

REPORT OF INQUIRY

INTO

**THE CARE OF A PATIENT WITH THREATENED MISCARRIAGE
AT ROYAL NORTH SHORE HOSPITAL ON 25 SEPTEMBER 2007**

Prof Clifford Hughes AO
Prof William Walters AM

26 October 2007

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TERMS OF REFERENCE

This inquiry is initiated under Section 122 of the *Health Services Act* (NSW) 1997.

It authorises Professor Cliff Hughes AO, Head of the Clinical Excellence Commission and Professor William Walters AM, Head of the Royal Hospital for Women Randwick, to jointly inquire into the administration and services of Royal North Shore Hospital, being a public hospital conducted by Northern Sydney and Central Coast Area Health Service in accordance with the following terms of reference:

1. To review and report on the adequacy and appropriateness of the clinical management and care of a patient with a threatened miscarriage who presented to Royal North Shore Hospital (the Hospital) Emergency Department on the evening of 25 September 2007 and who subsequently miscarried.
2. To review current practices and protocols at Royal North Shore Hospital and other hospitals within the NSW public health system concerning the clinical management, care and treatment of patients presenting with miscarriages or threatened miscarriages.
3. As a consequence of the above reviews, make recommendations concerning any action that should occur including referral to the Health Care Complaints Commission, changes considered appropriate to Hospital practices, policies or protocols or the development and implementation of state-wide policies, practices and protocols across the public health system.

The inquiry team is to report to me by 26 October 2007.

Debora Picone AM
Director-General, NSW Department of Health

26 September 2007

INQUIRY TEAM

Professor Clifford Hughes AO

MB.BS, FRACS, FACS, FACC, FICA(Hon), FCSANZ.

Professor Hughes is the Chief Executive Officer of the Clinical Excellence Commission of NSW. He was previously Head of Department of Cardiothoracic Surgery at Royal Prince Alfred Hospital, Sydney. He was a foundation member of the Australian Council for Safety and Quality in Health Care, chairman of the Therapeutic Device Evaluation Committee (Australian Government) and founding chairman of the NSW Special Committee Investigating Deaths Associated with Surgery. He was a councillor, senior examiner and Division chairman (Cardiothoracic) for the Royal Australasian College of Surgeons.

Professor Hughes has trained and worked in the public health sector all of his professional life. He trained at the University of New South Wales at Prince Henry and the Prince of Wales hospitals and also at Sutherland Hospital. Thirty years ago, as a general surgical trainee, he worked at the Royal North Shore Hospital. He undertook all his cardiac surgical training in public hospitals - at Royal Prince Alfred Hospital in Sydney, at Green Lane Hospital in Auckland and Johns Hopkins Hospital in Baltimore. Professor Hughes has also had experience in cardiothoracic surgery in Malaysia, Singapore, India and China, and twice as a General Surgeon in a small mission hospital in Bangladesh.

Professor William Walters AM

MB. BS, (Adel), PhD (Lond), FRANZCOG, FRCOG, FACHSHM (RACP)

Professor Walters is the Executive Clinical Director of the Royal Hospital for Women, Randwick. He is a Conjoint Professor at the University of NSW and Emeritus Professor at the University of Newcastle NSW. He is a senior obstetrician and Fellow of both the Royal Australian & New Zealand College of Obstetricians & Gynaecologists and the United Kingdom Royal College of Obstetricians & Gynaecologists. He has 180 publications in professional medical journals and books.

Professor Walters graduated in Medicine and Surgery from the University of Adelaide and undertook most of his training in obstetrics and gynaecology in the UK at the Jessop Hospital for Women in Sheffield, Hammersmith Hospital Postgraduate Medical School, London, and as a lecturer in obstetrics and gynaecology at the Aberdeen Maternity Hospital. Subsequently he was appointed senior lecturer, and then associate professor in obstetrics and gynaecology at Monash University and the Queen Victoria Memorial Hospital in Melbourne. Thereafter he was appointed Professor in Reproductive Medicine at the University of Newcastle and chair of the Department of Obstetrics and Gynaecology at John Hunter Hospital, Newcastle.

Professor Walters chairs the NSW Maternal and Perinatal Committee and the NSW Maternal and Perinatal Health Priority Taskforce and is a member of the NSW Health Care Advisory Council.

FOREWORD

At the outset we wish to express our sympathy for the distress that the early pregnancy patient and her partner experienced on the night of Tuesday 25 September 2007 and thereafter. They have experienced significant distress at the loss of their pregnancy and with the lack of privacy and dignity associated with that loss. The intense media attention in the following days and weeks no doubt added to this distress.

It would have been helpful to us in our inquiries and the preparation of this report to speak to the patient and partner to hear their personal account of the events that occurred at the Royal North Shore Hospital ED on that night. They were invited to speak to the inquiry team on several occasions but they declined. We respect their decision.

We also regret the distress experienced by members of staff in the ED as a result of these events and the ongoing pressures they will face through the various inquiries into these matters. It is important, nevertheless, that this matter be examined in its entirety and in detail, in order to bring about improvements to the systems of care for future generations of women who will inevitably present to EDs around the nation with a threatened miscarriage.

Miscarriage is a common medical event occurring in up to 20 per cent of recognised pregnancies. Problems associated with early pregnancy accounted for 11,254 presentations to NSW emergency departments in 2006-07. Of these, 9,536 related to miscarriage or threatened miscarriage, representing 84.8 per cent of the total. It should be noted that patients in early pregnancy who present with clinical signs of the type displayed by the patient whose management and care is the subject of this report almost invariably have a subsequent miscarriage.

The purpose of this inquiry is to investigate the circumstances surrounding a miscarriage that occurred in a toilet in the waiting room at the ED at RNSH on Tuesday 25 September 2007 and to identify ways in which the management and care of such patients presenting to public hospitals can be improved.

In reviewing the appropriateness of the management and care provided for the patient we have considered how she was triaged on presentation. The triage process is carried out to establish priority, based on the clinical urgency and safety of each individual patient. We have also considered the episode of care within the context of evolving changes in the management of such patients who present with threatened miscarriage.

We believe it is important to highlight the critical need for any woman (and her partner) experiencing miscarriage to be provided with privacy and treated with sensitivity and dignity during a time of great emotional distress and anguish. It is also important to provide the woman with adequate psycho-social support. As the events at RNSH on 25 September 2007 clearly show, when a patient with threatened miscarriage currently presents at a busy hospital ED after hours, it is sometimes difficult to ensure under the current model of care that she is provided with the necessary privacy and treated with the necessary dignity and sensitivity.

EXECUTIVE SUMMARY

This report examines the adequacy and appropriateness of the clinical management and care that was provided to a patient with a threatened miscarriage who presented to Royal North Shore Hospital (RNSH) Emergency Department on the evening of 25 September 2007 and who subsequently miscarried.

It reviews the current practices and protocols concerning the care and treatment of the many women who present to the NSW public health system with symptoms of threatened miscarriage. It also makes recommendations about changes considered necessary to improve the quality of clinical management of women in early pregnancy throughout NSW.

The objective in reviewing and reporting on these matters is to identify how the NSW public health system can apply the lessons learnt from the events that occurred at RNSH on 25 September to improve the model of care for the benefit of all such patients in NSW in the future.

The report notes that when the patient presented at the RNSH Emergency Department (ED) she was entering a system of care that did not have specific system-wide policies and guidelines in place for the management and care of women in the early stages of pregnancy experiencing bleeding and/or pain.

The review of the way in which the presentation was managed in the initial stages, including early assessment, found that it was undertaken appropriately and adequately by ED clinical staff, in compliance with current policies and procedures for the management and care of ED patients. It is also noted that within the prevailing model of care a patient's emotional needs are not considered under the Australian Triage Scale. It is recommended that the need for this emotional aspect of care be included in the ED protocols for the management and care of women with threatened miscarriage.

The inquiry did find that the patient was not clinically examined during a period of approximately one hour and twenty two minutes that elapsed after her vital signs had been taken. This delay was significantly longer than the accepted benchmark for Category 4 patients (1 hour). It has implications for the management and care of patients with threatened miscarriage in all NSW public health facilities and is addressed in the recommendations.

Apart from the requirement to develop and implement appropriate policies and guidelines for the management and care of patients with miscarriage or threatened miscarriage in NSW public health facilities, the inquiry team has identified a number of issues requiring attention relating to the physical environment of the RNSH ED specifically and perhaps EDs generally. These are addressed in the recommendations.

We sincerely hope that by developing and implementing the state-wide policies and procedures recommended in this report the NSW public health system will in future provide women with a more satisfactory patient journey and experience than that provided to the patient who miscarried at the Royal North Shore Hospital on 25 September 2007.

TERMS OF REFERENCE ONE: THE PATIENT JOURNEY AND EXPERIENCE

To review and report on the adequacy and appropriateness of the clinical management and care of a patient with a threatened miscarriage who presented to Royal North Shore Hospital (the Hospital) Emergency Department on the evening of 25 September 2007 and who subsequently miscarried.

The information in this section of the report is based on a review of the contemporaneous records and interviews with relevant RNSH ED staff.

At 7.11pm on Tuesday 25 September 2007 a 32 year old woman presented at the Emergency Department (ED) of RNSH and advised the triage nurse that she had experienced vaginal discharge approximately one hour earlier and had mild pelvic pain. She indicated that she had with her the results of an ultrasound scan which had been performed that morning, following an episode of pelvic pain the previous day. The ultrasound scan report indicated an active intrauterine pregnancy of 14 weeks gestation. The nurse assessed the patient as Category 4 on the Australian Triage Scale (ATS) of clinical urgency and assessed her as suitable to be treated in the Emergency Treatment area of the ED, which is set aside for ambulatory patients with non-critical illness or injury. The patient was allocated to the Emergency Treatment waiting area, but remained in the main ED waiting room because there were no chairs available in the Emergency Treatment area. The triage nurse provided the patient with an 'Advice Sheet About Bleeding in Early Pregnancy'. (Appendix 1).

At 7.15pm a patient presenting with massive haemoptysis (coughing up blood) was brought into the ED by ambulance. In order to allow her to assess this critical patient, the triage nurse asked the Clinical Initiatives Nurse to take the vital signs of the early pregnancy patient.

At approximately 7.25pm the Clinical Initiatives Nurse reported to the triage nurse that the patient's vital signs were within normal limits and that she did not have a fever. Shortly after, the triage nurse handed over to another nurse, advising that the early pregnancy patient's vital signs were stable and that her condition was consistent with a threatened miscarriage.

At approximately 7.45pm the patient's partner approached the triage desk to express concern about how long she had been waiting. At approximately 8.45pm the patient's partner signalled to the triage nurse, who followed him into the toilet adjacent to the ED. She found the patient had miscarried in the cubicle and was holding the fetus. After attending to her immediate needs, the triage nurse transferred the patient with the fetus to consultation room 5 at approximately 8.55pm and advised the Nurse Unit Manager that the woman had miscarried. The patient was attended at this time and thereafter by ED nursing staff. The Nurse Unit Manager notified the ED Staff Specialist, who was attending to a Category 2 patient with head trauma in a resuscitation bay at the time. At approximately 9.15pm the Staff Specialist attended the patient who had miscarried and noted that she was haemodynamically stable. The Staff Specialist asked the Nurse Unit Manager to contact the Obstetrics & Gynaecology (O & G) Registrar, who advised he was performing a caesarean section. He advised that a Senior Resident Medical Officer (SRMO) would be sent to attend the patient.

At approximately 9.30pm the O & G SRMO arrived and examined the patient to ensure there was no need for any other intervention. After discussing the miscarriage and the proposed management plan with the patient the SRMO withdrew to another area to examine the fetus. He recommended to the patient that she remain overnight to be monitored and to have an ultrasound scan performed in the morning. After the necessary paperwork was completed, the patient was transferred to ward 10D at 11.45pm. This is a short-stay surgical ward for patients who require in-patient care for less than 24 hours.

At 7.15am the following day the patient was invited to see a social worker. She advised that she would. At 9.25am the O & G Registrar and SRMO attended the patient. The social worker was present. At 10.55am the patient was counselled by the social worker.

A pelvic ultrasound scan was performed at 11.30am. The O & G Registrar later explained the scan result to the patient.

During the course of the morning the RNSH Patient Representative, the Acting General Manager and the Director of Nursing visited the patient. In the afternoon, prior to her discharge from hospital, the Acting General Manager and a social worker spoke with the patient. Arrangements were made for a follow-up appointment with her GP in one week. An appointment was also made for her to attend the outpatient clinic on 11 October.

The patient was discharged from the hospital at 2.45pm.

ANALYSIS

Presentation

On 25 September 2007, when the patient presented at the of RNSH ED, she was entering a system of care that did not have specific system-wide policies and guidelines in place for the management and care of women who, in the early stages of pregnancy were experiencing bleeding and/or pain. Yet, as indicated earlier, problems associated with early pregnancy accounted for 11,254 presentations to NSW EDs in 2006-07, including 573 presentations to RNSH. These problems are associated with a range of clinical conditions, including ectopic pregnancy (8 per cent at RNSH), complications following abortion, spontaneous miscarriage and threatened miscarriage.

The ED records indicate that the patient was triaged within a matter of minutes by the triage nurse. During the process, the nurse read the ultrasound scan report, which indicated an active intrauterine pregnancy of 14 weeks gestation. This report enabled the triage nurse to discount the possibility of an ectopic pregnancy, a condition which can be dangerous and potentially life-threatening for the patient. Identifying whether or not a patient is presenting with an ectopic pregnancy is one of the most critical tasks facing ED staff in assessing early pregnancy patients. Such presentations are not uncommon. In 2006-07 there were 1025 presentations for ectopic pregnancy in NSW EDs, representing 9.1 per cent of all problems associated with early pregnancy.

The nurse assessed the patient as Category 4 on the ATS, which is the most common rating of clinical urgency for women presenting with problems in early pregnancy. The NSW Health data for 2006-07 show that 61 per cent of such patients presenting to EDs were either ATS Category 4 or 5 (74 per cent at RNSH). Given that the triage nurse had discounted the possibility of ectopic pregnancy the rating was appropriate. The patient was assessed as suitable for the Emergency Treatment waiting area, but had to remain in the main ED waiting room because there were no chairs available in the Emergency Treatment area.

It must be noted that within the prevailing national model of emergency care a patient's emotional needs are not considered in the Australian Triage Scale. This scale correctly focuses on saving lives and assigning priority on the basis of patients' clinical needs. If a patient presenting with threatened miscarriage was given a higher triage rating, this could disadvantage

patients in more urgent need of clinical care. It is important, nevertheless, that the need for this emotional aspect of care is included in the ED protocols for the management and care of women with threatened miscarriage. This point is relevant in considering the appropriateness of the current model of care, and will be addressed in a later section of this report.

Based on her training and clinical experience, the triage nurse assessed that the patient was presenting with the signs of a threatened miscarriage. Accordingly, she provided the patient with a fact sheet entitled 'Advice Sheet About Bleeding in Early Pregnancy'. (Appendix 1) which contains information on bleeding in early pregnancy, threatened miscarriage and the normal procedures associated with presentations of this type.

At approximately 7.25pm the Clinical Initiatives Nurse took the patient's vital signs and reported to the triage nurse that they were within normal limits and that she did not have a fever. Shortly after, the triage nurse handed over to a colleague, advising the patient's vital signs were stable and her condition consistent with a threatened miscarriage.

Our review of the way in which the presentation was managed up to this point was that it was undertaken appropriately and adequately by ED clinical staff, in compliance with current policies and procedures for the management and care of ED patients.

Clinical Assessment

After she was triaged and had her vital signs taken (blood pressure, pulse and temperature) at approximately 7.23pm, the early pregnancy patient took a seat in the ED waiting room, directly in front of the triage desk.

At approximately 7.45pm the patient's male partner approached the triage nurse to express concern about how long she had been waiting. An hour later, at approximately 8.45pm, he signalled to the triage nurse, who followed him into the ED toilet, where she found the patient had miscarried.

This chronology indicates that the patient was not clinically examined during a period of approximately one hour and twenty two minutes that elapsed after her vital signs had been taken until the miscarriage occurred. This delay was significantly longer than the accepted benchmark for all Category 4 patients (70% of Category 4 patients should be seen within 1 hour). It should be noted that this benchmark may not be appropriate for women with threatened miscarriage and should be reviewed in the development of policies and protocols for the clinical management and care of such patients in all NSW public health facilities.

It is also necessary to consider the broader context of the activity taking place in the ED at RNSH that night. The level of activity was extremely high. It could reasonably be described as a 'spike' of activity that pushed the capacity of the department to the limit. Over the course of the day 136 patients presented, including 20 triaged as Category 1 or 2. At approximately 9.00pm all 26 available adult beds were in use (19 in the main area, three resuscitation and four consultation beds). Consultation room 4 (allocated for mental health patients), and consultation room 2 (eye and ENT patients), were not in use. They are allocated specifically for patients with these conditions. It should be noted that resuscitation 3 is a paediatric resuscitation room, which at the time, was being used for an adult patient. When all three resuscitation rooms are in use there is no capacity to care for a Category 1 patient arriving unexpectedly.

It should also be noted that according to hospital records there was a small shortfall of nursing staff in the ED on that evening. The evening shift requires 16 nurses in addition to the Nurse Unit Manager. A late notification of sick leave meant that there was one unfilled shift. The records show the following staff on duty (15 plus NUM):

- 1 – Nurse Unit Manager
- 1 – Clinical Nurse Specialist
- 2 – Registered Nurse Yr 8
- 1 – Registered Nurse Yr 6
- 1 – Registered Nurse Yr 5
- 1 – Registered Nurse Yr 4
- 4 – Registered Nurse Yr 3
- 1 – Registered Nurse Yr 2
- 1 – Registered Nurse Yr 1
- 2 – Enrolled Nurse Yr 5
- 1 – Endorsed Enrolled Nurse (I.V. Nurse)

At approximately 8.55pm, immediately following the miscarriage, the triage nurse transferred the patient and the fetus in a wheelchair to a consultation room. The response of ED clinical staff in the period immediately following the miscarriage was rapid and appropriate. The patient remained stable and able to be transferred to a hospital ward, requiring no significant medical intervention. The care and management of the patient beyond this point has been outlined in the factual account of the episode and, in our view, requires no further comment as it is considered adequate and appropriate.

The issue to focus on, therefore, is the time spent in the waiting room and the advice available to this patient. While there are signs recommending that if patients want to leave the waiting room they must inform the triage nurse, there is no specific mention of the toilets. Had the patient been made aware of the need to inform a nurse as soon as she felt the urge to go to the toilet, the nurse may have had the opportunity to find a more private location. As it was, the patient was unaware of the need to do this, and as a consequence was denied the privacy, and the attendant sensitivity and dignity, that a woman is entitled to receive at this time of emotional distress and anguish.

The 'Advice Sheet About Bleeding in Early Pregnancy' provided to the patient after triage does not advise a woman with threatened miscarriage should she need to go to the toilet. We will be addressing this matter in our recommendations regarding state-wide policies, practices and protocols.

TERMS OF REFERENCE TWO: CURRENT PRACTICES AND PROTOCOLS

To review current practices and protocols at Royal North Shore Hospital and other hospitals within the NSW public health system concerning the clinical management, care and treatment of patients presenting with miscarriages or threatened miscarriage.

While there are policies and procedures concerning the clinical management and care of patients presenting with miscarriages or threatened miscarriages in some NSW area health services and individual hospitals, there is currently no state-wide policy that applies across the NSW public health system. We are aware, however, that at the time the NSW Department of Health had begun working on policies in this area.

Relevant policies and procedures are in place in some area health services and facilities, including the following:

- Sydney South West Area Health Service
- North Coast Area Health Service
- Hunter New England Area Health Service
- Royal Hospital for Women
- Prince of Wales Hospital
- Royal Prince Alfred Hospital
- Westmead Hospital
- Nepean Hospital

These areas and individual facilities provide guidelines for the management and care of women who are less than 20 weeks pregnant and who are experiencing bleeding, pain or other problems related to their pregnancy. Royal Hospital for Women, for example, requires such patients who are in a stable condition to be referred to the hospital's Early Pregnancy Clinic and those requiring urgent attention to be referred to the Prince of Wales ED for assessment. The clinical policies and guidelines for patients with threatened miscarriage who present at the Prince of Wales ED state that '*Rapid assessment and definite management are desirable*' for these patients. A number of these hospitals provide an Early Pregnancy Assessment Service (EPAS) to co-ordinate assessment, scanning, diagnosis and management planning for women who experience pain and/or bleeding in early pregnancy. The EPAS also enables woman and their partners to access appropriate psycho-social support.

It is important to note that there were no specific policies and guidelines in place on the night of 25 September 2007 at the RNSH ED for patients presenting with miscarriage or threatened miscarriage. Clinical staff on duty in the ED were following broader system-wide policies and procedures relating to the triaging, management and care of patients presenting to EDs.

Following the events of 25 September 2007, the RNSH ED has developed an interim procedure for the management and care of patients with complications of early pregnancy. This procedure involves one consultation room (room 6) being kept aside for the use of these patients to provide a bed with some privacy to be available at all times. The flowchart of the draft procedure is attached to this report. (Appendix 2). If such an arrangement had been in place on 25 September the patient would have been clinically assessed (examined) and the nature and stage of the pregnancy complication would have been assessed more rapidly. The patient would then have been managed with dignity and privacy.

Considering the policies and guidelines for patients with threatened miscarriage across the entire range of health care facilities, it is obvious that the same options will not be available in every facility. If such patients present at Royal Prince Alfred Hospital, for example, they are assessed to determine whether they are in a clinically stable condition. If stable, they are referred to the Early Pregnancy Assessment Service. If unstable, patients with threatened miscarriage are referred to the hospital's ED for appropriate management and care. Early pregnancy patients attending the hospital are supported by the Antenatal Shared Care Program, which is run by the hospital and the woman's GP. The aim of this program, which involves a network of appropriately accredited GPs, is to provide a high standard of care for women who have a low-risk pregnancy.

At the other end of the spectrum, if the same patient experienced complications in a rural or remote area, she would have limited services available for O & G other than a GP, nurse or

midwife. The management and care provided by these practitioners may be entirely adequate and appropriate, depending on the nature of the presentation, but if the patient is in circulatory collapse or experiencing great pain, she requires access to an ED where she can be promptly triaged and admitted for an emergency O & G procedure if necessary.

To ensure that any woman experiencing complications in early pregnancy is provided with adequate and appropriate management and care it is recommended that system-wide policies and guidelines be developed for all public health facilities in NSW. Additional information on these proposals, which would provide guidance for all clinical staff in the NSW public health system, is outlined in the report recommendations. These guidelines for staff attending patients with threatened miscarriage should include the following check-list:

- Have I adequately ensured the safety of this patient?
- Is the patient being treated with courtesy and respect while she is waiting for treatment?
- Does the patient understand the process for her care, the way in which the hospital will provide that care and how she can have any questions answered?
- Is there capacity for this patient to receive appropriate treatment in the event of any unexpected change in her condition or dramatic increase in ED workloads?

Of course, any guidelines will need to be adapted to the local situation and clinical need.

ED – Physical Environment

Apart from the requirement for appropriate policies and procedures for patients with miscarriage or threatened miscarriage at NSW public health facilities, the inquiry team has identified a number of issues requiring attention relating to the physical environment of RNSH ED specifically and EDs generally.

1. The Waiting Room

Waiting rooms have long been a source of irritation and occasional distress for patients who are ill and are seeking treatment. They are impersonal and often uncomfortable. The name itself is annoying when people who believe they are in an ‘emergency’ (rightly or wrongly) sit in rows of uncomfortable chairs. A reception area is much more friendly, welcoming and reassuring. The patient may perceive that they have already arrived at the hospital and are now in the system. For the staff, however, even though the patients in the waiting room have been triaged and are in the system, they are not yet the primary focus of emergency care.

With the advent of the Clinical Initiative Nurses, waiting rooms are now, in fact, pre-treatment areas where initial assessment and even some diagnostic steps can begin. However, the Clinical Initiative Nurses are still not considered essential in the waiting room. They are regularly called into the ED itself to add ‘surge capacity’ during busy times. It is during these very times that waiting delays become particularly long and when the condition of patients in the waiting room can change. It is more, rather than less important, therefore, for a Clinical Initiative Nurse to be in the waiting room at these busy times.

Clinical observation of patients in the waiting room is critically important. In the RNSH ED waiting room partitions are opaque in the lower half. This makes it difficult for the triage nurse to see all patients. Partitions should be transparent or removed, so that all patients in the reception area can be observed at all times.

2. Security and Screens

NSW Health has a policy of zero tolerance of violence.

Due to increasing numbers of assaults on staff in EDs, concerns related to OH&S have resulted in various forms of protective screens being installed between triage staff and patients. Provision of these protective measures for staff is to be commended, but it raises questions concerning the protection of patients in the waiting room.

NSW Department of Health policies, including the policy titled 'Protecting People and Property: NSW Health Policy Guidelines for Security Risk Management in Health Facilities', indicate:

- a. a risk management approach should be implemented when determining the nature and level of access controls to be put in place.
- b. building design should ensure, where possible, that waiting areas
 - Are comfortable, decorated in muted colours and spacious
 - Have a clear path to commonly used fittings and facilities (eg phones, water and snack dispensers, toilets etc)
 - Have adequate signage, seating, ventilation and temperature control
 - Have furnishings that cannot be moved and/or used as weapons
 - Are well maintained (eg water and snack dispensers, lighting, phones are in working order and clean and tidy etc)

Furthermore, the Australian Health Facility Guidelines provide policies for screens, counters, partitions and other design strategies to control security risks. We believe that the application of these policies should be reviewed within the ED precinct at RNSH.

The policy directive titled 'Training Program – A Safer Place to Work: Preventing/Managing Violent Behaviour – NSW Health' mandates training for ED staff in at least two modules on dealing with aggression minimisation. This training will support the safety of patients, the Clinical Initiative Nurse and others in the waiting room.

3. Staff refreshment areas

It was noted during this inquiry that due to the high level of activity in the ED some staff members were taking late meal breaks and finishing their shifts late. The dedication of these staff members is to be commended.

It is recognised that staff members need to take refreshments and that these should be available close to the workplace. It is recommended that separate staff areas be provided close to the workplace, where staff members can have a meal or take a tea break.

4. Public toilets

Public toilets should be clean, in close proximity to the waiting room and have a call button for emergencies. They should be easily identified with simple signage.

ED – Communication

1. Effective communication

The core components of quality care of patients in an ED are:

- Safety
- Ease of access
- Efficiency
- Efficacy
- Appropriateness
- Consumer participation

Each of these components requires that attention be paid to effective communication. This is recognised in the hospitality industry, which places great store in the communication training of all staff as a pre-requisite of their employment and an essential component of customer focus.

The increasing emphasis on competence, performance and clinical outcomes in health has tended to distract staff, and indeed the health care system more generally, from the essentials of good communication. Traditionally, clinicians with good communication skills were perceived as having a 'good bedside manner'. As we have sought to improve our expertise in producing good outcomes, the focus on developing good communication skills is no longer viewed as a key priority. This needs to be re-focused, particularly as new models of care are developed and which may not be familiar to many patients.

All staff should have communication training before they embark on frontline positions and there should be regular updates on the skills that are so crucial in dealing with the critically ill, the urgent and the less critically ill patients who present to EDs.

Patient safety is of paramount importance in the health care system, but as this episode demonstrates, the focus on patient safety should not overshadow the need for quality of care for each patient. Effective communication is an essential element in delivering quality of care.

2. Signage and written advice for patients

Signage in EDs is often confusing, poorly placed, uses professional language and may add to confusion rather than reduce it. The word triage, for example, is a 200 year old French military term. Clearly this is not the intent of the current system and the term should be abandoned for use with the public. Perhaps a better term for the triage desk is the Priority Desk.

The NSW Department of Health should develop signage guidelines/templates in order to provide uniform signage at all hospitals.

Simple signage with plain language should be used wherever possible in EDs to avoid confusion. Language that may not be understood by some members of the public, such as 'Triage', should

be abandoned in public areas. It could be replaced by the term 'Priority', with instructions such as 'All patients must report to the Priority Desk on arrival for initial assessment'. Patients could then be directed to the administration officers where paperwork will be completed. This area should be referred to as 'Reception' rather than 'Admission Desk' to reduce the impression of a distant bureaucracy and to provide a more welcoming approach to patients who are our first responsibility.

When patients are given their priority category, they should also be given a leaflet indicating what that priority means and explaining why they may experience delays. The leaflet should also indicate the different pathways for different clinical groups, for instance paediatrics, mental health and sexual assault. There should be a clear sign in the ED saying that 'if your condition changes, you should notify the staff member at the Priority Desk immediately'.

A series of brochures outlining the steps that are likely to be encountered by patients with the 10 most common conditions could be prepared for distribution to patients presenting with those conditions. The *'Advice Sheet About Bleeding in Early Pregnancy'*, for women presenting with threatened miscarriage, should include the advice: "Let the nurse know immediately if you feel the urge to go to the toilet".

It is pleasing to note that staff members in the ED at RNSH wear uniforms which clearly identify their role. These identifiers, however, are not known to visitors and patients attending for the first time. They require explanation in either the leaflet referred to previously or by wall signage. The explanation should be large enough for people with impaired vision to read.

The Role of the ED

It is clear that public perception of the ED is different from the way clinicians see it. Doctors and nurses see it as an area where emergency medicine is practised based on a carefully prescribed set of clinical priorities to ensure the safety of each patient. For many members of the public, however, the ED is the place to go when they cannot find any other medical assistance available.

The effect of this perception is that EDs become very busy places, particularly after hours, when many people present with relatively minor conditions that could be more appropriately managed in a GP clinic or other primary care facility. This situation is compounded by the number of chronically ill patients, who are generally older with complex health needs, who present to EDs. These patients cannot adequately be managed by GPs and require significant time and resources to be adequately managed and cared for in the ED.

There is an urgent need for a public education program around this issue.

The design and layout of the RNSH ED reflects the different health needs of various patients. The Emergency Treatment area is provided to deal specifically with patients presenting with less critical conditions, thereby reducing the clinical load on the main ED. A paediatrics area is provided specifically for the treatment of children. The public perception of how this system operates, however, can be quite misleading. On the night of 25 September 2007 the male partner of the early pregnancy patient complained to staff that he had observed children with minor complaints such as coughs and colds being directed through to what he believed to be the main ED treatment area. In fact, they were being taken through to the designated and separate children's area. In the same way, patients being directed to the Emergency Treatment area with less critical health needs could be perceived as being given priority for treatment.

The patients or people accompanying them are not responsible for this incorrect perception. It results from a lack of information about how the triage system works and the different models of care that are provided for patients with different clinical needs. In the RNSH ED a sign below the triage nurse's desk lists the various triage categories and the relevant treatment pathways. It is expressed in clinical terms, however, and therefore does not address the patients' information needs. Providing patients and the people accompanying them with the leaflet suggested in the section headed *Signage and written advice for patients* would help to reduce this confusion.

Alternative Pathway for Early Pregnancy Patients

It is understood that NSW Health is currently considering alternative approaches to the management and care of chronically ill, older patients with complex health needs. This includes the development of Medical Assessment Units. The objective of this alternative approach is to provide these patients with the medical assessment and in-patient treatment they require, while at the same time reducing the clinical load they currently place on the ED.

A similar approach could be adopted to provide a more appropriate pathway for the management and care of patients with threatened miscarriage whose condition is stable. An area with privacy, facilities for examination and for a partner to be present would provide an ideal solution. This would not have to be part of the ED but should be close by and have access, on call as required, to staff with expertise in midwifery and O & G.

Many early pregnancy patients, in fact, could be better managed by a midwife, in a GP clinic or other non-urgent outpatient facility, so long as they are adequately assessed and have ready access to an ED in the event of a rapid change in condition.

At RNSH ED the consultation area currently set aside for the management and care of sexual assault patients provides a possible solution. It is close to the ED and consists of three rooms, including an examination room. It is not in high demand for its current designated purpose. Nevertheless, there is a possibility that it may be in use for other purposes when a patient with threatened miscarriage presents. That potential contingency will need to be managed at the time. The staffing issues associated with the use of this area would also need to be addressed, but could involve the cooperation of the gynaecology and obstetrics units as well as midwives, nurse practitioners and, of course, the ED itself.

Educational material on early pregnancy

It is clear that there is a significant lack of readily available educational material for women in the first trimester of pregnancy. Many women do not seek medical attention until they book in to an obstetrician at the end of the trimester. It is important, therefore, that a new approach to providing this educational material be implemented as quickly as possible. The main point of contact with women at the earliest stage of pregnancy is the pregnancy test kit. We recommend that governments explore the possibility of gaining the commitment of manufacturers/distributors of these kits and pharmacists, to provide evidence-based information on early pregnancy, including miscarriage, as part of each kit. This should be a condition of supply.

A number of relevant help line services for women in early pregnancy have been identified, including those provided by Tresillian, Mothersafe, Bonnie Babes Foundation and Sids and Kids. Hospitals, including RNSH, also have dedicated volunteers, chaplains and established relationships with service organisations. It is recommended that EDs and Early Pregnancy

Advisory Services develop linkages and memoranda of understanding with organisations providing relevant help line services that are willing to provide psycho-social support for women in early pregnancy and their partners.

The inquiry team has also noted that obstetricians in NSW have developed a voluntary advice line, the Pregnancy Advice Line (PAL), which enables any doctor managing a pregnancy to obtain expert pregnancy advice at any time. This model should be supported and promoted by local public health facilities, Area Health Services and the NSW Department of Health.

TERMS OF REFERENCE THREE: RECOMMENDATIONS

As a consequence of the above reviews, make recommendations concerning any action that should occur including referral to the Health Care Complaints Commission, changes considered appropriate to Hospital practices, policies or protocols or the development and implementation of state-wide policies, practices and protocols across the public health system.

Having reviewed the adequacy and appropriateness of the clinical management and care of a patient with threatened miscarriage who presented at Royal North Shore Hospital ED on the evening of 25 September who subsequently miscarried, and having reviewed current practices and protocols concerning the clinical management, care and treatment of such patients, we make the following recommendations.

In relation to referral to the Health Care Complaints Commission it is recommended that:

1. No clinical staff members involved in the management and care of the early pregnancy patient at RNSH ED be referred to the Health Care Complaints Commission by the inquiry team.

In relation to the presentation of patients with miscarriage or threatened miscarriage it is recommended that:

2a. New system-wide models of care to be developed as a matter of urgency for all public health facilities in NSW concerning the management, care and treatment of patients presenting with miscarriages or threatened miscarriages. This process should include a review of the maximum waiting time under ATS categories for women with threatened miscarriage.

2b. Models of care for low risk pregnancy such as the Early Pregnancy Assessment Service (EPAS) should be developed in all Area Health Services. Relevant clinicians must be involved to individualise these guidelines to clinical need and local circumstances.

3. Patients presenting to a NSW public health facility with threatened miscarriage be provided with privacy and treated with sensitivity and dignity. They are also to be provided with timely and appropriate psycho-social support. It is important that the need for this emotional aspect of care is included in the ED protocols for the management and care of women with threatened miscarriage.

4. Patients presenting with an early pregnancy complication be examined as soon as possible to assess the nature of the complication, the stage it has reached and an appropriate ATS category.

5. Guidelines for staff attending patients with threatened miscarriage include the following checklist:

- Have I adequately ensured the safety of this patient?
- Is the patient being treated with courtesy and respect while she is waiting for treatment?
- Does the patient understand the process for her care, the way in which the hospital will provide that care and how she can have any questions answered?
- Is there capacity for this patient to receive appropriate treatment in the event of any unexpected change in her condition or dramatic increase in ED workloads?

6. Fact sheets provided for patients with threatened miscarriage include the following directive: "Let the nurse know immediately if you feel the urge to go to the toilet".

In relation to the presentation of patients with miscarriage or threatened miscarriage at Royal North Shore Hospital ED it is recommended that:

7. As an interim measure, consultation room 6 be considered as a private area for the management and care of patients with threatened miscarriage. The staffing issues associated with the use of this area for this purpose are to be addressed. A more permanent solution will need to be developed in consultation with the staff of the relevant units.

In relation to the role of Clinical Initiative Nurses in EDs it is recommended that:

8. Clinical Initiative Nurses be assigned primarily to the ED waiting room, particularly at busy times, when waiting times can be particularly long. The practice of calling the Clinical Initiative Nurse into the ED itself to add surge capacity during busy times is to be reviewed and alternative staffing arrangements employed.

In relation to signage in EDs it is recommended that:

9. The NSW Department of Health develop signage guidelines/templates in order to provide uniform signage in all hospitals.

10. Simple signage with plain language be used wherever possible in EDs to avoid confusion. Language that may not be understood by some members of the public, such as 'Triage Desk', should be abandoned for public use. It could be replaced by the term 'Priority Desk'.

11. The term 'Reception' be used instead of 'Admission Desk' and 'Reception Area' instead of 'Waiting Room'.

12. Prominent signs be provided in the ED stating: 'If your condition changes you should notify the nurse immediately'.

In relation to communication with ED patients it is recommended that:

13. Public education programs be developed to address the perceptions of the public concerning the role of Emergency Departments for low risk and non-urgent presentations

14. Fact sheets be developed for patients presenting to EDs explaining what their ATS category means and why they may experience delays. The fact sheets are also to indicate the different pathways provided for different clinical groups.

15. Fact sheets for ED patients should help them identify the role of clinical staff members. This information could also be displayed on wall signage.

16. All staff members be provided with appropriate communication training before taking up frontline positions in the health system, such as the ED, to assist them in communicating effectively with patients and members of the public.

In relation to the security and physical environment of EDs it is recommended that:

17. The application of NSW Department of Health policies and Australian Health Facility Guidelines relating to security risks be reviewed within the ED precinct at RNSH.

18. A staff area be provided close to the ED workplace where staff members can have a meal or take a tea break.

19. Partitions in ED waiting rooms be transparent or removed so that all patients can be observed at all times.

20. Public toilets in EDs be clean, in close proximity to the waiting room and have a call button for emergencies.

In relation to the provision of educational material on early pregnancy it is recommended that:

21. Governments explore the possibility of gaining the commitment of manufacturers/distributors of early pregnancy kits and pharmacists to provide evidence-based information on early pregnancy, including miscarriage, as part of each kit. This should be a condition of supply.

22. EDs and Early Pregnancy Advisory Services develop linkages and memoranda of understanding with organisations providing help line services that are willing to provide psycho-social support for women in early pregnancy and their partners.

CONCLUSIONS

This inquiry has examined the adequacy and appropriateness of the clinical management and care that was provided to a patient with threatened miscarriage who presented to the ED at RNSH on the night of 25 September 2007.

We have noted that there were no specific policies and guidelines in place at the RNSH ED for patients presenting with miscarriage or threatened miscarriage on that evening. Clinical staff on duty in the ED were following broader, system-wide policies and procedures relating to the triaging, management and care of patients presenting to EDs.

We do know that this matter has been addressed by the ED staff at RNSH (Appendix 2).

This has implications for the management and care of patients with threatened miscarriage in all NSW public health facilities. We therefore recommend that appropriate state-wide policies and procedures for the management and care of such patients be developed and implemented as a matter of urgency.

Such policies and procedures should ensure that when a patient with early pregnancy complications presents at a hospital she should be seen immediately by the clinical staff and then examined promptly to assess her condition. It has been shown that most early pregnancy patients can be safely managed with a more conservative approach. The patient should be advised that she is miscarrying, and be given the choice of either staying at the hospital for observation or going home to wait for nature to take its course. The risks of infection and bleeding should be explained. She should also be advised that there is usually no need for further medical intervention except for an examination to ensure that no pregnancy tissue is retained in the cervix or vagina following the miscarriage.

We note that an increasing number of women, aware that they are about to miscarry, choose to remain at home in a familiar environment with their partner or family members.

Having noted this appropriately more conservative approach to medical intervention, we believe it is important to highlight the critical need for any woman (and her partner) experiencing miscarriage to be provided with privacy and treated with sensitivity and dignity during a time of great emotional distress and anguish. It is also important to provide her with adequate and appropriate psycho-social support.

The other matter that should not be overlooked in this report is the impact this incident and associated public controversy has had on the RNSH and its staff. Given the lack of relevant policies and procedures to guide them in the management and care of the early pregnancy patient, individual staff members in the hospital's ED cannot be held responsible for the inadequacies in the health care system that have been revealed as a result of this incident.

Emotional debate and controversy that impugns the professional integrity and reputation of clinical staff can all too easily turn into a self-fulfilling prophecy. This can, in turn, adversely influence public confidence in a hospital and the quality of its services.

Despite the impact this incident has had on the morale of clinical staff working in a good hospital with a proud tradition of quality care they are committed to improving the quality of care and responding to the lessons learnt as a result of this event.

Our objective in reviewing and reporting on these matters is to identify how the entire NSW public health system can apply these lessons to improve the model of care for all such patients in the state.

We sincerely hope that by developing and implementing the state-wide policies and procedures recommended in this report that the NSW public health system will in future provide women with a more satisfactory patient journey and experience than that provided to the patient who miscarried at the Royal North Shore Hospital on 25 September 2007.

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 Staff of the NSW Health Quality and Safety branch
 Staff of the Clinical Excellence Commission
 Clinical staff of the Royal North Shore Hospital
 NSW Midwives Association
 Bonnie Babes Foundation, NSW
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LIST OF ABBREVIATIONS

ATS - Australian Triage Scale
 ED - Emergency Department
 EFT - Equivalent Full Time
 EPAS - Early Pregnancy Assessment Service
 GP - General Practitioner
 NUM – Nurse Unit Manager
 O & G - Obstetrics & Gynaecology
 OH & S – Occupational Health and Safety
 RNSH – Royal North Shore Hospital

SRMO - Senior Resident Medical Officer

APPENDIX 1

Northern Sydney Health



EMERGENCY MEDICINE YAL NORTH SHORE HOSPITAL

ADVICE SHEET ABOUT BLEEDING IN EARLY PREGNANCY

Did you know that when a woman knows she is pregnant about one in seven (or 15%) of those pregnancies will end in miscarriage?

What is a threatened miscarriage?

A threatened miscarriage is the term used for pregnancies in which there is some early vaginal bleeding which occurs over several days or weeks. The amount of blood loss can vary greatly. If any bleeding occurs it is important to consult a doctor. A threatened miscarriage *may* result in a miscarriage, although, if the symptoms cease, the pregnancy may continue and the outcome is usually good.

What is a miscarriage?

A miscarriage is the spontaneous ending of pregnancy usually during the first three months. In most cases, there is some problem with the pregnancy. In some cases the baby has not developed at all, and there is just a small amount of tissue in the uterus. There are many reasons why pregnancies fail after the first three months, but we often don't know the cause.

In the vast majority of cases miscarriage occurs by chance and could have happened to anyone. Many women have at least one miscarriage during their reproductive life and go on to have normal pregnancies.

Why is my blood group checked?

We check your blood group because women with an Rh (Rhesus) Negative blood group can make antibodies against the cells from an Rh positive baby. These antibodies can have harmful effects in your next pregnancy. This can be prevented by giving you a special injection at the time of miscarriage.

Why do I need an ultra sound?

You will be asked to see your family doctor tomorrow to arrange an ultrasound, or return to the hospital (usually the next day) for an ultrasound. The ultrasound will help your family doctor or our Emergency staff give you advice about the status of your pregnancy.

- If you are returning to the hospital for your ultrasound, call the Ultrasound Department in the morning on 9926 8505 to book an appointment. Following your ultrasound, please come directly to the Emergency Department. Because we must, at all times, provide an emergency service you will go through the “triage” system once again. This may seem difficult under the circumstances but we hope you understand that we are unable to make appointments.
- If you see your family doctor to arrange your ultrasound, information will be available in a similar time frame.
- Please decide your preferred approach in consultation with Emergency staff. And remember, both approaches are equally acceptable.

What is a curette?

A curette is an instrument shaped like a small spoon. It is used to remove blood clots and placental tissue from the uterus. A curette is performed in an operating theatre by specialist medical and nursing staff. You may experience some bleeding for a week after a curette has been performed.

Is anyone or anything to blame for my miscarriage?

People do not “cause” a miscarriage. Whether you played tennis, went dancing, or had sexual intercourse, it is extremely unlikely that anything that you did caused or hastened your miscarriage.

Likewise, there is nothing that you could have done to prevent it happening. Pap smears or internal examinations do not cause miscarriages.

When can I try to get pregnant again?

No one is sure whether it is better to try straight away, or to wait until you have a normal period. Whichever you choose, the chances are good that everything will be normal.

After one miscarriage, the risk of miscarriage in future pregnancies is about 20%. If you have three miscarriages in a row, we suggest you see your doctor as tests to identify a cause may be useful. However most often these tests do not find a problem. It's important to remember that even if you have three miscarriages in a row, you still have up to a 75% chance you will carry your next pregnancy to full term.

How will I cope with a miscarriage emotionally?

Whether a pregnancy fails at the end or at the beginning woman often feel a great sense of loss, disappointment and sometimes even anger. These feelings may last for months or even longer. It's important to allow yourself to grieve and give yourself time to get over your loss.

Can I get more information?

The hospital can provide you and your family with support and information. Your nurse or doctor will help.

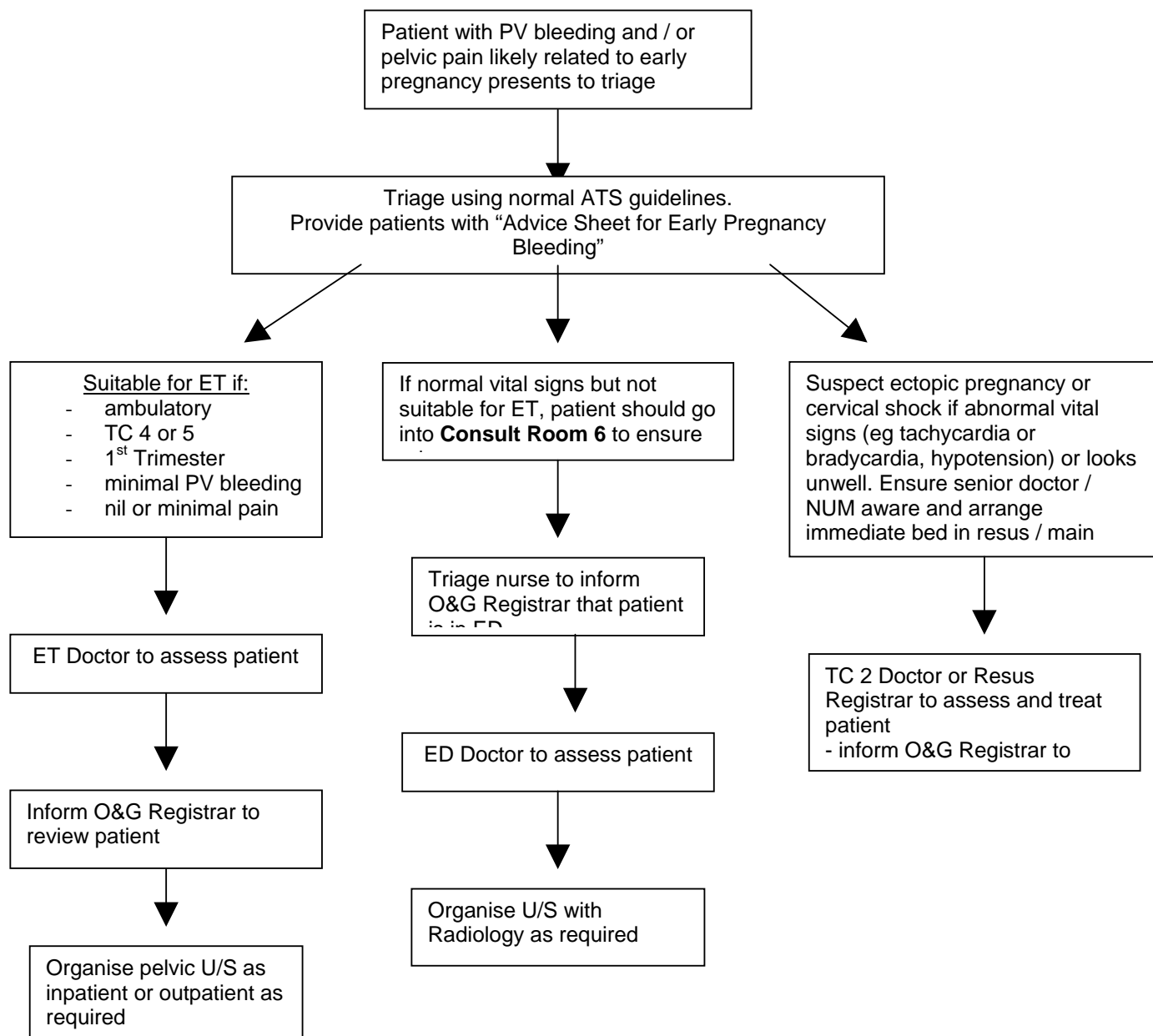
What support services are available for families who experience a miscarriage?

SIDS and Kids NSW	Counselling support and information	1800 651 186
Your local GP	Information and medical advice	
Social Work Department	Counselling and resources	9926 7580
Chaplains & Ministers	Offer spiritual comfort and rituals	
Bonnie Babes Foundation		03 9758 2800

APPENDIX 2

DRAFT PROCEDURE FOR PRESENTATION OF PATIENTS WITH COMPLICATIONS OF EARLY PREGNANCY

RNSH EMERGENCY DEPARTMENT



Notes

- Consult Room 6 is to only be used for the treatment of patients with early pregnancy complications for the duration of this guideline
- Vaginal examination in a patient with early pregnancy bleeding is not always required and has a poor predictive value compared to ultrasound
- Vaginal examination should be performed where ectopic pregnancy is suspected or where there may be products of conception in the cervical os which need to be removed.
- Vaginal examination must be performed with a chaperone present

Robert Day - ED Director
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