Inquiry under Part 14 of the Health Services Act 2016 (WA)

Independent Inquiry into Perth Children's Hospital

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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

November 2021

The Independent Inquiry

- On Saturday 3 April 2021, 7-year-old girl with a short history of illness, Aishwarya Aswath, was brought to the Emergency Department (ED) at Perth Children's Hospital (PCH) by her parents, Aswath Chavittupara and Prasitha Sasidharan. Aishwarya's care, her extremely rapid deterioration in the ED and her tragic death has resulted in immense loss, anguish and pain suffered by the family.
- Following the report of the consequent RCA, the Director General of the Western Australian Department of Health convened an Independent Inquiry into PCH. The establishment of the Inquiry was a recommendation of the RCA, providing an opportunity to examine in broader perspective, the factors which may have contributed to Aishwarya's death in the ED, and more generally the approach to clinical governance, risk, adverse incidents and the culture of consumer service at PCH.

Independent Inquiry Team

Members

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Chief Operating Officer, Australian Commission on Safety and Quality in Health Care

Family Representative

Suresh Rajan
President, Ethnic Communities Council of Western Australia

Terms of Reference

The Independent Inquiry will investigate:

- Any matters raised by the Aswath family in relation to the care and treatment of their daughter;
- The conduct of the RCA, any issues identified by the RCA, and the recommendations made on the basis of those findings;
- The ED's staffing, patient flow model, clinical supervision and education programs (as recommended in the RCA);
- The culture of customer service within the ED in relation to children and their families particularly those of culturally and linguistically diverse (CALD) backgrounds;
- Roles and responsibilities of clinicians, management and the executive at PCH, and their escalation of issues to the Child and Adolescent Health Service Board;
- PCH's clinical incident management processes, including an assessment of previous SAC1 incidents to identify potentially preventable factors;
- PCH's clinical risk management processes;
- The performance of PCH in relation to safety and quality measures as compared to national peers.

Methods and Process of Inquiry

- Sought and received documentation
- Met with family and representative on 6 occasions
- Reviewed over 3500 documents and submissions
- Identified further questions by respondent category
- Established individuals and panels to be interviewed
- Conducted virtual interviews with over 50 people
- Drafted report; received fact-checks; submitted final

Contextual Observations

- Family anguish; public/press reaction, anger and blame
- Dedicated, caring workforce; devasted by tragic death
- Global challenges of sepsis recognition and response
- External and internal tensions: executive, clinicians, ED
- COVID-19 pandemic direct and indirect challenges
  - Activity (CAMH, RSV), workforce shifts/recruitment, protocols
- Vulnerability: w’force strategies; contingency resourcing

Findings & Recommendations

Matters raised by the Aswath family: Findings

- Family tragedy and crisis of enormous proportions
- Privilege of family engagement, understanding, comfort
- Opportunity to listen, learn, respond and record concerns
- Focus on responses and attitudes, ED and beyond (OD)
- Document concerns, perceptions, sentiments, disagreements
- Anguish, disbelief, distrust; inadequate care and compassion
- Commitment to better system and prevention of recurrence

Findings & Recommendations

Matters raised by the Aswath family: Recommendations

1. The Executive team and senior clinicians approach the family in a process of open disclosure and seek to engage them in a healing dialogue.

2. In acknowledging the devastating tragedy that was the death of Aishwarya, the health system and CAHS engage the family's partnership in implementing recommendations and maintaining learnings, improvements and reforms.

3. Expand the PCH capacity to train and support ED staff in communication, partnering with consumers and customer relations.

4. The importance of the parent's extraordinary role in the recognition of deterioration, or indeed any change in the behaviour or health status of their child, be reinforced and embedded throughout all clinical and administrative protocols and training curricula.

5. The Call and Respond Early (CARE) Call system, as adapted to ED settings, be progressed, evaluated, sustained and rolled out across multiple WA locations, as part of the Aishwarya's CARE Call led by the Department.

Findings & Recommendations

RCA conduct, issues and recommendations made: Findings

- The death of Aishwarya required the hospital to conduct an RCA
- RCA process robust and diligent, with rigorous examination of the factors that may have contributed to this tragic death
- Low threshold: all possible factors for action or further work
- Extraordinary size and membership; pressure of time and scrutiny
- Report not endorsed by Executive team: process, time, role
- Recommendations accepted / pursued; Inquiry team supports
- Provided to family in full; no opportunity for contextual explanation
- Public release; press/community response; damaged RCA cred
- Reports to Ahpra; need and opportunity to heal and rebuild trust

Findings & Recommendations

RCA conduct, issues and recommendations made: Recommendations

6. The Executive team engage the Board and the health system clinicians and managers in their shared understanding of the purpose of the RCA, its role within the hospital's safety program and its limitations as an investigative tool.

7. The hospital's RCA policy and procedures include guidance that is issued to both RCA team members and interviewees that clearly outlines their roles, responsibilities, the confidentiality extended to the RCA process, together with how the RCA findings will be used.

8. A consumer-friendly document should explain the purpose and format of the RCA process and clarify how the patient and their family may be involved in the RCA process, the opportunity to be interviewed and when and in what form they will receive the report.

9. The WA Department of Health supports the implementation of the recommendations of the draft Clinical Excellence Division Review of the Guidance for Procedures Associated with Notification of Reportable Conduct to provide a clearer more cohesive policy framework for managing complaints and concerns about clinicians.

Findings & Recommendations

ED staffing, patient flow, clinical supervision and education: Findings

- New ED design and location; challenges in staffing and operation
- ED buffer and location for non-ED activity pressure; access block
- Late 2020 surge; concerns and escalations; response insufficient
- Staff: exhaustion, loss of morale, frustration, relative isolation
- Nursing workforce especially affected; education and supervision
- Medical workforce; JMO wellness, support, training and leave
- Limited statewide networking of services and shared response

Findings & Recommendations

ED staffing, pt flow, clin supervision, education: Recommendations

10. Embed an appropriately resourced ED nursing capability framework and ED-based education team to facilitate career pathways and continuing education.

11. Minimise the use of casual and temporary contract staff in the continuing development of workforce strategies.

12. Plan and monitor the ED workforce to be contemporary, balanced and adequate across the disciplines and the spectrum of seniority.

13. Expand measures to enable junior medical staff to access leave and continuing education.

14. Enhance the structure, function and governance of the PCH Patient Flow Unit (PFU) to optimally coordinate patient referrals and flow, including out of hours, with no inappropriate requests for ED to manage non-ED patients.

15. Progress strategies to enable early discharge of children, such as criteria-based discharge, to improve predictable daily hospital capacity.

16. Elevate the hospital-wide priority placed on children waiting in ED, who require inpatient beds or consultant review.

Findings & Recommendations

Culture of ED customer service, especially CALD families: Findings

- Documents, surveys, interviews: PCH and system wide, incl ED
- Policies, initiatives, feedback/complaint response loops; gaps +
- WA-wide PEHS survey (incl 0-15) mid or better; ED module mixed
- CALD families: gaps in data, monitor, educ, competency, practice
- Parents as:
  - experts in recognition of change in their child's behaviour or health status
  - both partners in care of their child and recipients of family centered care
  - participants and partners in system-wide improvements and codesign
- Consumer engagement: formal / visible; not meaningful partnership
- CARE Call to ED; WA-wide Aishwarya's CARE Call applauded

Findings & Recommendations

Culture of ED customer service, esp CALD families: Recommendations

17. Consumer engagement and participation be openly explored and progressed, with the intent of productive engagement and meaningful partnership.

18. Partner with consumers in progressing a quality improvement framework.

19. Measures be designed and implemented to identify and monitor health care utilisation by culturally and linguistically diverse (CALD) patients and families.

20. The organisation review and progress its approach to the development, implementation and monitoring of CALD capability strategies, along with commensurate staff competence training programs, enlisting the support of external agencies and expertise.

Findings & Recommendations

Roles, responsibilities, escalation and governance: Findings

- History of tensions; rebuilding and gradual, improved engagement
- Staff surveys: mid or above WA cohort; low response rate, esp ED
- ED more phys isolated but part of very large medical service:Unit4
- Board engaged, active, informed; Exec challenges; escalation up
- Devastated by Aishwarya’s tragic death and subsequent events
- Opportunity and imperative to reset, heal, find a way forward

Findings & Recommendations

Roles, responsibilities, escalation and governance: Recommendations

21. The framework, work plan and commitments that underpin the implementation of the RCA recommendations and the ANF 10-point Plan be given the highest priority, be appropriately resourced and be designed to be sustainable.

22. Evaluation and monitoring of agreed indicators be incorporated into all of the implementation plans, including the sepsis pathway and trigger tool, and be supported with sustained resourcing.

23. The program of relationship healing and of restoration of trust be fully embraced and maintained, with not only absolute commitment but also appropriate expertise and resources.

Findings & Recommendations

Incident management process; prior SAC1's: Findings

- Policies; resources; procedures; SAC1 threshold; transparency
- RCA all SAC1's; good record; learnings and implementation?
- M&M Review Comm: all deaths, no morb; flex depth; follow up?
- Connectedness of findings, responses, implem and monitoring
- SAC1's 1/20-4/21: 3/24 deaths; 6/24 behav; 9/24 infect, 3/5 ED
- Sepsis challenges; national attempt; PCH CPG; pathway/trigger

Findings & Recommendations

Incident management process; prior SAC1's: Recommendations

24. Embed a learning culture that ensures findings and outcomes of reviews and reports are communicated widely and treated as an ongoing opportunity to reflect and improve systems, processes and activities.

Findings & Recommendations

Clinical risk management process: Findings

- Risk management addressed at org/system level; clinical risk less
- Escalation pathway for ED regarding clin risk suboptimal / unclear

Clinical risk management process: Recommendations

25. Integrate and prioritise clinical risk in the risk management policy and reinforce the escalation pathways for departments and services.

26. Review the organisational and committee structures, aiming to streamline pathways for progression / escalation of clinical and organisational risks, with appropriate engagement of the ED and other service departments.

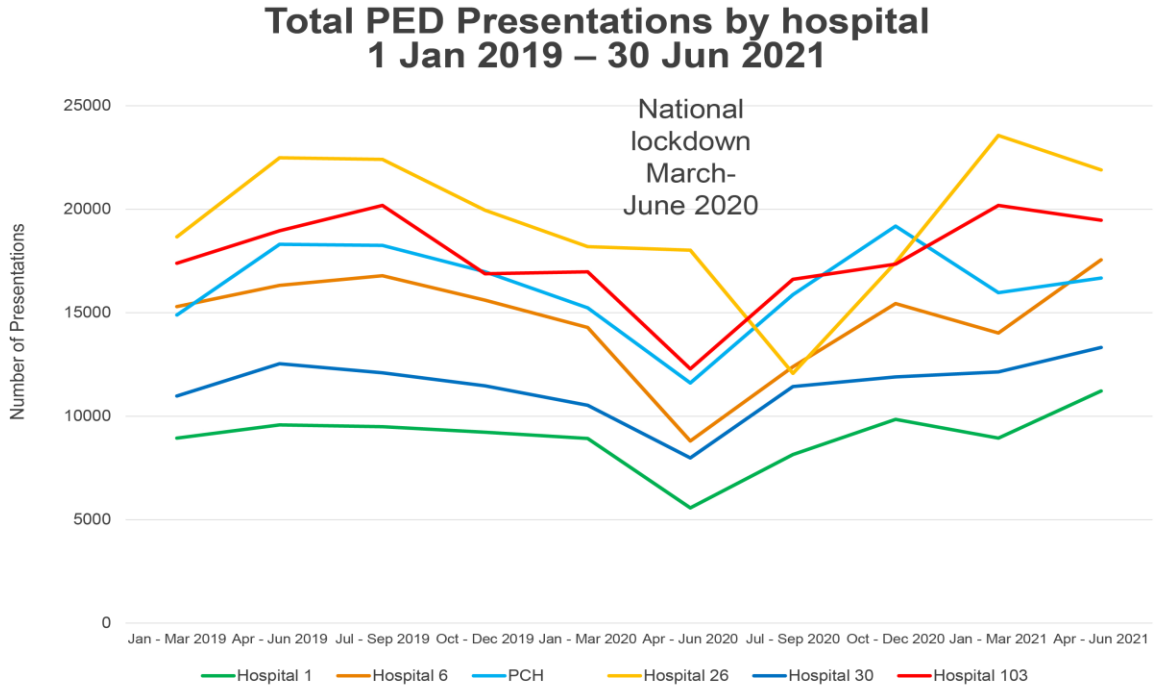
Findings & Recommendations

Benchmarking performance: Findings

- History of robust participation at WA and national (HR, CHA) level
- Above average in ED perform (waits, NEAT/WEAT, ALOS, admit)
- Cohort of ANZ children's hospitals optimal: CHA platform/progress
- Consistent national trends in activity; unseasonal sharp rise 2020
- Concerns and warnings across all PED's; PCH disprop, rise to top
- Activity relative to nursing workforce; PCH highest, gap widens
- Apr-June 2021: activity up, perf improve; S&Q (DNW, re-presents)
    - PCH wide S&Q: Hospital Acquired Complications exemplary

Benchmarking performance: Findings

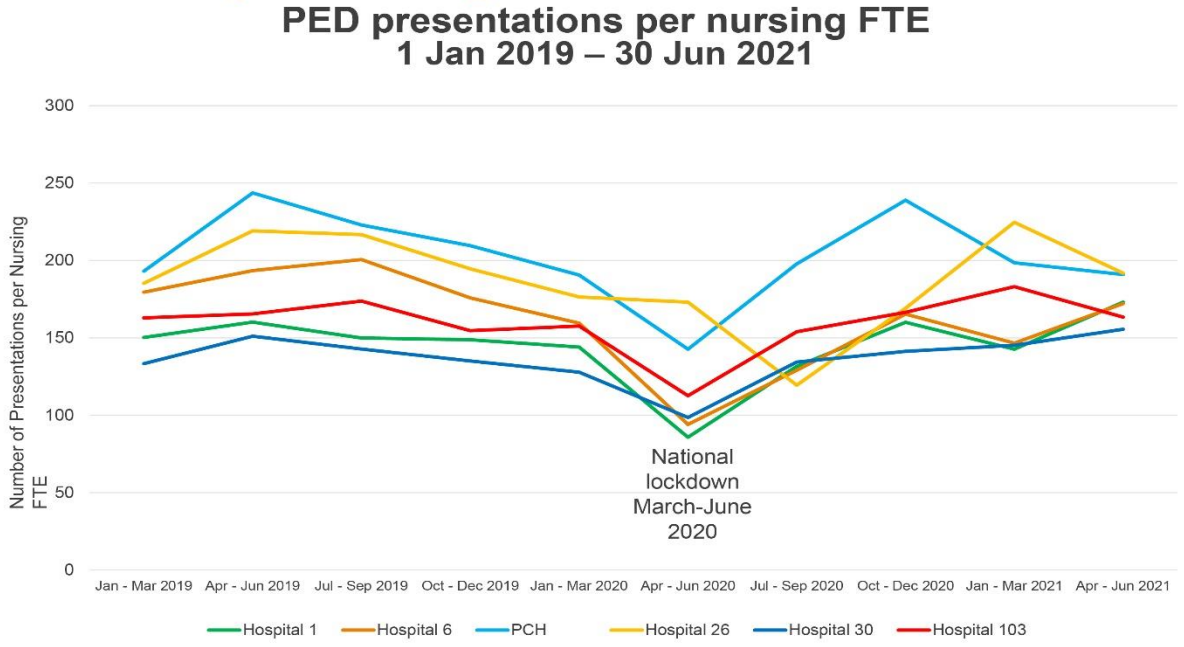
PED Activity:



CHILDREN'S HEALTHCARE AUSTRALASIA

Benchmarking performance: Findings

PED Activity vs Nursing FTE:



CHILDREN'S HEALTHCARE AUSTRALASIA

Findings & Recommendations

Benchmarking performance: Recommendations

27. The benefits of sharing and collaboration with other children's hospitals continue to receive appropriate emphasis, particularly in relation to ED and workforce challenges.

28. Reforms identified to enhance, improve and sustain the workforce include regular sharing of information with peers across WA and the nation.

29. CAHS engage the WA Department of Health in seeking to establish formal networks across children's healthcare in metropolitan and regional WA, with the aim of improving access, encouraging standardisation of care, supporting community confidence in local facilities and managing activity flows.

30. Engage peer-group children's hospitals in response to the national PED trends, warnings and proposed actions identified through the collaborative efforts of the Directors of Australian PEDs.

The Way Forward

- Learnings from: the past, tragic death, RCA, this Inquiry
- Comprehensive responses, implementation, monitoring
- Emphasis on sepsis recognition trigger, pathway and care
- Patient deterioration focus; parent / carer role in escalation
- Resourcing enhancements; reforms; commitments
- Ensure evaluation and sustainable, responsive support
- Opportunity and imperative to reset, heal, find a way forward
- Engage Aishwarya's family as partners for a better system

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