Post implementation safety risk assessment for Adjusted Medical Model of Care, Bathurst Health Service

Final Report

March 2023

NSW GOVERNMENT

CLINICAL EXCELLENCE COMMISSION

Background

On 3 February 2023, the Western NSW Local Health District (WNSWLHD) were informed by the Royal Australasian College of Physicians (RACP) that they had withdrawn accreditation for Basic Physician Trainees (BPTs) at Bathurst Health Service. With the clinical year commencing on 6 February 2023, and with difficulties sourcing available locum registrars, an adjusted model of care in the Medicine Department has been implemented. From 13 February the structure of the medical teams was changed to two 'super' teams with each having a mix of VMO/Staff Specialist Consultants and locum Consultants as well as two allocated interns. At the morning handover, the patients admitted in the last 24 hours are redistributed in an equitable manner to all the Consultants present on site.

As an additional assurance measure, the Chief Executive WNSWLHD requested an independent safety assessment of the arrangements to assist from a clinical governance perspective in ensuring ongoing clinical safety.

Service Description

The Western NSW Local Health District (WNSWLHD) is one of the largest Local Health Districts in New South Wales covering an area of 246,676 square kilometres. The local population is 270 000 with the largest rural mental health service in Australia, three major rural referral hospitals at Orange, Dubbo and Bathurst, 38 inpatient facilities including 25 Multipurpose Services (MPSs) and District Health Services at Mudgee, Cowra, Parkes and Forbes.

Bathurst Health Service is a Level C referral facility with 120 beds providing a range of services to the 45,000 residents. The health service is also due to undergo a $250m redevelopment.

Bathurst provides allied health, ambulatory care, coronary care, emergency medicine, intensive care, general medicine, mental health drug & alcohol, maternity & gynaecology, oncology, paediatrics, pathology, radiology, rehabilitation and surgery services.

Bathurst also has active hospital in the home and primary community health services to the surrounding townships of Blayney, Oberon, Perthville, Hill End, Sofala and Rylstone.

Bathurst Health Service has a strong partnership with the University of Western Sydney and Charles Sturt University, conducting research and providing student clinical placements, education and patient referral opportunities.

The medical department has a service capability of 4 and is staffed by a mixture of staff specialists and VMOs. Whilst all the Medical Consultants provide general medicine, a number have a range of subspeciality interests including cardiology, geriatrics, respiratory, renal, haematology,

gastroenterology and endocrinology. The medical service usually has 4 BPTs however is currently being replaced by two experienced locum medical registrars and 2 locum VMOs.

At the time of assessment, the hospital was experiencing code black for a number of days due to the unprecedented demand on medical admissions (with 17 admissions over 24 hours on the day of assessment).

Adjusted model of care

The sudden and unexpected withdrawal of BPTs by the RACP has resulted in Bathurst Hospital putting in place an adjusted model of care in the Medicine Department. From Monday 13 February 2023, the structure of the medical teams changed to two super teams. Each super team has a mix of regular Staff Specialists and VMOs, one allocated locum Medical Registrars as well as two allocated interns. The Locum VMOs had not been formally assigned junior medical staff.

At the morning allocation meeting, the patients admitted in the last 24 hours are redistributed in an equitable manner across Medical Consultants. This meeting was essentially focused on allocation of patients. Refer to Appendix One and Two

Review process

The Clinical Excellence Commission completed a Risk Assessment (aligned with ISO 31000 – 2018) of the safety systems implemented because of the adjusted model of care in the Medicine department at Bathurst Hospital.

The aim of the risk assessment was to identify those processes and process steps that may have changed as a result of the adjusted model, any threats posed by such changes, the consequence, likelihood and risk rating of such threats, any existing controls to mitigate such threats and any additional controls that might be required.

The risk assessment was conducted using a combination of desktop exercises, on-site interviews and mock patient journeys. Key informants at the site were identified for interview as well as hospital and LHD executive staff including the LHD Director Medical Services and Executive Director Quality, Clinical Safety and Nursing.

The table below lists key staff who were consulted as part of this risk assessment:

Name	Role
Prof Mark Arnold	Chief Medical Officer
Adrian Fahy	Acting CE and Exec Director Quality Clinical Safety and Nursing
Dr Marco Metelo	Director of Medical Services Bathurst Health Service

Name	Role
Kylie Peers	A/Director of Nursing, Bathurst Health Service
Dr Pavan Tumkur Phanindra	Director, Emergency Department
Heidi Lees	Nurse Unit Manager, Emergency Department
Dr Sean Jenkins Dr Alex Davison	Locum Medical Registrars
Melissa Jeffree	A/ Nurse Unit Manager General Medicine
Tara Evers	Facility Business Manager
Melissa Belfanti	Primary, Community and Allied Health Manager
Mark Josephson	Human Resource Partner
Karen Deal	A/Health information and Administration Manager
Cathy Marshall	Former A/General Manager
Kylie Rogan	Administration Supervisor
Tracy Wittich	Director of Nursing and Midwifery
Terri Latimore	Patient Safety Partner
Laura Cusack	Acting Workplace Culture & Staff Education Co-ordinator (ICU CNE/CNS)
Jo Holden	Service Transformation and General Manager, Bathurst Health Service
Dr Khalid Al-Zubaidi	General Medicine Physician, Acting HoD
Dr Riton Das	General Medicine Physician
Dr Mehdi Farhan	General Medicine Physician
Dr Imad Haloob	General Medicine Physician
Dr Bruce McGarity	General Medicine Physician
Dr Gandhi Ponniah	General Medicine Physician
Dr Nizia Shahid	General Medicine JMO
Dr Alaa A FM Alhendal	General Medicine JMO
Dr Kaitlyn Brunacci	General Medicine JMO
Dr Shawal Arshad	General Medicine JMO
Ashleigh Marsland	Flow Manager
Dr Angus Hayes	ICU Registrar
Linda Cant	Primary, Community and Allied Health, HoD OT
Elizabeth Lennon	Primary, Community and Allied Health, HoD Physio
Melissa Jeferee	General Medicine Acting NUM

Name	Role
Dr Ross Wilson	VMO General Practitioner, Western Sydney University

Processes were reviewed to assess the potential risk to patient safety as per [1] PD2022_023 Enterprise-Wide Risk Management. All threats were assessed for likelihood and consequence to establish a risk rating

Likelihood refers to the likelihood of the threat materialising (considering the current controls/mitigations).

Consequence refers to the consequence or impact that would be incurred if the threat materialised

Risk is calculated as a product of likelihood and consequence

Summary of findings

- The assessment team examined the processes from admission to discharge of medical patients at Bathurst Hospital and found no evidence of extreme safety risks. The information was reliant on the accurate recount from those interviewed. There were 9 high risks and 5 medium risks identified (Refer Appendix Three). There are additional controls proposed that would further mitigate identified risks and these are listed below in Table 1.
- The response from the Executive to the abrupt removal of BPTs has been significant. The lack of warning and the loss of a crucial workforce is a crisis event for any service. Resources have been rapidly deployed to support and maintain patient safety as the service works towards the development of a longer-term strategy. The Director Medical Services has been instrumental in the response, providing strong leadership and stability at this time of uncertainty and attending daily meetings with the clinical staff. It is noted that he had left the country to visit a sick relative in Europe during the assessment which necessitated greater leadership from the Medical Consultants.
- The hospital has replaced the 4 BPTS (Basic Physician Trainees) with 2 experienced locum medical registrar locums and 2 locum VMO Medical Consultants to ensure patient safety. The Medical Consultants have responded by increasing their attendance, collegiality and commitment to the service to ensure increased supervision and support for the junior medical workforce.
- The reinstatement of the BPTs could take many months, hence in the medium term over 3-6 months, there is a high risk of an inability to maintain adequate staffing of the service with locums.
- Bathurst Health Service need to develop a monitoring system of key performance indicators (KPIs) to ensure timely weekly oversight of safety and quality by the Executive and clinicians.

Table 1 Proposed Additional Controls for Implementation

The safety assessment found no extreme risks, 9 high risks and 5 medium risks. High and medium risks are listed in the table below with proposed additional controls. Bathurst Health Service are encouraged to use this document to track actions against the proposed additional controls.

Risk priority	Process step	Threat	Proposed additional controls	MM comments
High	Assessment in ED will no longer be performed by BPTs	Locum staff may not be familiar with ED processes	• Strengthen the current induction process for locums, particularly those who start outside of normal business hours	• Accepted – owner workforce manager & ED Director
High	Care co-ordination is now provided through two super teams consisting of Consultants and interns.	Delays in care planning and clinical deterioration due to confusion over the junior doctor responsible for individual admitted patients and reduced registrar staffing	• Explore the feasibility of having a three-team model • Clarify, document and communicate junior staff responsibility for care for patients admitted between 2200- 0800 • Finalise recruitment of Medical Head of Department • Regular mini performance and workload allocation review for locum staff • Performance reviews for locum staff • Formalise the process for 3 daily safety huddles/handover accountability • Ensure that there are minimum of two Registrars rostered on during the day • Clarify, document and communicate responsibility for telemetry management	• **Explore the feasibility of having a three-team model** • Not accepted (Explore the feasibility of having a three-team model) BHS has 6 local Physicians with limited availability (most SS fractional appointments and VMOs with commitments in the district); thus limiting factors to provide on site supervision to JMOs and locum registrars; having 3 medical teams will dilute supervision hours and lead to JMOs working unsupervised on site • **Clarify, document and communicate junior staff responsibility for care for patients admitted between 2200- 0800** Accepted – DMS & ICU HOD & ED HOD • **Finalise recruitment of Medical Head of Department** – Accepted – DMS • **Regular mini performance and workload allocation review for locum staff** – Not accepted – workload of <u>all</u> medical teams is recorded daily on morning handover. Performance review of locums occurs

				regularly via IIMS management and feedback by consultants and nursing staff – if poor performance locums are not engaged as risk management strategy and receive feedback by DMS or Physicians. • **Performance reviews for locum staff** – as above • **Formalize the process for 3 daily safety – huddles/handover accountability –** DMS to look at CEC documentation and implement at Medical Handover • **Ensure that there are minimum of two Registrars rostered on during the day** – accepted – DMS & Workforce unit • **Clarify, document and communicate responsibility for telemetry management** – Accepted - Physicians Department/ HOD of Medicine
High	Care continuity	Reduced care continuity due to frequent reallocation which may lead to treatment delays	• Clarify, document and communicate junior staff responsibility for care for patients admitted between 2200- 0800 • Executive to confirm, document and communicate roles and responsibilities of locum staff. • Allocate resources /responsibility for updating the Electronic Patient Journey Board (EPJB) after each allocation meeting	• **Clarify, document and communicate junior staff responsibility for care for patients admitted between 2200- 0800** – as above • **Executive to confirm, document and communicate roles and responsibilities of locum staff.** Accepted – DMS MEMO • **Allocate resources /responsibility for updating the Electronic Patient Journey Board (EPJB) after each allocation meeting** – accepted – Workforce culture and Education Officer

Risk priority	Process step	Threat	Proposed additional controls
			• **Minimise the number of junior doctor / Registrar changes in daily team allocations** – Accepted – Workforce unit • **Ensure that a brief clinical history and treatment plan is shared for each new admission at allocation meeting and multidisciplinary morning handover –** accepted – HoD Medicine/Medicine department • **Ensure Senior ED night doctor attends daily allocation meeting to provide clinical handover on admitted patients** – accepted – DMS&ED Director • **Where possible, ensure that Consultant Ward Rounds occur in the morning.** Accepted - HoD Medicine & DMS • **Explore the option of the On-call consultant accepting all patients up to a pre-determined amount (e.g. 10) before reallocation is considered** – not accepted – daily admissions is on average 10 and JMOs report that distributing patients daily smooths workload and allows for better discharge planning and operational flow of the facility; also carries less Physician Burnout and workload is spread over the week • **Include the General Medicine NUM in the daily allocation meeting.** – replace with control to increase education to nursing team (DON & Workforce people culture and education officer)

			• **Where possible, ensure that Consultant Ward Rounds occur in the morning.** As above
High	Medication reconciliation	Reduced medication reconciliation at multiple points from ED to discharge	• **Review and redesign medication reconciliation processes to improve reliability of prescribing practices** – this is completed via additional Pharmacy hours in ED – Confirm with Head of Pharmacy
High	Over reliance on telephone contact with consultants	Delayed recognition of clinical deterioration – delayed review of the patients by a locum registrar or consultant particularly for dialysis and oncology patients	• **Clarify, document and communicate junior staff responsibility for care for patients admitted between 2200-0800** – as above • **Finalise recruitment of Medical Head of Department** – as above • **Standardised performance assessment for locum staff** – as above • **Improve reliability of use of eMR Task List** – Support in-principle - further investigation required

Risk priority	Process step	Threat	Proposed additional controls
High	Reliance on locum medical staff who may be unknown to the regular team members	Altered team dynamics may impact graded assertiveness and create escalation confusion for junior nursing and medical staff	**Identified team support for speaking up for safety –** Accepted - speaking out for safety is being rolled out to front line staff and will embed in JMO orientation • **ISBAR handover** – agreed – DMS & Medicine department • **Daily multidisciplinary meetings** – Agree - DMS & Medicine department
High	Rostering / staff numbers Loss of 4 BPTS replaced by Locum Registrars	Unavailability of sufficient number of adequately trained locums	• **Review rostering to ensure that there are always a minimum of 2 Registrars rostered during the day** – as above
High	Orientation / induction	Locum staff may not be appropriately oriented	• **Strengthen the current induction process for locums, particularly those who start outside of normal business hours** – as above
High	Consultant workload	Consultant workload and responsibility may lead to burnout and resignations	• **Formal consultation process with Executives of hospital and LHDs – Accepted in principle** • **Engage an independent senior Physician to undertake a review of the workforce and the future medical model of care. –** Accepted as part of self-assessment RACP accreditation process • Review Workforce Plan for Medical Service – Accepted in principle • **Share Medical Services Clinical Plan with Consultants** – agree - DMS • **Review junior medical staffing on weekends –** Accepted in principle noting phased approach: 1. JMO hours have been expanded in 2023 to meet demand 2. Further clarification of duties required and development of role descriptions

Medium	MET system	Nursing staff unclear about who to call for medical/clinical review leading to unnecessary MET calls	• **Clarify, document and communicate junior staff responsibility for care for patients admitted between 2200-0800** – as above • **Finalise recruitment of Medical Head of Department** – as above • **Standardised performance assessment for locum staff.** As above • **Review process to ensure Registrar is allocated to each team daily –** accepted DMS MEMO • **Ensure all VMOs have allocated JMO staff rostered – not accepted –** VMOs have allocated locum registrars as not on site to provide adequate supervision to JMOs • **Clarify, document and communicate responsibility of MET allocation to make the process more consistent –** accepted – Working party organized via Laura Cussack

Risk priority	Process step	Threat	Proposed additional controls
Medium	Stroke pager	Lack of clarity about roles and responsibilities leading to delayed or inappropriate response	• **Develop, document and communicate a process that clarifies roles and responsibilities for stroke pager** – accepted - DMS

Medium	Outpatient	Expectation that Consultants will leave outpatient clinics to respond to clinical deterioration	• **Allocate and roster junior staff to each Consultant** – as above
Medium	Changed junior staff supervision	Lack of a direct and consistent Registrar leads to reduced or delayed Intern supervision and may lead to burnout and resignations	• **Explore the feasibility of having a three-team model** – as above • **Review rostering to ensure that there are always a minimum of 2 Registrars rostered during the day**- as above • **Formalise dedicated education for JMOs** – Accepted – DPET and Jane Corbert Jones (education officer Western Uni)
Medium	Increased junior Staff workload	Intern workload and responsibility during periods of unprecedented demand (code black) may lead to burnout and resignations	• Explore the feasibility of having a three-team model – as above • Where possible, ensure that Ward Rounds occur in the morning – as above

Appendix One

memo

Health
Western NSW
Local Health District

		DIVISION	Bathurst Health Service
TO	All-Staff – Bathurst Health Service		
FROM	Cathy Marshall		
TEL	02 6330 5300	DATE	10 February 2023
SUBJECT	Medical Coverage		

Due to the sudden and unexpected withdrawal of BPTs by the RACP last Friday, and difficulties sourcing available locum medical registrars, we have put in place an adjusted model of care in the Medicine Department for the coming weeks.

From Monday 13 February, the structure of the medical teams will change to two super teams as below. Each super team will have a mix of resident Physicians and locum Physicians, as well as two allocated interns.

SUPER TEAMS from 09/02/2023 TO 12/02/2023		
TEAM A	**Physician (GM & SW Cardiology)** **Physician (GM & Haematology)** **Physician (GM & SW Cardio/Gastro)** **Physician (GM)** **Physician (GM)** Intern Intern	**Dr Khalid Al-Zubaidi** **Dr Riton Das** **Dr Bruce McGarity** **Dr Gandhi Ponniah** **Dr Ahmed Al-Omary** Nizia Shahid Kaitlyn Brunacci
TEAM B	**Physician (GM & Gastro)** **Physician (GM & Geriatrics)** **Physician (GM & Endocrine)** **Physician (GM & Nephrology)** Intern Intern	**Dr Siddarth Sethi** **Dr Mehdi Farhan** **Dr Ahmed Hussein** **Dr Rachel Elliott** Alaa Alhendal Arshad Shawal

At the morning handover, the patients admitted in the last 24 hours will be redistributed in an equitable manner to all the Physicians present on site. This will ensure that each Physician takes a reasonable number of patients.

Physician duties:

1. Locum Medical registrars will be prioritised for acute care, deteriorating/sick inpatients and ED admissions.
2. As you are aware, current JMOs are transitioning from medical students to interns and this is their first term as interns. JMOs will need understanding and support from all of us.

3. JMOs will be supported directly by consultants during ward rounds and for day-to-day issues with patient care. This means being available by phone as well.
4. Any delays/concerns in provision of inpatient care should be directly escalated to the treating Consultants by contacting them over phone via switch.
5. For example, Pharmacist identifies medication error/omissions -> notify JMO -> delay/inaction -> inform treating Consultant.
6. Allied health issues -> notify JMO -> delay/inaction -> notify NUM -> inform treating Consultant.
7. Patient needs/issues should be flagged during daily MDT.
8. Consultants are encouraged to talk to Ward NUM daily after the ward rounds to clarify regarding any concerns with their patient care/JMOs well-being.
9. Consultants will be required to monitor discharge summaries, in particular medications and follow-up plans.
10. Consultants are encouraged to update patient next of kin regarding care plan on a regular basis. This will take huge burden off the JMOs.
11. The Physician will carry the clinical duties required to manage the patient and provide a care plan for the patient, along with other duties such as documentation, prescribing medications, difficult conversations with patients and families (for example breaking bad news and family meetings), specialist consults (JMOs are not to provide consults). Physicians will have to carry the regular duties without Medical registrar support.
12. The supervision of the JMOs allocated to each team is to be Consultant-led by the resident Physicians that have been nominated as supervisors of the term as per the below table. JMOs are to round with the allocated Consultant Supervisor to fulfil supervision responsibilities and be available all time for JMO support.
13. JMO supervision should not be delegated to locum medical registrars. JMOs are to round with the allocated supervisors.

SUPERVISOR STRUCTURE			
TEAM A	**Physician (GM & SW Cardiology)**	**Dr Khalid Al-Zubaidi**	Kaitlyn Brunacci
	Physician (GM & Haematology)	**Dr Riton Das**	Nizia Shahid
TEAM B	**Physician (GM & Geriatrics)**	**Dr Mehdi Farhan**	Arshad Shawal
	Physician (GM&Gastro)	**Dr Siddarth Sethi**	Alaa Alhendal

At a minimum the Medicine Department will have a day Medical Registrar and an evening Medical Registrar. The duties of the registrars as per below:

Locum Day Registrar duties:

1. Carry the on call pager and stroke pager; attend related duties from 0800 to 1600.
2. Attend MET calls and medical reviews requested by the wards; attend related duties from 0800 to 1600.
3. Attend medical reviews solicited by the ED department from 0800 to 1400. Please note, patients will be directly admitted after one hour of the ED request as per the ED admission policy; FAQ attached. This is to protect the workload of the day medical registrar. **This duty can be carried over by a Locum Physician as allocated on morning handover – this will be updated via the on call roster available on the staff intranet page.**
4. If a patient is admitted by the day team but still in ED queries are to be referred to the day medical registrar until 1600 only.

Locum Evening Registrar duties:

1. Carry on call pager and attend related duties from 1600 to 2200.
2. Carry stroke pager and attend related duties from 1600 to 0800.

3. Attend medical reviews solicited by the ED department from 1400. Please note, patients will be directly admitted after one hour of the ED request as per the ED admission policy; FAQ attached. This is to protect the workload of the evening medical registrar
4. Attend MET calls and medical reviews requested by the wards; attend related duties from 1600 to 2200.

JMO duties:

1. Duties related to discharge process (discharge summaries/scripts).
2. Ward Jobs (cannulas and bloods).
3. Family updates.
4. Attend MET calls of patients allocated to respective team.

WARD NUM duties:

1. Be available for rounding with Consultants and/or receive handover of clinical matters.

ED duties:

Emergency medicine doctors are responsible for:

1. Initial optimisation of medications.

Initial fluid management.

3. DVT prophylaxis as per guidelines.
4. Imaging and Pathology for clinical decision making regarding the cause of presentation.
5. Last medical consultation for the evening Med Reg is at 9 pm. This is to give sufficient time for the evening Registrar to finalise duties and finish shift at 10 pm.

MET CALL Process

1. MET calls are attended 24/7 by MET call team which made of:
    a. ICU registrar.
    b. ICU liaison nurse.
    c. ED resus nurse.
    d. Campus Nurse Manager.
    Note: The ICU registrar is the team leader and is required to attend, manage and provide an update to the AMO via phone during daylight hours (0800 to 2000). This only applies for medical inpatients; all other subspecialties the first on call is to be contacted.
2. The MET call team is further assisted by:
    a. From 0800 to 1600: Day Medical registrar and the JMO of the team
    b. From 1600 to 2200: Evening medical registrar and the after-hours JMO (2100).
3. From 2200 to 0800 the MET call is solely attended by the call team.
4. The night ICU registrar presents at morning handover patients that have deteriorated overnight.
5. If further assistance is required ED doctors may be called to assist under the direction of the Campus Nurse Manager at 24/7.

Change can at times be a little bumpy. If you have any concerns please advise Marco Metelo via Marco.SimoesMeteloDeAlmeidaLourenco@health.nsw.gov.au or phone 0439 540 920.

Cathy Marshall General Manager

Appendix Two