Investigation into Medical Wards, Bundaberg Hospital, Wide Bay Hospital and Health Service

Clinical Review

3 November 2022

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1. Executive Summary

Following concerns raised from both internal allegations and reports via a patient advocate on the use of sedating medications within the Bundaberg Hospital, this clinical review was commissioned with the purpose of reviewing and providing expert clinical advice regarding the treatment provided to patients prescribed and/or administered S8 and S4 medications with a sedative effect in Medical Ward 3 within the Bundaberg Hospital, Wide Bay Hospital and Health Service.

Based on the review of the documents, other written information and materials, as well as interviews conducted with relevant WBHHHS staff, the Investigators find the following:

- The Clinical Review team did not find evidence of patient harm or death from prescribing and/or administration of S8 and S4 medications with a sedative effect, with side-effects consistent with the type and dosing of pharmacological agents used.
- The review found that the prescription and administration of S8 and S4 medicines with a sedative effect appeared to be clinically indicated according to the current local policy, although the built environment on Medical Ward 3 reduces the options for potentially more effective first line non-drug interventions, meaning that pharmacological interventions have to be used earlier, more frequently and potentially in higher doses.
- The review found that there was relevant documentation that S8 and S4 medicines were being used and prescribed to treat pain and responsive behaviours associated with delirium and/or dementia, as opposed to simply for sedation in the absence of documented clinical need.
- There were several medications which were removed from Pyxis whereby no evidence was found in the patient's chart or medication chart confirming that doses had been given, with gaps observed in both phone order and Patient's own medicines (S8 / DS4 medicines) book documentation.
- The review team did not uncover any further specific evidence of harm or death resulting from the prescription or administration of S4 and/or S8 medications with a potentially sedating effect from the multiple modalities of confidential feedback offered to staff during the course of this review, as well as the reported concerns raised by both the patient advocate and ward social worker from families.
- S8 / DS4 records were maintained with regular audits, however there was a lack of clarity across a number of interviewees on the S8 and DS4 audit processes.
- In relation to documentation, while the review team found that the level of compliance with existing policies and procedures appeared adequate, there appeared to be some process inconsistencies surrounding delivery advices, patient's own medicines and phone orders.

On considering the evidence evaluated in the course of this review, the following recommendations should be considered in relation to the above findings:

Built Environment

- The review team recommends the HHS considers engaging environmental consultants via Dementia Training Australia and the Health Care Improvement Unit to look at both interim and long-term options with the current campus and the new build of Bundaberg Base Hospital to create a more cognitive enabling environment for patients and reduce the impact of the environment on the need for early use of pharmacological therapies.

Model of Care:

- In combination with further work on the built environment, it is recommended that the HHS revisits it's model of care for cognitively impaired older patients to incorporate full intra-professional involvement with Nursing, Allied Health and Medicine.

- Consideration should be made for modalities to access, coordinate and fund specialist advice and support for complex cognitively impaired older patients, including local coordination, interprofessional huddles and robust formal linkages to Geriatric Medicine, both locally and inter-HHS, and Old Age Psychiatry, as well as post discharge supports.
- This could include consideration of immediate addition of a Dementia &Delirium Clinical Nurse Consultant (CNC) and/or Nurse Navigator as an interim measure and extension of the current Residential Aged Care Facility (RACF) In-reach and Hospital in the Home (HiTH) programs to support high risk patients with acute responsive behaviours or delirium within their own home (including an RACF) should also be considered where possible.

Pharmacological and Physical Restraint:

- All attempts should be continued to be made to minimise the use of both physical and chemical restraints, as per Wide Bay HHS Policy PRO-0443-Restraint-of-Adult-Patient-V4.1.pdf (health.qld.gov.au) and a robust audit policy associated with this procedure should be added to review the use of both modalities.
- Consideration should be made of the development of a separate rapid sedation procedure with an associated audit schedule and limitation of the use of multiple sedating agents and use of parenteral route outside of specific indications.
- Harmonisation of multiple potentially conflicting policies regarding types and doses of medications used, especially with regard to the concurrent use of multiple agents across pharmacological classes and reducing the use of intramuscular (IM) or intravenous (IV) sedation.
- Informed consent should be obtained as soon as possible from either the patient or substitute decision maker in all cases, including education and counselling as to the indication, duration, effect and potential side effects of using these agents.

Education and Training:

- The reviewers recommend an expansion of the current Dementia and Delirium education package to include medical and allied health staff, as well as the addition of a contents quiz rather than just reflections and ensuring this is mandatory for all relevant staff.
- Training on the management of dementia and delirium should be included within Occupational Violence Prevention training for all staff to emphasise de-escalation and non-drug management of responsive behaviours.
- Additional targeted prescribing and medication training and education for all junior doctors involved in the care of older patients, especially those covering out of normal business hours.
- Consideration should also be given for Graded Assertiveness Training across all professions and improved communication training within craft groups.
- Consideration should also be given to extending education on medications to allow adequate consent and communication with patients and their families/substitute decision makers on centrally acting medications.
- The review team also recommends the addition of specific education and training for rural generalists and general physicians in the care of complex, older cognitively impaired patients.

Communicating with Patients and their Care Partners:

- It is recommended that discussion and consent for the use of these agents with patients and their care partners is formalised to allow relevant information of these medications use, their expected side effects and escalation processes for consumers.

- Information should be provided to consumers including both the physical side effects of these medications, what should be considered expected and what should be considered excessive or unexpected.
- Communication should be initiated by the prescriber but backed up by both the pharmacist and ward team.

Medication Management, Policy and Monitoring:

- The Pyxis procedure should be benchmarked against other similar documents across the state and reviewed finalised. This revised document should include an increased focus and frequency of drug audits
- Use the full functionality of Pyxis to ensure regular, comprehensive understanding of patterns of medicine use to identify outliers for further investigation
- The documentation of 'waste' / disposal of S8 / DS4 medicines should be reviewed to ensure this is being captured in Pyxis
- S8 / DS4 audit schedule should be confirmed and aligned with the Procedure Controlled Drugs and Designated Schedule 4 Medications-Management
- Complete audits against the Procedure Controlled Drugs and Designated Schedule 4 Medications-Management with the auditing process and reporting lines for the audit results to be clarified with clear communication across disciplines, including clear mechanisms for feedback and action plans when discrepancies are identified, with particular emphasis on phone orders and patients own medication.
- Missing medication processes should be followed, with reporting monitored, where the custody of S8 and DS4 medication cannot be confirmed, for example missing witness signatures.
- It is recommended that further education and training of nursing and medical staff relating to the requirements for phone orders for S8 / DS4 medicines is undertaken by the HHS.

Workplace Culture and Reporting:

- The review team recommend that more structured feedback of BPA results to staff and development of BPA action plans are undertaken to identify ways to improve culture, especially concerning integrated team working and transdisciplinary communication.
- The workplace would benefit from greater visibility of senior staff within the ward areas, building on existing initiatives.
- The review team recommend that Human Resources practice include exit interviews for all staff on resignation to gain feedback on hospital strengths and to help identify areas of improvement.