

- ‘clinical pathways’ are multidisciplinary tools designed to plan and document patient care, and to monitor variances from planned care. An assortment of models is used at RMH, with little consistency of design and no apparent organisation-wide rationale. Many models did not adopt a multidisciplinary approach and were labour intensive, and there was no evidence of monitoring differences between planned and actual care; and
- some clinical areas used ‘problem lists’ to plan care. These were handwritten with provision for documentation of outcomes. Problem lists were rewritten daily, which made tracking of progress difficult. In many cases, problem lists were incomplete.

8.2.4 Implementation and Evaluation of Care

There is no standard at RMH that addresses requirements for documentation of care. A large number of audited records demonstrated a poor understanding of the need to document the implementation and evaluation of care. There was a considerable degree of variability between, and within, clinical areas. Documentation in specialist areas generally was more comprehensive than in non-specialist areas.

Examples of problems found in the area of implementation and evaluation of care include:

- a lack of documentation of the outcomes and follow-up evaluation of patient care. Documentation often failed to refer to a patient’s previous health status. In almost all of the documentation audited, there was a failure, to varying degrees, to include statements indicating what follow-up assessment and care was provided to patients. In some cases, the omissions were serious;
- outcomes of medications administered for pain were often not documented. One medical record documented eleven doses of a narcotic administered for pain without written evaluation of effect. Many of those, which were followed up, were unclear, for example, analgesia given with ‘effect’, not indicating whether pain was completely or partially relieved; and

- one Department had an individual progress notes pro forma, which included an ‘outcome’ column. This would be useful if used correctly, however, the column was not used to document outcomes but instead contained nurses’ signatures.

A positive aspect of documentation was the minimal use of ambiguous terms such as ‘good’ and ‘satisfactory’ and the objective reporting style used by staff.

RMH nurse managers were almost universally critical of the quality of documentation of patient care, while nurse clinicians were less inclined to comment. Nurse managers were conscious of the formal lack of monitoring and evaluation of documentation standards: Some comments included:

Paperwork varies from ward to ward. If you are Bank and floating as an agency, it is a nightmare. You go in and have patients and know nothing of them.

We document every time we see a patient, whether or not we do give them a wash or they have a full bed change.

RMH management has begun to act on concerns relating to documentation, resulting from their own review, has recently conducted an internal audit and is actioning a range of issues aimed at improving existing practice. The outcome of the actions to improve documentation should be monitored when the process is complete.

Recommendations:

- 50. RMH develops a standard for handling medical records.**
- 51. RMH nursing leadership develops a rationale for information to be included in nursing documentation and provides relevant education to all clinical staff.**
- 52. RMH develops outcome standards for documentation relating to:**
 - **nursing assessment**
 - **planning care**
 - **implementation of care**
 - **outcome/evaluation of care.**
- 53. RMH works with all stakeholders to design improvements to the Medical Record Progress Notes which would assist in alerting staff when patient follow up action is required.**
- 54. RMH develops a process for regularly monitoring the quality of medical record documentation.**

9 NURSING MANAGEMENT AND OVERSEEING OF CLINICAL PRACTICE AT WARD LEVEL

9.1 Background

In Australia and overseas, Directors of Nursing, supported by Nurse Units Managers (also called Charge Nurses), traditionally have assumed primary responsibility for the management of nursing in health service organisations. Nurses in these senior positions have also played, and continue to play, a key management and leadership role in ensuring agreed nursing standards of care are upheld and quality patient outcomes are achieved.

In Victoria, it is the formally stated position of the Victorian Council of Peak Nursing Organisations (VCPNO) whose membership includes the Australian College of Nurse Management, the Royal College of Nursing Australian (Victorian Chapter), the Victorian Council of Deans (formerly the Heads of Schools/Faculties of Nursing – Victoria), and the Australian Nursing Federation (Victorian Branch), that:

All health service facilities organisational structures must include the position of Director of Nursing (however titled) who must be a registered nurse and whose position must maintain:

- **Executive Role** participation in corporate planning, organisation and evaluation with Board of Management/Board of Directors, Senior Executive and Advisory Committees involving patient care – nursing service.
- **Divisional Role** in accountability and responsibility for standards of patient care and nursing practice, through nursing personnel management, communication, financial management, staff development/education, quality activities including peer review and research.
- **Unit Level Management Structures**, where decentralised clinical groups are established, to reflect equal and complementary relationships among registered nurses, medical practitioners, allied health professionals and managerial personnel. Nursing positions in these units must reflect a professional relationship with and the appropriate authority of the Director of Nursing.
- **Delegation of Nursing Care Responsibilities**, which must only be to registered nursing practitioners in compliance with the Nurses Board of Victoria Guidelines.¹⁴

A Charge Nurse/Nurse Unit Manager, in this context, is a registered nurse with responsibility for managing directly and coordinating a particular ward, unit or team. The range of responsibilities encompassed by the Charge Nurse/Nurse Unit Manager role includes teaching/mentoring/supervision of clinical practice/promoting excellence in nursing practice/personnel management/involvement in relevant internal committees and participation in Quality Improvement programs.

¹⁴ Victorian Council of Peak Nursing Organisations, *Position Statement: The Position of Director of Nursing in the health services organisational structure*, 1997

At RMH, overall responsibility for the management of clinical practice has been delegated to six Divisional Directors. Five of these are medical practitioners and the sixth is a nurse. These Divisional Directors are assisted, at the operational level, by Divisional Directors of Nursing. It is the Nurse Unit Managers, however, who take primary responsibility for ensuring clinical effectiveness at the point of service delivery.

Nurse Unit Managers responding to the Inquiry indicated that they understood the importance of their role in providing education and support to nurse clinicians. They stated that they regarded their management and leadership role as important in regard to such things as:

...ensuring high standards of care, education for staff and some external education, upskilling in Information Technology, which will help lead us into the future.

...clinical care in the workplace, improving communication and helping people develop in their role.

...developing and implementing policies and procedures [...] that are actually there, but have not been put into practice.

9.2 Monitoring and Evaluating Clinical Practice

Respondents indicated that Departments, wards and units at RMH conduct and plan their own quality improvement systems to monitor clinical practice. The processes used are, however, *ad hoc*, and lack the formal structure otherwise required for quality improvement. In some areas, such as ICU, nursing staff work as a team with medical staff to solve clinical problems and monitor risk factors. Other areas may have a nurse with a delegated responsibility for quality improvement. Areas such as Neuroscience may use case studies to inform improvements in patient care. Some areas have no formal nursing structure for quality improvement. Identification of areas where improvement is needed appears to be made by the Nurse Unit Manager, on a random basis, without an obvious link to corporate objectives. In the absence of universally accepted quality improvement models and benchmarking, there is heavy reliance on informal peer review to appraise work performance.

The RMH position description of the Nurse Unit Manager establishes responsibility for the quality of clinical practice and performance management of staff. Effective performance review processes can promote the continuing development and improvement of staff. If performance review is not done well, the results can be extremely negative. It is important parties understand the process, and the reviewer has the expertise to conduct the review in a positive and constructive manner.

RMH policies and processes for performance review include a model *pro forma*. Its use is not mandatory, however, key elements of the process are documented and must be completed. The key performance indicator for performance review is the percentage of staff performance reviews completed per annum. It would be more beneficial to the process to include the quality of performance review and resulting changes.

Prior to the Inquiry, work performance was appraised primarily on an informal basis, by peers engaged in direct and participatory observation of each other's work. The Nurse Unit Managers and Associate Nurse Unit Managers all observe the clinical practice of nurses working in their ward/unit, as do other senior nurses (eg Clinical Nurse Specialists and Clinical Nurse Consultants) and give feed back, but on an *ad hoc* basis only. It was recognised by respondents (including managers) that this situation was unsatisfactory and inconsistent with quality management standards.

A new process for staff appraisal has been introduced recently at RMH. Education in conducting performance review has now commenced for Nurse Unit Managers. Generally those interviewed did not, however, see value in the process and clinical staff have not yet received training.

Recommendation:

- 55. RMH provides education and guidance for all staff on the need for, and benefits of, effective performance review and development processes.**

9.3 Clinical Standards and Competencies

Standards and mandatory registered nurse competencies pertinent to specialty areas have been developed at RMH and are assessed periodically. Standards and mandatory registered nurse competencies pertinent to generalist (non-speciality) areas, however, have not yet been developed and made the subject of periodical assessment.

RMH has recognised the difficulty of evaluating clinical performance and, in conjunction, with the University of Melbourne, is workshopping a research project on the way in which the clinical level of performance can be improved.

Recommendations:

- 56. Comprehensive and outcome oriented best practice standards and mandatory registered nurse competencies pertinent to generalist and speciality areas of practice are developed and/or adopted by RMH and assessed on a regular basis.**
- 57. RMH participates in State and National initiatives aimed at the development and implementation of best practice standards for clinical nursing practise.**

9.4 Nurse Unit Manager Supervisory Capacity

Clinical supervision is an important component of effective clinical governance. Clinical supervision is a formal process of professional support, skill development and learning that enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance the safety and quality of care in complex clinical situations. It is central to the process of learning and to the expansion of assessment, analytical and reflective practice skills¹⁵.

¹⁵ A Morton-Cooper, & A Palmer, *Mentoring, Preceptorship and Clinical Supervisions. A guide to professional support roles in clinical practices*, 2nd edn, 2000

In its recent report on nurse recruitment and retention in Victoria, the Nurse Recruitment and Retention Committee, Victoria Department of Human Services (2001) recommended that all registered nurses receive two hours per month of clinical supervision. Specifically, the Committee recommended that:

...clinical supervision for registered nurses is introduced into the public hospital system as a strategy for regaining experienced, qualified nurses in clinical settings and that each nurse, regardless of full-time or part-time status, will receive two hours per month of clinical supervision time.¹⁶ (Recommendation 79(a), p.10).

The Committee contends that such a provision may prove to be effective, relevant and satisfying to nurses and provide a relevant clinical component to enhance the current performance review methods.

It is a key responsibility of Nurse Unit Managers to provide clinical supervision to nursing staff. The workloads of Nurse Unit Managers, however, frequently preclude them from fulfilling this role and from being visible on the wards. Much of their time is consumed with fulfilling the difficult management responsibilities associated with conflict management and managing staff discontent, staff appraisals, and paperwork. Nurse Unit Managers find 'paperwork' particularly onerous. As one respondent put it:

So much more paperwork. I appreciate that it has to be done, but in fact it has a huge impact on our workload.

As a result of their increasing administrative responsibilities, Nurse Unit Managers believe that Associate Nurse Unit Managers are taking on more of the daily clinical supervision and management tasks, in addition to their clinical/direct patient care load.

Recommendation:

- 58. RMH reviews the administrative workload of Nurse Unit Managers and Associate Nurse Unit Managers to ensure an appropriate level of clinical supervision and support is maintained.**

At RMH, only the services of one bed manager (a person designated with the responsibility to manage 'bed availability', via admissions, discharges and transfers) and one nursing supervisor are available during the nightshift, when the level of senior staff is reduced. Night duty staff interviewed considered these provisions to be inadequate. Senior nursing resources during the night duty shift period should be reviewed to determine whether sufficient resources are available to sustain the provision of safe and high quality patient care.

Recommendation:

- 59. RMH reviews the level of supervisory support available to nursing staff working night duty.**

¹⁶ Department of Human Services, Recommendation 79(a), p.10

9.5 Nurse Staffing

There is, currently, a global shortage of nurses, widely recognised as being the worst shortage in the last 50 years.¹⁷ This is having a significant and negative impact on health care and the capacities of health care systems around the world (including the Australian health care system) to respond appropriately and effectively to the health needs of the individuals, groups and communities they serve.¹⁸

The RMH has not been immune to the global and local shortage of nurses. Difficulties in recruiting and retaining appropriately qualified nurses at RMH have affected significantly the capacity of nursing staff to provide appropriate and high quality care to patients and their families. As one respondent commented:

Suddenly we have corridors full and families screaming at us: why hasn't our father gone to the ward, he is sick? I am trying to defuse the situation, and I am saying, I am sorry, we do not have enough staff, and I am trying to get them to a ward, but they do not understand.

In an effort to provide better services and to meet patient care needs, the RMH employed a high number of casual nursing staff. In one area, for example, it was reported that, prior to recent initiatives by the Victorian State Government to improve permanent nursing staff levels in public hospitals, over 50% of staff had been employed on a casual basis.

Reasons for the casualisation of the RMH nursing workforce are complex. In addition to the general problems associated with nurses' working conditions – a problem recognised throughout the world¹⁹ - some respondents suggested that RMH is particularly disadvantaged when recruiting new staff or attracting graduate nurse year applicants, by its location in the Melbourne central business district and the associated problems with parking and staff security.

The ratio of junior nursing staff to senior nursing staff was viewed by nurse clinicians responding to the Inquiry as problematic. In their view, high numbers of junior and inexperienced nursing staff contributed to a drop in nursing care standards. They reported that this problem was compounded by the general lack of staff resources and an unwillingness by staff from other wards/units to share their resources.

¹⁷ L Hodges, B Williams and D Cannan, *Taking political responsibility for nursing's future*, 11(1) 2002, pp.15-24

¹⁸ R Steinbrook, 'Nursing in the crossfire', *England Journal of Medicine*, 346(22), pp. 1757-1766

¹⁹ A recent comparative study of over 43,000 nurses from more than 700 hospitals in the United States of America, Canada, England, Scotland, and Germany (1998-1999), undertaken by the International Hospital Outcomes Research Consortium, (Aiken, *et al*, 2001), has found that nurses feel 'under siege' with hospitals being unable to find 'enough nurses willing to work under current conditions in inpatient settings' (Aiken, *et al*, 2001:51). The study also found that fewer than half of the nurses surveyed in each country reported that 'management in their hospitals is responsive to their concerns, provides opportunities for nurses to participate in decision making, and acknowledges nurses' contributions to patient care' (Aiken, *et al*, 2000: 47-8). A major concern raised by these and other related findings of the study is the negative impact that the 'large numbers of dissatisfied and emotionally exhausted nurses [could have] on the quality of patient care and patient outcomes' (Aiken, *et al*, 2000:45). Significantly, almost half of the North American nurses surveyed believed that 'the quality of patient care in their institutions had deteriorated in the past year' (Aiken, *et al*, 2001: 43). Australian studies have made similar findings (see Johnstone 2002)

The adequacy of numbers and seniority of RMH nursing staff has not been specifically analysed by the Inquiry. It should be noted, however, that recent state government initiatives have significantly increased the availability of permanent, as opposed to casual, nursing staff, in most metropolitan public hospitals.

9.6 Educational and Research Resources and Programs

Nurse educators share responsibility with Nurse Unit Managers for providing clinical supervision to nursing staff. During the early 1990s, the number of nurse educators was cut dramatically as part of the organisation's restructuring.

Over the past two years, the number of nurse educators at RMH has increased from five to 20. This includes fifteen nurse educators dedicated to the development of nursing staff at RMH and support to nurses within the Graduate Nurse Program (that is, nurses who are newly graduated and who are in their first year of employment since obtaining registration as a nurse in division 1 of the Register of the Nurses Board of Victoria). There are a further five nurse educators employed for post-graduate nursing students.

The professional development needs of other clinical staff are not being met at a level commensurate with their role, level of practice and responsibilities. Nurse educators feel frustrated by what they perceive to be an excessive and under-resourced workload, lack of recognition, and a lack of infrastructure to support them in their role.

A range of educational professional development activities is offered at RMH. For example, consistent with the educational and staff development practices of other Victorian hospitals, maintenance of cardio-pulmonary resuscitation (CPR) competency is mandatory for all staff involved in clinical practice. In 2000, 90% of registered nurses completed the mandatory CPR competency training program. A database is currently being developed to monitor compliance with this standard on an organisational basis. No data have been collected on whether nursing staff completing the CPR competency training feel 'competent' to practice CPR or whether further training might be necessary for some nurses, especially those working in areas where cardiac arrest is not a common occurrence or, at least, occurs too infrequently to enable staff to gauge the level of their competency to perform CPR in an emergency situation.

Recommendations:

- 60. Infrastructure support for nurse educators is reviewed and, where deficient, developed to ensure nurse educators can function effectively in their role.**
- 61. The effectiveness of the CPR competency training is evaluated systematically.**
- 62. RMH considers introducing additional mandatory education or competency testing in priority areas identified by clinical staff and nurse educators, e.g. administering medications, administering patient controlled analgesia (PCA) and epidural management, documentation, and aggression management.**

9.7 Nursing Practice and Policy Development²⁰

The implementation of good quality research is likely to have improved outcomes for patients and is therefore important for quality patient care²¹. Nevertheless, research uptake is notoriously slow in clinical domains.²² There are many factors that influence the effective uptake of research evidence into practice; notable among these are (i) the nature and quality of the evidence, (ii) the nature and quality of the context in which the proposed change is to be implemented, and (iii) the mechanism by which change is facilitated.²³ It is known, for example, that ‘if an intervention that is found to be highly effective is rejected by clinicians and patients, then despite its gold standard status, it is unlikely to be widely taken up’²⁴. It is also known that, despite the ‘gold standard status’ of an intervention, unless clinicians (and patients) are facilitated to understand what they have to change, how and why, desired outcomes (research uptake/evidence based practice) will not be achieved.²⁵ Thus, if a program to implement evidence-based practice is to be successful, attention must be given to ensuring that a clear understanding exists in regard to:

- the nature and quality of the evidence being used;
- the quality of the context in terms of its ability to cope with change; and
- the type of facilitation needed to ensure a successful change process.²⁶

There is increasing recognition in nursing of the need to support and foster a strong focus on facilitating and leading, tracking, evaluating and establishing as benchmark the implementation of evidence-based care. To this end, a number of health care agencies are conjointly appointing ‘Research Practice Development Nurses’ to lead research practice and policy development (otherwise known as ‘Practice Development’) in specialised areas and to improve generally the uptake of research in clinical nursing practice. The recognised benefits of Nursing/Practice Development include:

- fostering a high degree of integrity and accountability in patient care delivery;
- improving the quality of care and health outcomes for patients; (acknowledging that many other variables contribute to the quality and effectiveness of care);
- improving *patient-centred* care;²⁷
- facilitating practice theory generation and application;

²⁰ Excerpt from M Johnstone, O Kanitsaki, and M Flaherty, (2002a). *Evidence-based Nursing Practice Development (Acute Care Gerontology) in an Acute Care Hospital* (RMIT Faculty of Life Sciences Research Grant Application, funded and in progress during 2002-2003)

²¹ A Kitson, et al. 1998. Enabling the implementation of evidence based practice: a conceptual framework. *Quality in Health Care*, 7: pp. 149-158.

²² L Trinder & S Reynolds, (eds), *Evidence-based practice: a critical appraisal*, 2000

²³ A Kitson, et al. *op cit*.

²⁴ A Kitson, et al. *op cit*.

²⁵ A Kitson, et al. *op cit*

²⁶ A Kitson, et al. *op cit*.

²⁷ Royal College of Nursing, Australia and the Australian Nursing Federation, *Project to support nurses to involve consumers in their health care*, 2001

- increasing staff skills and awareness of opportunities and ability to apply research and practice development resources;
- enhancing a culture of ‘learning to learn’ in the clinical practice domain; and
- enhancing existing clinical risk management (CRM) strategies/programs and reduce the risk of adverse events associated with poor staffing levels and skill mix²⁸.

Recommendation:

- 63. RMH considers the development of a 'Nursing Practice Development' program as a means of fostering expertise in evidence based nursing care.**

9.8 Resolving Ethical Issues

During interview, all nurses were asked about ethical issues and the degree to which they felt supported in addressing ethical issues in the work place. Respondents indicated the RMH does not have formal mechanisms for nurses to raise ethical issues, receive feedback or gain immediate advice and support when dealing with ethical problems encountered during the course of their work. Although the RMH has a hospital research ethics committee²⁹ that includes nursing representation, this Committee does not address specific nursing ethics but concentrates on research. There is a professional nurses’ forum called the Council of Nursing Practice that meets to discuss issues affecting practice including patient issues and matters affecting practice. Its membership is open to all nursing staff however, attendance is variable.

This situation is not unique to the RMH. While some Victorian health care agencies (for example, the Royal District Nursing Service) have processes in place to assist nurses in particular to deal with ethical issues encountered during the course of their work, this tends to be the exception rather than the norm.

It is widely recognised that nurses have to deal with many complex ethical issues during the course of their work. In a recent survey³⁰ of 400 randomly selected Victorian registered nurses, respondents identified the following five issues as being among the top five and most frequently encountered problems in nursing practice:

- protecting patients’ rights and human dignity;
- providing care with possible risk to your health (e.g., TB, HIV, violence);
- respecting/not respecting informed consent to treatment;

²⁸ Department of Human Services, *Improving patient safety in Victorian hospitals*, 2000

²⁹ Melbourne Health Research Directorate Human Research Ethics Committee

³⁰ M Johnstone, C DaCosta, and S Turale, (2002b). *Registered Nurses’ experience of ethical issues in nursing practice: Final report to the Nurses Board of Victoria* (59p)(Funded by the Nurses Board of Victoria, Major Grant).

- staffing patterns that limit patient access to nursing care; and
- use/non use of physical/chemical restraints³¹

A combined analysis of reports revealed the following as being the most personally disturbing issues faced by the nurses surveyed:

- staffing patterns that limited patient access to nursing care;
- prolonging the dying process with inappropriate measures;
- working with an unethical/incompetent/impaired colleague ;
- caring for patients/families who are uninformed/misinformed;
- providing care with possible health risk; and
- not considering a patient's quality of life.

Almost one quarter (23.9%) of the nurses surveyed reported having direct involvement in an ethical and/or human rights' issues between one-to-five times per year; 20.4% reported being involved directly in an ethical and/or human rights' issues between one-to-four times per week. Only 5% reported that they were never involved in an ethics or human rights issue in the past 12 months.

When confronted with an ethical or human rights' issues, the nurses surveyed reported that they were most likely to handle these through discussions with nursing peers (86.9%), and nursing leadership (70.4%). Only 47% of nurses surveyed reported they would discuss the issue with the patient's doctor, and only 41% indicated that they would discuss it with another professional. Less than 5% reported that they would make a decision without consulting anyone. The nurses reported that they were unlikely to consult with the patient's family, and only 2.3% indicated that they would consult an ethics committee for advice.

Of particular relevance to the Inquiry, only 8.3% of the nurses surveyed believed that their places of employment provided adequate resources to help them to deal with ethics and human rights issues in their nursing practice. In contrast 28.4% of nurses believed that their work place resources were only slightly adequate, and 10.6% rated their work places resources as *totally inadequate*. Only 38.4% of the nurses surveyed said they had an ethics committee at their places of employment.

Of the 153 nurses reporting a workplace ethics committee, 92.4% reported that it had included nurses and 63.7% knew how to access these committees when they needed to do so. Approximately 10% accessed their work place ethics committees in the past year, and close to 73% wanted to have more information about their workplace ethics committees.

³¹ *ibid*

An analysis of the qualitative comments provided by 82 respondents revealed three key areas requiring attention: poor working conditions, the need for further and ongoing education on nursing and health care ethics, and the need for improved attention to be given to ethical issues in nursing not otherwise addressed in nursing domains. A brief summary of specific findings is as follows:

1. Poor working conditions were described as including:
 - poor management;
 - poor communication among staff;
 - nurses having to work in under-resourced conditions (especially aged care);
 - violence in the workplace (bullying and abuse by other staff and patients); and
 - feeling ‘undervalued’ and disrespected (especially by attendant medical staff).
2. Need for further and continuing education:
 - to facilitate the nurse’s role/empower nurses as ‘patient advocates’;
 - to improve interdisciplinary ethical decision making;
 - to improve knowledge of emerging issues; and
 - to meet needs of care givers and care recipients.
3. Specific ethical issues identified as needing attention:
 - informed consent (especially with children and older adults);
 - family involvement in decision making;
 - end of life decision making;
 - nurses rights;
 - reporting unethical and/or incompetent colleagues; and
 - confidentiality and privacy issues in telephone counselling (Johnstone et al 2002).

On the basis of responses to the Inquiry, it is evident that the issues identified in the Johnstone et al (2002) survey are relevant to nursing staff at RMH.

Recommendation:

- 64. RMH develops formal mechanisms for nurses to raise ethical issues, receive feedback or gain immediate advice and support when dealing with ethical problems encountered during the course of their work.**

10 SYSTEMS FOR STAFF SUPPORT

10.1 Introduction

All hospitals require clear and accessible staff support structures. These are essential to staff well-being and also make good business sense:

A health promoting organisation will also focus on its own occupational health, its work practices and its relationship with its staff³².

Supportive structures may be formal or informal and they need to be in place at the corporate and divisional levels.

Throughout the latter part of the 1990's resource constraints at RMH had a serious adverse impact on nursing support services. High workloads, exposure to stressful situations, poor roster and shiftwork arrangements, combined with a reduction in staff support positions, contributed to low morale and a drop in standards. More recently, budgets have been improved to redress these problems but full recovery will take time. Although nurse clinicians said they now feel better supported by their peers, their Nurse Unit Managers and Associate Nurse Unit Managers also expressed concerns about a perceived lack of high level management support.

By contrast senior managers at RMH stated they feel well supported and displayed the competence and knowledge required to research and access available organisational, professional and, where relevant, external resources.

Nursing staff are just as susceptible to emotional and physical hazards in the workplace as any other group. Nurses with impairments, whether through illness, substance or drug abuse, require assistance and this has not been forthcoming until very recently at RMH. The establishment of a Victoria wide health program for nurses based on the Victorian Doctors' Health Program would be of assistance.

At the Hospital level all staff experiencing illness, whether emotional or physical, should have access to on-site health care while on duty.

Recommendation:

- 65. Key stakeholders such as the Nurses Board of Victoria and peak nursing organisations be involved in a Government sponsored advisory group to explore the feasibility of developing a health support program for nurses in Victoria similar to the Victorian Doctors' Health Program.**

Recommendation:

- 66. RMH develop services to ensure staff experiencing illness at work have access to on-site healthcare. (see also Recommendation 29).**

³² K Eager, P Garrett, & V Lin, *Health Planning Australian Perspectives*, 2001, p.309

10.2 Staff Support Services

10.2.1 Background

The need to promote programs designed to value, support and develop the skills of nursing staff within a quality framework has been recognised at RMH. The management of RMH acknowledges a lack of staff support services in the recent past has had serious consequences, and has developed new structures to link a range of support services. Divisional Directors of Nursing interviewed commended the work of the HR Service (HR) in this regard.

Divisional Directors are charged with the major responsibility for organisational change at the operational level, and were recruited according to their aptitude for working in a collegiate manner as part of the management team. Hospital staff view this as a positive initiative and the new structure has begun to have a positive impact on team work and the sharing of knowledge and expertise.

I feel extremely well supported not only by HR but by our finance area and I am sure the other divisions would say the same things. We have a feeling that we have these people around us

A range of employee support services is now in place at RMH. Some of these are discussed below.

10.2.2 Employee Assistance Program

Melbourne Health has established an Employee Assistance Program (EAP) designed to incorporate existing and new staff support programs. The aim of EAP is to meet staff needs by encouraging a culture of proactively managing critical incidents.

The range of services available to staff within the EAP includes:

- immediate support to staff suffering from trauma or cumulative stress;
- critical incident stress debriefing for staff and teams;
- a peer support program, facilitated by a group of specially trained co-workers, available to support employees in coping with personal and work related issues;
- harassment contact officers;
- access to external counselors;
- staff health service;
- pastoral care services; and

- access to executive team members, human resource managers and consultants, the Occupational Health and Safety Services Unit and the Peer Support Program Coordinator.

10.2.3 Peer Support Program

The Peer Support Program (PSP) involves a volunteer group of RMH staff who provide support to their colleagues on a 24-hour basis. Each month, around 25 people are recruited formally as 'Peer Supporters', and a 10-12 week training program is provided. Training covers affirmative action, anti-discrimination, anti-bullying and counselling techniques. From October 2001 to 31 March 2002, 339 staff from a variety of disciplines, clinical and non-clinical areas, accessed the PSP. Of that number, 146 were nursing staff, i.e. approx 43%. All staff interviewed considered the PSP as encouraging, positive and effective. The new structures, however, being recent, will take time to be fully effective and they will need to be monitored to determine their effectiveness and, where necessary, adapted to ensure they have the desired outcomes.

10.2.4 Staff Satisfaction Survey

A staff satisfaction survey was conducted in 2000. It revealed many concerns by staff and the top ten issues were presented to the Board. A project plan was then developed by HR to address them. High priority action was recommended to:

- improve significantly occupational health and safety performance;
- develop support processes to retain staff by development of a culture that valued staff;
- introduce cultural change to link productivity with staff commitment;
- identify improvements in productivity and patient satisfaction;
- recognise interdependencies in nurse-medico partnerships;
- develop processes to enable employees and line managers to have more control over personal and team development and performance;
- introduce better rostering systems;
- develop effective communication and change management strategies;
- negotiate key issues with industrial relations representatives; and
- identify and seek to close organisational performance gaps.

RMH needs to communicate to staff at all levels that the issues identified by them are being addressed. A further survey is planned for 2002.

10.2.5 Staff Orientation Programs

RMH has an overall hospital orientation program for new staff, the effectiveness of which is reviewed by HR. Local areas, however, design and implement their own orientation programs. Some are formal and evaluated; others are informal and are not evaluated. Clinical departments allocate time to allow for staff orientation with the appointment of mentors to work with and assist new staff members.

There is currently no orientation program that is specific to the needs of nurse unit managers. This is a missed opportunity, as a well designed and well implemented formal orientation program for nurse unit managers that incorporates management expectations of clinical governance, communication and staff support, would provide opportunities for enhanced leadership and be a catalyst for cultural change.

Recommendations:

- 67. RMH Human Resources Service assesses as a matter of priority organisational culture and satisfaction levels of non-management staff and develops strategies to address adverse cultural and morale issues.**
- 68. RMH Human Resources Service develops a standard for staff orientation for implementation at the Departmental level. All programs should be documented formally and monitored for effectiveness.**

10.3 Aggression Management

In multifaceted health care organisations, complex interactions occur between diverse professional groups, non-professional groups and highly vulnerable, often traumatised, patients and families. Situations of conflict can occur. It is the responsibility of the organisation to have processes in place to reduce these risks and, where incidents do occur, to mediate and resolve the conflicts so a reasonable working environment and patient and staff satisfaction can be maintained.

Aggression can, and does occur between patients, staff and patients, and between staff. RMH had a functional aggression management committee, however, this appears to have languished and has not been operational for some time. The devastating and lasting effects aggressive episodes can have confirm the need for formal structures to support anyone affected by aggression. While the PSP is now available for staff who experience aggression at RMH, there are no formal processes in place that would automatically trigger debriefing and ensure it is offered every time it is needed.

Patient aggression is a major problem for clinical staff, particularly those on night duty. Nurses often feel aggrieved by perceived injustices to themselves and their colleagues. The management of aggressive patients can be complex and requires clear and consistent policies.

I have been in many instances with patients who have been verbally and physically aggressive. There is nothing much you can do about it. The family is stressed, these are the things that are happening in their life, and they take it out on us. If it gets too much you call the security guard, but on a ward there is nothing much you can do about it.

Many patients who exhibit aggressive behaviour may be suffering mental and/or physical problems. In certain areas, such as the Emergency Department, staff are often concerned for their personal safety. Issues raised by staff included:

- lack of support for nurses from doctors, when nurses are dealing with aggressive patients; and
- the Psychiatry Registrar does not attend at night, therefore, optimal management of patients admitted during the night requiring expert psychiatric care is compromised, resulting in aggressive incidents.

A controversial issue raised by staff was that of aggression or lack of respect between nursing staff. Although opinions differed as to the extent of such behaviours, staff considered lack of leadership was a contributing factor. RMH management acknowledges the existence of the problem and has expressed a strong desire to address staff concerns about it. RMH management is making strong efforts to promote a culture of mutual respect among all staff.

Recommendations:

- 69. RMH re-establishes the Aggression Management Committee to address current issues of aggression whatever their source.**
- 70. RMH considers the feasibility of rostering the Psychiatry Registrar and/or appropriately trained psychiatric nurses on duty or on call during the night.**
- 71. RMH management continues to monitor nursing relationships to ensure that nurses, particularly junior nurses, feel confident of the respect of their peers.**
- 72. RMH management devises strategies for listening actively to staff issues, and provide opportunities for staff feedback.**

10.4 Communication

Communication difficulties are not uncommon in complex organisations. RMH is no exception, with the majority of staff who were interviewed identifying poor communication as a major source of patient and staff dissatisfaction.

Management at RMH has begun to make efforts to bridge the communication gap. A communications matrix for staff is documented and sets out the methods of contact between staff and management. This matrix is manifested in a series of pre-planned presentations, from managers to staff, to explain key operational and other issues related to the Hospital. Individual lines of communication are explained in the staff presentations and are documented in the 'key relationship' section of position descriptions.

There were marked differences of opinion about the adequacy of corporate communication at senior management, middle management and operational or clinical levels. Nurse clinicians said they felt powerless and frustrated by a failure on the part of management to listen to their concerns, ideas and opinions. It will require a major effort on the part of management to change these perceptions. Some comments made were:

One of the great difficulties is communication, particularly for a person on night duty – things hardly ever reach you. There is a huge neglect in that respect.

The current leaders do listen. Before that – no, absolutely not.

Nursing staff do not receive feedback on issues they raise with administration.

Some nurses acknowledged that staff themselves do not always take advantage of opportunities made available to them by management and fail to accept their own responsibilities by informing themselves of organisational issues.

Recommendation:

- 73. RMH establishes shared accountabilities for communication and establishes a process for educating staff and monitoring the effectiveness of communication across the organisation.**

11 CONCLUSION

RMH, in common with all metropolitan hospitals experienced major structural changes from 1995. A review in 2000 found the networks had become too large, and there had been an undue emphasis on commercial viability at the expense of quality patient care and staff support. At RMH the structural changes had an adverse impact on staff morale and standards. They coincided with complexities including financial implications of scientific and technological changes, increased public scrutiny, increasing demands for services, long waiting lists, higher patient acuity and shorter length of stay, widespread nursing shortages and increasing use of casual staff.

RMH also experienced considerable leadership instability, which resulted in staff perceiving management to be lacking in accountability, non-consultative, without vision and overly focussed on fiscal management. This, in turn, led to mistrust, low morale and a drop in standards. Staff now express more confidence in leadership but the positive effects of recent recruitment of new managers have yet to filter throughout RMH. If staff are not well supported by management patient care will suffer.

RMH has lacked clear policies and procedures to guide staff in important areas such as medications management, incident reporting, staff complaints and standards of documentation. Much work remains to be done until RMH achieves the standards that the public is entitled to expect from a major teaching hospital. RMH, in common with all metropolitan hospitals faces increasing complex demands from the public and from Government. These will only be met by strong leadership and well trained and motivated senior managers committed to team work.

There is cause for optimism at RMH. Additional funding has been made available to tackle the nursing shortage and the new management team, selected specifically for leadership and team building abilities, has begun to tackle the many problems involved in a complex health environment. Positive results are already apparent but more needs to be done to ensure RMH can meet the significant challenges it faces in providing a comprehensive range of services to a rapidly increasing, ageing and diverse population.

11.1 Appendix 1

ROYAL MELBOURNE HOSPITAL INTERVIEWS

1. Chief Executive Officer
2. Acting Executive Director, Medical Services
3. Executive Director, Nursing Services
4. Director, Quality & Performance Measurement
5. Representative of Safety and Service Improvement Committee Performance
6. Director, Human Resources.
7. Director, Pharmacy Service
8. Director, Allied Health Coordinator
9. Manager, Health Information Services
10. Night Supervisor
11. Divisional Leaders:
 - Division of Outpatients, Ambulatory Care and Community Services
 - Division of Cardiac Services
 - Division of Emergency and Perioperative Services
 - Division of Medicine, Aged Care and Rehabilitation Services
 - Division of Neuroscience
 - Division of Surgery and Intensive Care Unit
12. Nurse Unit Manager – Seven –(Including one interviewee from each of the five divisions.) [Randomly Selected]
13. Associate Nurse Unit Managers – Six – (Seven interviewees including one from each of five divisions.) [Randomly Selected]
14. Clinical Incident Manager
15. Principal Nurse Educator
16. Nurse Clinicians Division One and Two. – 5 Groups of Nurses. Approximately sixty interviewed in total.
 - Convenience sample according to availability of nurses, the diversity of information received and time frames.

11.2 References

Aiken, LH, Clarke, SP, Sloane, DM, Sochalski, JA (2001) 'Nurses' reports on hospital care in five countries'. *Health Affairs* 20(3) 2001, pp. 43-53.

Australian Nursing Federation (1998) *Position Statement: The role of the Charge Nurse(however titled)* ANF (Vic Branch), Melbourne.

Australian Standard Records Management. Part 1: General.. Standard 7.2.1, 2002

Department of Human Services, Policy and Strategic Projects Division, Nurse Recruitment and Retention Committee Final Report, May 2001

Department of Human Services, *Improving patient safety in Victorian Hospitals*, 2000 p. vi

Department of Human Services, Acute Health Division, *Clinical Risk Management Strategy*, 2001

Duckett, S.J. *The Australian Health Care System*. Oxford University Press, New York, 2000

Eager, K., Garrett, P., Lin V. *Health Planning Australian Perspectives*, Allen & Unwin, NSW, Australia, 2001

Hodges, L., Williams, B., and Cannan, D. Taking political responsibility for nursing's future. *MEDSURG Nursing*, 11(1), 2002, pp. 15-24.

Johnstone, M. 'Poor working conditions and the capacity of nurses to provide moral care'. *Contemporary Nurse*, 12(1), 2002, pp.7-15.

Johnstone, M, Kanitsaki, O and Flaherty, M (2002a). *Evidence-based Nursing Practice Development (Acute Care Gerontology) in an Acute Care Hospital* (RMIT Faculty of Life Sciences Research Grant Application, funded and in progress during 2002-2003, Melbourne).

Johnstone, M, DaCosta, C and Turale, S (2002). *Registered Nurses' experience of ethical issues in nursing practice: Final report to the Nurses Board of Victoria* (59p)(Funded by the Nurses Board of Victoria, Major Grant).

Kitson, A. et al. 1998. Enabling the implementation of evidence based practice: a conceptual framework. *Quality in Health Care*,

Morton-Cooper, A and Palmer, A, *Mentoring, preceptorship and clinical supervisions: a guide to professional support roles in clinical practice, 2nd edition*. Blackwell Science, Oxford, 2000

Royal College of Nursing, Australia and the Australian Nursing Federation, *Project to support nurses to involve consumers in their health care*. Melbourne: Australian Nursing Federation, 2001

Safety & Quality Council Publication *Core Standards for Health Care Safety*; Consultation Paper, August 2001

Safety & Quality Council Publication. *Safety in Practice; Making Health Care Safer; Second Report to the Australian Health Ministers' Conference*, August 2001

Safety & Quality Council Publication *Improving Medication Safety; Report of a Medication Safety Workshop*, July 2001

Safety & Quality Council Publication, *Second National Report on Patient Safety, Improving Medication Safety*, July 2002

Secker- Walker, J., Donaldson, L. *Clinical Governance; the context of risk management in Clinical Risk Management -enhancing patient safety*, BMJ Books 2001

Senge, Peter M., *The Fifth Discipline*. Random Century Group Australian (Pty) Ltd, 1990

Steinbrook, R. 2002. Nursing in the crossfire *New England Journal of Medicine* 346(22), 2002, pp. 1757-1766.

Trinder, L & Reynolds,S (eds). *Evidence-based practice: a critical appraisal*. Blackwell Science, Oxford, 2000

Victorian Council of Peak Nursing Organisations, *Position Statement: The Position of Director of Nursing in the health services organisational structure*, VCPNO, Ringwood, 1997

Wallace, M., *Health Care and the Law*, 3rd edn, Law Book Co, Sydney 2001

Walshe, K and Dineen, M. *Clinical risk management; making a difference?* London; The NHS Confederation., 1998



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