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August 2015

Submission to End of Life Choices Parliamentary Inquiry**A case-study of a person in palliative care from April 2013 to May 2014**

"Elle" was born in country Victoria in 1935 , married in Melbourne 1955 , bore two children then had 4 or 5 miscarriages , and adopted two more children . The family moved from Melbourne in 1963 and settled in the country . She had enjoyed good health , but as a youngster developed a severe rash when given penicillin . When her appendix was removed in 1954 she experienced severe post-operative nausea and vomiting (ponv) for several days . She experienced exactly the same ponv at the Eye and Ear Hospital in the 1990's with the result that a ceramic device which had been implanted in her ear was dislodged within hours of implantation and this left her with hearing impairment which became severe in later years .

From 1963 to 2013 she attended basically the same group of medical practitioners and enjoyed relatively good as she aged . She registered to be an Organ Donor in July 2006 . She had a knee replacement in April 2011 at a hospital (not the same hospital as referred to later) whose records at pre-admission did not show a sensitivity to Morphine but did note previous problems with ponv. In theatre in April 2011 she had a spinal which included intrathecal Morphine (200mcg) . She subsequently had severe ponv , a MET call was made ; the family saw Elle experience 48 hours of delusion, dissociation where she did not know any of us , and aggression with her wanting to strike us . It was a frightening experience . Upon discharge from that hospital she was wearing a Fentanyl patch for pain-relief . Her GP explained that although Fentanyl is an opioid akin to Morphine the medication is in micro-doses which are slowly absorbed through the skin over several days , and he amended her medical history at her regular Medical Clinic to show her aversion to Morphine ; that history already showed allergy to Penicillin , Codeine , Sulfonamides , and Erthromycins .

Cancer , ovarian , advanced , metastasised was diagnosed mid-April 2013 . The impact was shattering and immediate . She became immersed in numerous medical appointments , X-Rays, CT Scans, blood tests ; she needed medication for depression and was afflicted by severe bouts of dry-retching and nausea which left her exhausted and which continued for 4 weeks during which her GP trialled various pain-relief and anti-nausea medications . He carefully explained to her the purpose of each change of medication ; anti-nausea drug Maxolon was trialled without any benefit and was discarded ; Targin was tried for pain-relief but found to be contributing to nausea , so it was discontinued and she was advised to avoid oxycodone medications .

REFERRAL TO ONCOLOGIST AND PALLIATIVE CARE .

The G.P's referral letter included a Summary of Patient History to 18/4/13 which included her allergy to Codeine , Morphine , Penicillin , Sulfonamides , and E.E.S (Erthromycins). Dr. S.J quickly established good rapport , explained the disease was terminal but that chemotherapy could improve quality of life for whatever time was left ; Elle agreed to have chemo and the first cycle was listed to start on 23 May .

Rapid progress of the disease promoted a build-up of fluid in her body , and 2 litres were drained from her stomach on 15/5/13 . Next day her G.P discontinued her use of anti-nausea medication Stemetil and it was replaced with Haloperidol (Serenace) 500mcg, half-a-tablet twice a day ; it took a couple of days to "click-in" but proved to be very effective for her .Further fluid build-up caused hospitalisation on 20/5/13. Upon admission I handed to Dr.S.P nine small pages of notes showing her food and fluid intakes and medication changes 29/4/13-20/5/13. He asked permission to copy for her file (Yes)and later returned them saying he had taken copies . / 2

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On 20/5/13 she was admitted to hospital to have fluid drained from her right lung ; had 800mls ascitic fluid drained 22/5/13. That evening at an Information Session at the Chemotherapy Unit attended by Elle and four family members , the oncology and chemo providers stressed the need for all participants providing care to Elle to be fully informed so as to provide the best care possible . We cautioned against their proposal to give Maxolon as an anti-nausea medication and explained that her G.P had trialled it and discarded it , and Senior Oncologist Dr. JML came in and assured Elle that it was safe for her use , and she reluctantly consented .She had her first session (5 hours) of chemo next day and was discharged on 24/5/13 .

SEVEN DAYS OF NAUSEA, DRY-RETCING, AND VOMITING

After 2 days of persistent nausea/dry-retching / vomiting and loss of bowel-control she was taken by ambulance to hospital on 26/5/13 at 1100hrs .In Emergency Dept she was given Maxolon, a Fentanyl patch for pain-relief and was discharged with more Maxolon tablets at 1520hrs.

On 27/5/13 while being examined at her regular Medical Clinic she had several bouts of vomiting and her G.P advised her to go straight to hospital ; she did, it took 6.75 hours for her to be admitted and she was discharged on 29/5/13 .with diarrhoea and more Maxolon tablets .The Discharge Medications Summary showed that she had been given Oxycodone in the form of Endone (without her knowledge despite having refused it with request that the nurse double-check with the doctor) We explained that her G.P had trialled Targin , found it to be contributing to nausea and advised her to cease using it and avoid oxycodones in future .

On 6/6/13 her oncologist Dr.SJ apologised for the oxycodone having been given to her . He then doubled her regular dosage of Maxolon and proposed to have a syringe-driver fitted to her stomach to deliver 60mg Maxolon plus 1mg Haloperidol(Serenace) daily .Next day the palliative care nurse visiting our home said the idea of a syringe-driver had been cancelled .We obtained a second opinion at her Medical Clinicand reluctantly increased the Maxolon tablets dose on 11/6/13 . Over the following days she developed trembling , numbness and shaking , was examined by her G.P and he cut her Maxolon dose in half .

On 12/6/13 Elle granted me Enduring Medical Power of Attorney .

On 19/6/13 a home-visit nurse Ms.DS observed Elle with numb fingers , nausea , trembling and with severe shakes . DS reported these symptoms to her Senior Clinician and at 1750 that evening nurse Ms ED from the Chemo Unit at hospital rang Elle at home and told her she had had an Adverse Reaction and was to stop taking Maxolon , and to get her G.P to prescribe Ondansetron 8mg for her nausea instead . Elle did so , and within a few days there was a huge change for the better ; as a result we ensured that Maxolon was included in the list of her medication allergies .

LETTER OF CONCERN .

On 21/6/13 Elle and I wrote to the hospital expressing deep concern regarding the oxycodone being given without her knowledge or consent; we related that a nurse had placed two whole green Serenace tablets in front of Elle , saying "here, take your medicine" which Elle rejected as an "overdose", and further that on another occasion a nurse had placed five whole Serenace tablets in front of Elle saying "This medicine is for you " and Elle rejected it . We asked what changes would be made for the better .

We also provided the hospital with a copy of a letter from the hospital anaesthetist where the knee replacement had been done , which concluded that she should avoid Morphine , and we asked that it be included in in her hospital medical records .

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We received a reply dated 25/9/13 which in essence said :

- . the hospital is committed to the new National Safety & Quality in Healthcare Standards of which Standard 3 relates to Medication Safety
- . education is being given to staff to emphasise the new medication policy which dictates a collaborative approach between the patient , the carers , and members of the treating team
- . committed to Carers Recognition Act 2012 , and presentations are being given to staff to respect and involve carers in care planning and treatment .
- . an assurance that all of Elle's allergies are listed on the Patient Alert Sheet at the very front of the hospital file
- . offered sincere apology for the stressful situations experienced .

On 1/7/13 Elle was admitted to hospital with suspected pneumonia /blood clots and she was discharged on 4/7/13. Morphine and Maxolon were both listed in her recorded allergies , however we later discovered that an entry for 10mg i.v Maxolon was made on the "Once only nurse initiated medicines chart " but there was no entry to show when given or by whom .

NOTE. It was a shock to learn in December 2013 that someone claimed to have performed a "rechallenge" on 2/7/13 which concluded that Elle could tolerate Maxolon

On 10/7/13 Elle collapsed at home , was taken by ambulance to hospital and found to have clots in both lungs .After discussion with oncology Dr. BH on 10/7/13 she requested that no resuscitation be performed in the event of a cardiac arrest , and appropriate paperwork was completed . She was now taking Diazepam for anxiety and depression . Was discharged on 16/7/13 with a letter enabling us to obtain bottled oxygen at our own expense , which she used over the next ten weeks .

NOTE. It was not until October 2014 (after Elle's death) that I discovered evidence on file to show that a plan had been hatched but not completed . See my later notes in this submission .

During July 2013 Oncologist Dr SJ proposed a halving of the chemo cancer drugs , and an operation in 3 months to debulk the cancerous tissue(reproductive organs), and Elle agreed .The chemo sessions would reduce from 5 hours to 1 hour ; good news that the Cancer Antigen CA125 count had reduced from 3020 on 11June to just 533 on 9/July . She was now having daily injections of blood-thinner Clexane at home .

Nausea persisted daily needing Ondansetron 8mg wafer twice a day to get from one chemo session to the next . (Serenace had been discontinued on 5/7/13). The CA125 count came down to 102 on 28/9/13 and chemo was suspended to allow her to build up for an operation in October . In view of the medication errors experienced at this hospital we prepared a typed sheet showing which medications she took daily , optional medications , medications to which she had allergy and with what reactions , and also highlighted her severe hearing loss /how to communicate .

OPERATION AT MONASH MEDICAL, MOORABBIN .

Attended pre-admission check 9/10/13 at which we presented typed sheet of medical details , also copy of letter from anaesthetist (at knee-replacement 2011 operation) advising avoid Morphine , and we described her severe ponv throughout he life .

Immediately before the operation (epidural)on 23/10/13 , Elle signed her Statement of Choices and surgeon Dr.SH signed as witness. For the first time ever she had no ponv ; she was treated for suspected infection 25/10/13 , given anti-biotics on 27/10/13 , was discharged 29/10/13 with a slight cough and wearing a Fentanyl 12mcg patch for pain-relief . We subsequently requested and were given a letter detailing the anaesthetics which had been used with such success .

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4.

FURTHER ADMISSION TO SUBJECT HOSPITAL i.e. not Monash Moorabbin .

After one day at home coughing, wheezing and short-of-breath Elle was examined by a doctor at her Medical Clinic who, after ringing the Medical Registrar at the hospital, gave Elle a two-page Medical History Summary and advised her to "take it and yourself to hospital a.s.a.p to have fluid drained from your lung". We got to E.D at 1730hrs , X-Ray at 1900hrs , into a bed in E.D at 0045hrs on 1/11/13 , and finally was admitted to a Ward at 1400hrs on 2/11/13 . Later that afternoon a fluorescent-green gunk indicative of "Pseudomonas infection" was found in her left ear and reported to staff . It took 6 days before she got ear-drops for that infection .

It is normal practice to suspend blood-thinning medication for 4 days before having a "Cutting" procedure , and at the earliest opportunity Elle had 1300mls drained from right lung on 4/11/13 . She was now on oxygen and very depressed .

On 8/11/13 medical staff expressed dissatisfaction with her Statement of Choices and with the Not For Resuscitation completed form which was on her file; they wanted their own "slightly different forms" to be used instead . Elle became very upset and demanded that they leave the room . I had some discussion with a doctor in a corridor, and later with a middle-aged nurse , and explained Elle had used the forms provided to her from Austin Health, Respecting Patient Choices Office , Heidelberg but they maintained their attitude .

Throughout this admission period of 18 days the Oncologist Dr SJ kept vacillating as to when future chemo sessions would/would not be held . Elle then requested that a written Plan of her future Health Care be prepared and given to her prior to Discharge . Oncologist Dr. SJ agreed and a meeting was held on the night of 15/11/13 attended by Dr.SJ and his assistant Dr.S , Elle, me , two daughters , Social Worker Ms.N , and Palliative Care nurse Ms.M.D. , the outcome being Oncologist Dr SJ undertook to have a Health Care Plan drawn up and a copy given to Elle prior to Discharge, that a copy be sent to her G.P and one to Palliative Care so that " all are on the same page", and that a "Physio " plan would also be made available .

Ultimately , by negotiating through the Patient Liaison Officer Ms. M.P , a meeting of all parties was arranged for 30/12/13 to progress the Health Care Plan

17/11/13 Elle learned that her only niece had been diagnosed with advanced stomach cancer .

18/11/13 Discharged from Hospital , no Health Care Plan , no Physio plan , and Elle in low spirits , disappointed and depressed .

19/11/13 she saw her G.P and got Ciproxin HC anti-biotic drops for the pseudomonas ear infection .

2/12/13 She saw oncologist Dr SJ in his consulting room. He apologised for no Health Care Plan yet and said he will get it done upon his return from overseas ; Elle asked him for a script for more Ondansetron anti-nausea 8mg wafers and he said "yes" then gave her two folded scripts and the paperwork for two more chemo sessions to be on 9/12/13 and 16/12/13 which we took across to the Chemotherapy Unit . When we got to the Chemo Unit I unfolded the two scripts and found one to be made out for Maxolon Tablets . We were both shocked . I wrote a big cross on the Maxolon script and took it straight back to his rooms , handed it to him and requested that he amend his records to show the allergy to Maxalon so as to accord with the hospital records . He apologised for having written the script and said he would amend his records .

5.

MAXOLON DEBACLE in December 2013.

9/12/13 we attended Chemo Unit at 1400hrs; Elle's breathing was laboured, was examined by lady-doctor Ms. R.B and given OK for chemo. Nurse Ms.M.R asked "any allergies" and I told her the names of the medications and stood beside her and read them as she wrote them down, Maxolon was included. She got another nurse to check Elle's particulars before connecting the drip; chemo finished at about 1600. Elle had a lot of nausea for the next few days.

16/12/13 we went to Chemo Unit at 1420 and for the first time Elle was given a wristband to wear, made of clear plastic with a white paper label showing her name. Again breathing was laboured, examined by lady Dr. R.B and cleared. Nurse Ms.S went and spoke with a senior nurse Ms. S.O, then came back and got another nurse to check Elle's particulars, hooked up the medication drip, and left (for a cuppa?). When she returned I asked what was the medication in the drip and she replied "Maxolon". I demanded that it be stopped immediately, she said "it's too late". I asked to see the Patient Alert Sheet at the front of Elle's file; it showed 8 medications including Maxolon. The staff then stated that Elle had been given Maxolon on 9/12/13, and when I asked "On whose authority" was told "the file is noted *allergy rechallenged and tolerated*". (I am quite sure that there was no such wording on the Alert Sheet which I saw on that day).

I asked Elle loudly "Has anyone asked you to take Maxolon today, or told you that you are to be given it today?" Clear answer "No". I then asked her loudly "Do you want to be given Maxolon today?" Clear answer "No".

Elle was plainly distressed; Lady Dr. R.B examined her and asked "How do you feel?" and Elle replied "I feel rotten, I have got lots of nausea, I just want to give up and die".

The Chemo Unit Manager and nurse each apologised several times. I suggested to the Manager that a red "allergy wristband" should have been given to Elle upon entry, and she went away and came back with 10 red wristband which she gave me and said "bring one with you each time you come here".

It took 20 minutes to drive home; Elle took 2 Stemetil tablets for nausea and "crashed out" on the bed from 1700 to 2000. Strong nausea persisted for several days, she needed to be on oxygen for several hours each day, and fluid accumulated in her right lung. She was very despondent and told me that the way her wishes were ignored made her feel worthless. On 23/12/13 she had 2.25 litres of fluid drained from right lung, and we handed a written complaint to Patient Liaison Officer Ms.M.P; we received an acknowledgement letter with apology on 30/12/13.

On 30/12/13 at a meeting previously arranged to formulate her Health Care Plan, staff started to discuss aspects of the formal complaint; at the first opportunity I stated "You have not had time to do a proper investigation to establish the facts, so let us get on with the Health Care Plan", which is what we did. It was agreed that Elle's G.P needs to have input, and a further discussion meeting was set for 31/1/14. A draft plan was discussed on 31/1/14 but we had no input from the G.P. and while the family lodged final input on 1 February, the Health Care Plan was never finalised.

Through January/February 2014 another 4 chemo sessions saw the CA125 count drop from 1440 (30/11/13) to 542 (7/2/14) and oncologist Dr.S.J proposed an operation to waterproof the right lung, to which Elle agreed. On 28/2/14 she had 500 mls drained from the lung.

6.

OPERATION MARCH 2014

At pre-admission clinic on 7/3/14 we presented an updated typed sheet of Elle's medications with her allergies and reactions printed in "bold" and 6 of them with underlined words "Not to be given to her". We also provided anaesthetist Dr.S with a copy of the anaesthetic charts from the Monash Moorabbin operation ; he wrote a note warning against using Morphine and gave it to Elle for her to give to whoever was going to anaesthetise her at the operation ; which is what she did .

On 18/3/14 A different person Dr. R.D was the anaesthetist. We gave him the note and copies of the Monash Moorabbin papers . He was brusque, dismissive, and disrespectful of Elle's privacy .The operation went smoothly and there was no ponv. Next morning Elle suffered some sort of collapse and a team of doctors were attending her when I rang at 0927hrs ; from that moment onwards she suffered a succession of mistreatments :

19/3/14 I found green gunk in her left ear , asked nurse to take swab for suspected "Pseudomonas infection" and advised her that Elle had been treated for that in this hospital in November 2013 .When nurse took the swab it showed fluorescent green and had red on the tip(indicative of blood . Although we made daily requests for follow-up, there was no medication prescribed for that infection until Discharge on 24.3.14. In the meantime the medical staff were having difficulty trying to find the cause of an infection in the two wounds in her chest .

24/3/14 At Discharge we learned she had been given Tramadol without any prior knowledge or discussion or consent .I immediately went to hospital pharmacy and got a copy of the Manufacturer's Product Information Leaflet which states upfront :

When you must not take it

Do Not take this medicine if:

. you have had any of the following :

Epilepsy

known sensitivity to opioids (such as Morphine or Codeine)

and the list continues.

Elle promptly refused to take home the Tramadol tablets which they had prescribed for her . Her ear had not been treated despite our daily requests , so we we asked that Dr.H.S come and examine her ear . He did so and promptly prescribed Ciproxin HC ear drops . The Discharge Medications Summary was then reprinted to show the ear drops and included a warning to say "It is important to finish the course of Ciproxin Ear drops" ; Elle started using them that day and night .

25/3/14 Elle received a call from nurse to "urgently come to E.D because of blood infection" and Elle refused to go to hospital (she vowed to never go there again) ; at 2140 that night Dr. H.S rang from the hospital to say " the blood-test results will not be known until tomorrow" and "get your G.P to check" which she did next day .

26/3/14 She got an urgent call to "go to E.D , pseudomonas in bloodstream" . We took all of her medications with us and offered them to the hospital but were told "not needed, the hospital will provide". Dr.S took a photocopy of the Discharge Medications Summary dated 24/3/14 which had that warning on it . When Elle was admitted to the Ward I left the bag of her medicines and ear drops in her bedside cupboard .We subsequently discovered that no Ciproxin HC ear-drops were given to her on evening of 26/3 , none morning or evening 27/3, and none on morning 28/3/14.

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On 27/3/14 we wrote asking for a full reply within 10 days to our complaint of 23/12/13 .

On 7/4/4/ we lodged a formal complaint with hospital re *actions of anaesthetist at interview at 0800hrs on 18/3/14 , *use of Tramadol , *failure to follow-up ear swab , *failure to give Ciproxin HC ear-drops over 3 days .

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7.

On 13/4/14 , having not received a reply regarding the Maxolon complaint , and being concerned with a continuation of mistreatments , we lodged a copy of both complaints with Health Services Commission and sought their intervention .

Elle's spirit was broken ; depression 9/4/14, swollen legs 14/4/14 , convinced that death is near 19/4/14 , deeply depressed 23/4/14 , a Grief Counsellor visited her on 1/5/14 and again 7/5/14 , and Elle was on oxygen day and night .

13/5/14 A hospital-type bed and air-mattress was installed in our lounge room at home .

16/5/14 Elle had 1500mls drained from her lung .

17/5/14 Collapsed at home after lunch. Rang for an ambulance and 2 arrived . Elle refused to go to that hospital for treatment, and at her insistence was taken to the hospital in which she had her knee replaced in 2011. After examination it was explained to her that her lung was two-thirds full of fluid accumulated since yesterday and it would eventually fill and start spilling into the other lung. They offered drainage , and realistically pointed out that after drainage it would most likely refill within a shorter time . She declined treatment other than for pain-relief and for nausea and we returned home at midnight .

19/5/14 Elle died at home at 2100hrs with her family members beside her .

Search for the truth i.e the facts .

We had discussions with Health Services Commission staff over 2 to 3 months , unsure of what course of action we would settle upon . We thought that a review of Elle's treatments by an independent medical authority would ensue, but it didn't , and we were given more time .

29/8/14 I made an F.O.I application for a copy of Elle's hospital file and on 24/10/14 received 3 bundles of several hundred loose papers in jumbled order and having no separators . It took five weeks to sort into sensible chronological order which established that some vital information was missing for the day of collapse in the Critical Care Unit on 19/3/14 , and that other information was missing . This resulted in an application to F.O.I in Melbourne and success on 2/3/15 .

31/10/14 Made F.O.I application to a Community Health Service for copies of reports made by Palliative Care nurses who had visited Elle at home over time , and received them promptly on 14/11/14 .they included specifically a report of the Maxolon /shaking incident witnessed on 19/6/13and include the words "Senior Palliative Care Clinician advised that tremors and unsteadiness are extra-pyramidal side-effects of the Maxolon/Serenace combination". There was also a 21/6/13 report of a home visit "to follow up in regards to constipation , and nausea and tremors from medication adverse effect" and goes on to record "Maxolon ceased , and client states tremors have greatly improved".

1/12/14 With no independent Medical review of treatment through Health Services Commission, we took our copy of the hospital file to a lady G.P and asked for a review of the treatment given at and after the lung operation on 18/3/14 , and any Tramadol/collapse connection? I retrieved the file on 10/2/15 , the G.P was very sympathetic but did not give a written assessment .

11/2/15 I rang HSC and said "we will go ahead with conciliation " , and on 13.2.15 rang again to withdraw that request and asked for more time .

8.

Search for the truth i.e the facts .

While examining the file it became disconcerting to find many instances where the number of allergies recorded in the Emergency Department did not transfer onto ward records ; and a number of times where prescriptions were written for medications registered as an allergy .

THE MAXOLON "RE-CHALLENGE"

The hospital took 3 months to investigate and reply to our 21/6/13 letter re medication & allergy concerns. During that time the Patient Alert Sheet with the alleged "re-challenged" on it should have been at the front of the file . The question has to be asked "Did the investigation follow-up to check validity of authorisation, protocol procedure , and observations recorded?" If not , why not?

The Medication History Prior to Admission Form (MHF) signed by pharmacist Ms D.S on 2/7/13 lists all of Elle's allergies yet the ward Medication Chart for period 1 to 4 July shows an entry for Maxolon 10mg i.v , stat., but no entry in columns to show "time given" and "given by". Elle was discharged on 4/7/13 and was re-admitted on 10/7/13 for 6 days .

The MHF signed by intern-pharmacist Ms. JL on 11 July listed all the allergies ,yet there are entries on the ward "As Required PRN Medications Sheet" showing scripts written by Dr.B for Endone and for Maxolon(Metoclopramide), both of these are allergies, and one for Ondansetron which gives Elle great relief from nausea .The Endone script has small print on it to say "Monitor patient for delerium JL" , the Maxolon script has small print saying "Monitor patient for abnormal movement, and give Ondansetron first JL ". There are no entries in the "time given" and "given by" columns. The Endone script is defaced and has "Cease" written beside it . There is an entry showing Ondansetron 4mg i.v given at 0545 on 12/7/13 and an indistinct "n" in the "given by" column .

Those entries show Dr.B and intern-pharmacist Ms JL planned to administer drugs and observe reactions , and actually administered Ondansetron. . The question arises "Did they give the drugs and purposely not signed as having done so? There are NO entries in the file Progress Notes for each of those two admission periods describing or authorising a proposed rechallenge of Elle's allergy to Endone and to Maxolon .

Why was there no mention of a successful Maxolon allergy re-challenge in either of the two Discharge letters to Oncologist Dr.SJ and to Elle's G.P Dr.PR?.

Go back to the top of page 3 and read the assurances the hospital gave us about "commitment to Standards ". This behaviour cannot be excused .

Disturbing Recent Discoveries .

On 20/5/15 a friend alerted me to the fact of newspaper articles May/June 2013 detailing a history of internal dissatisfaction at the hospital regarding medication errors and the safety of its pharmaceutical practices ; the problems had prompted a 2012 Independent Review of Pharmacy Services . In June 2013 the Pharmacy Director and the Deputy Director both resigned and it seems that more pharmacy staff resigned in the months following .

Elle and I were totally unaware of that . From 19/4/13 when first told that she had cancer we were totally immersed in a rush of appointments , tests , X-Ray , CT-Scans , trips to G.P , to the chemist; at the time of publication she was in and out of hospital followed by 3 weeks of intense nausea , and neither of us had the time or inclination to be reading the local newspaper .

I enclose redacted copies of 2 articles 30/5/13 and 16/6/13 for your edification .

Continues

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9.

We believe those two articles show the context in which the mistreatments of Elle occurred; i.e not just as “one off” incidents but as a continuation of a “culture” which had existed for some years and , despite the hospital introducing changes making presentations to staff and running education sessions , the culture persisted to April 2014 with disastrous effects for Elle .

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On 24/2/15 I enquired at our pharmacy and was told that Serenace (Haloperidol) is a narcoleptic drug which reacts badly with Maxolon; I then obtained a copy of a Mims Summary of Haloperidol/Maxolon Interaction which classifies the interaction severity as Moderate 2 and gives Precautionary Advice to “Monitor patient for extra-pyramidal symptoms during concurrent administration”

It has helped us to understand why Elle experienced such intense nausea, dry-retching-vomiting , numbness,trembling and severe shaking from 24/5/13 (the day after her first chemo) to 21/6/13 when told by nurse ED of Chemo Unit “stop taking Maxolon , you have an adverse reaction”. Without rancour , we ask constructively , why did it take so long?.

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While reviewing the file in preparing this submission I note that in respect of the Tramadol complaint , the hospital concluded there had been no documented adverse reaction .

We see that the file shows Elle was first given Tramadol at 1710hrs on 18/3/14. On 19/3/14 at 0500 her BP was 120/80 and Heart Rate 62SR, she complained of being cold and was given four blankets. At 0930 she had a sudden loss of consciousness for a few minutes and BP dropped to 70/40 and Heart Rate to 48. She was taken from High Dependency Unit to the Intensive(Critical) Care Unit ., and a central line was put in .

Next entry in Progress Notes, by Dr.AT shows” right internal jugular central line was put in after obtaining verbal consent --prep drape strict aseptic conditions-- needle inserted under u/s guidance” This gives rise to several questions ;

1. Did the sudden loss of consciousness coupled with BP 70/40 and HR48 meet the criteria for a MET call?
2. Was such a MET call made?
3. How was prior verbal consent obtained and given by whom.
4. Can it be said with certainty whether or not it was/might have been connected with Tramadol?
5. Would this incident be regarded as a “significant event”?
6. Why was no mention of this event made in the Discharge Letter to inform Oncologist Dr.SJ and G.P Dr.PR?

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The Hospital reply 10/6/14 explained the delay in processing the swab from Elle's ear on 19/3/14 as “it was received by Pathology on that day and time(2.30pm)however in Bossnet this was listed as a respiratory swab, apparently incorrectly labelled”, but the reply did not explain why it was not followed up, or why it took so long .

I enclose a redacted copy of an article from the same newspaper on 30/7/15 stating the State Government has launched a review of the Services Contract between the Hospital and a private pathology Company. It seems that problems in pathology services had been raised in 2011, and that more serious concerns have been expressed more recently that shifting vast amounts of testing out of the hospital campus laboratory (and sending samples to Melbourne) might result in delays and compromise the quality of hospital care.

We will be seeking further information from the hospital.

10.

RATIONALE.

The family have diligently sought to know the truth and context of actually happened to break Elle's spirit so completely. The search is extending and intensifying the grieving process , as each new piece of information adds to our realisation that so much of her suffering in a palliative care status was both avoidable and unnecessary.

We are frustrated and disappointed that we have not been able to have her file independently reviewed by a qualified medical officer /statutory body , despite offering to bear the cost of however many thousands of dollars that would entail .

We are dedicated to seeking change in hospital policies , practices , and systems-oversight for the purpose of protecting other vulnerable patients from the type of mistreatments experienced by Elle .Through the auspices of Health Services Commission Victoria we are , in good faith , seeking to enter into conciliation with the Board of Directors .

It is fortuitous that at this precise time Government has launched the End of Life Choices Inquiry.

End of Life Choices.**Terms of Reference #1****Facilitate Realisation of Preferred Choices.**

We found the booklet Take Control(Victoria Legal Aid)simple and easy to use to appoint Enduring Medical Power of Attorney. I cannot recall who suggested Advanced Care Planning , but we were pleased to obtain the Information Sheet , Statement of Choices , and Refusal of Treatment forms from the Respecting Patient Choices office at Austin Health, Heidelberg.

Understandably it took Elle quite some time to work through the emotionally-challenging task of formulating her "last wishes" . To be later confronted while in a hospital bed with news that "these forms are not acceptable, you will need to use our hospital forms" was quite a shock and stirred a strong emotion-filled response"Get out of the room , I don't want to discuss it". Up until then we had not even considered the possibility that there are various formats of these forms , and I still have no idea of whether the differences are "cosmetic" or "vital".

Matters for your consideration.

Are there a variety of formats of these forms ?

Are the differences significant , meaningful , critical?

Is there a need to stipulate that only one official format will be used?

Is the paramount principle that"Patient Choices Will Be Respected"?

Does / Should this entail being given precedence over competing wishes?

Is this a common problem worthy of assessment and action by your Committee ?

Resuscitation.

On 10/7/13 Elle collapsed to the floor , ambulance to hospital , clots on both lungs ; in Emergency Dept a doctor completed a hospital Not For Cardiopulmonary Resuscitation form after discussion with her. It did not require her signature . On 23/10/13 at another hospital , Elle signed her Statement of Choices immediately prior to an operation (surgeon signed as witness) . I now see in small print at the bottom "Statement of Choices is only a guide , i.e not legally binding".

On 19/3/14 a day after a lung operation , she lapsed into unconsciousness and was resuscitated (not by CPR), and survived for 2 months in rapidly declining health .

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11 .

On 17/5/4 Elle collapsed, was rushed to a hospital , it was explained “ your lung has filled with fluid since being drained yesterday; we can drain it for you ; it will refill with fluid more quickly”. She declined treatment ,came home at midnight , struggled for breath for 45 hours on increasing doses of pain-relief medications , and died .

Matters for your consideration.

Is this a scenario which arises among Palliative Care Patients? Occasionally or frequently?
Should such a patient facing imminent death be given the right to be provided with terminal medication to enable a pain-free dignified peaceful death? We would strongly say “Yes”.
What action will your Committee take in this respect?

Organ Donorship by Palliative Care Patients .

Elle registered for Organ Donorship in 2006 at age 71 . She regarded it as the most valuable gift that she could pass on to a desperate person , and felt re-assured when her G.P explained that tissue donorship would be more likely an outcome . When cancer was diagnosed she and I discussed this matter at home and we both thought the existence of cancer would preclude organ donorship ; but she felt comfort in her belief that tissue donorship might still occur . She never raised it with the Organ Donor Officer at the hospital . Upon reflection , I realise that a potentially large pool of registered Organ Donors may have many Palliative Care patients within its midst facing uncertainty .

Matter for your consideration;

Does the concept of “educating existing palliative care organ-donor-registered patients to the potential of suitable tissue donation” merit investigation by your Committee?

Term of Reference # 2 , Legislation .

I regret not having had access to a copy of National Safety & Quality in Healthcare Standards ,nor the Carers Recognition Act 2012 in the past few weeks , and wonder whether both of those need reviewing and beefing-up in respect of medication policy and a more collaborative approach between patient/carers/treating team.

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In Closing :

The attached three newspaper articles refer to serious deficiencies in hospital care which have existed for too long. It is fair to question what part “insufficient funding” played in the hospital
*not employing sufficient pharmacists to effectively oversight the medication of patients, and
*transferring pathology services away from campus , and then facing undue delays which compromised patient care .

Matter for your consideration .

Should the Government be giving more funding to the hospital to overcome these deficiencies?

I thank you for the opportunity given to offer experience-based input for consideration , and I congratulate you for undertaking the responsible task ahead of you .

Fin.

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MONDAY 11
SHOWER
OR TWO

State to probe pathology

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highest priority at [redacted] lab. Last week, [redacted] chief executive declined to respond to the union's claims and questions from [redacted]. However, he said he welcomed the review.

[redacted] chief executive [redacted] welcomed the government review by Paxton Partners and denied union claims healthcare standards had been allowed to drop at the hospital.

"We have already begun working with the consultants and have full confidence in their review of the management of the pathology contract," [redacted] said.

"Unlike [redacted], we respect the process and won't be drawn on commentary about the delivery of pathology services by [redacted] until we know the outcome of the review."

[redacted] labelled [redacted] "mischievous", saying he was attempting to use [redacted] its services and patients in his industrial campaign with [redacted].

He said [redacted] had recently undergone an extensive accreditation process measuring the hospital's performance in delivering a high standard of healthcare.

"A survey team from the Australian Council of Healthcare Standards examined our policies and processes and determined we had satisfactorily met core national standards and

Service concerns revealed

MEETING minutes of an internal committee obtained by the Medical Scientists Association of Victoria through freedom of information and seen by [redacted] refer to discussions about pathology turnaround times and apparent concern about the service agreement.

The Pathology Liaison Consultative Committee minutes suggest in a December 2011 meeting, [redacted] chief executive [redacted] raised concerns about whether [redacted] (a trading name used by [redacted]) was able to fulfil the service agreement.

[redacted] last week moved to clarify this, saying he indicated he had concerns about changes to the pathology service and it was recommended these be discussed in more detail with [redacted].

"My comment was made within the context of a much broader discussion," [redacted] said.

A subsequent committee meeting on 12 February 2013 made reference to the emergency department

turnaround time being "unachievable". A figure attached to that statement has been deleted under freedom of information.

Minutes from an April 2013 meeting reference a meeting between representatives from [redacted] and two other [redacted] hospitals and an agreement by the group to make a recommendation to Health Purchasing Victoria - the statutory authority that works with hospitals to manage collective contracts - for a reduction in the turnaround time threshold.

According to the minutes, this reduction would be from 99 per cent to 90 per cent with a view to increasing the threshold to 95 per cent with the next contract. The minutes also suggested there was a recommendation to tighten the ward turnaround time from six hours to four hours.

[redacted] was unable to confirm whether these recommendations were received by HPV or if the changes were implemented.

exceeded the level of quality in some areas," [redacted] said.

[redacted] has spent considerable time and resources responding to the MSAV's requests for information and comments in the media and I hope the Paxton Partners review will put some clarity around some of the issues which are of concern to [redacted] and the union's members."

Health Purchasing Victoria, the statutory authority that works with hospitals to manage collective contracts, said it acted in collaboration

with health services.

"With all tenders, HPV is guided in the development of specifications because we recognise that it is health services themselves who best understand their diverse clinical and operational requirements," HPV acting chief executive Eileen Keane said.

"Every tender response is evaluated by a reference group, comprising of health service clinical and subject matter experts, who develop the strategy, market approach,

selection criteria, evaluation and recommendation.

"HPV's tender process is a robust and competitive process which includes a range of selection criteria, of which contract performance is included. Contract performance is managed by the health services."

Ms Keane said the authority would work with the department of health and human services to address relevant findings or recommendations from the state government review.

State to probe pathology

By [redacted]

THE State Government has launched a review of the services contract between [redacted]

and a private pathology company amid union accusations of a decline in standards.

The review will aim to ensure all parties are meeting the terms of the contract and the community is receiving the best pathology services available, a spokesperson for Acting Health Minister John Fren said.

The Medical Scientists Association of Victoria claims major operational changes by [redacted], such as shifting "vast amounts of testing" out of the [redacted] laboratory, have impacted on the company's capacity to meet quality and service standards.

The MSAV claims the hospital "failed to act".

Union secretary [redacted] argues that [redacted] has violated the pathology services contract which he says includes a requirement for pathology testing and services to be performed in the [redacted] lab.

"The closer the testing is to where treatment occurs, the quicker the turnaround time is," [redacted] said.

"If you move a sample to [redacted] you are going to risk turnaround times and the quality of healthcare in hospital."

In June, the union hit out at [redacted] over a decision to transfer tissue processing services from the hospital lab to [redacted], arguing it would increase turnaround times and affect patient care.

But [redacted] said the centralisation of its histology service would in fact reduce turnaround times, while [redacted] said it had been assured its tests would receive the

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Breaking point

Hospital pharmacy staff resign over resource shortages

BY [REDACTED] Hospital has been forced to defend the safety of its pharmaceutical practices following the resignation of its two pharmacy directors last week.

Several sources told [REDACTED] that mounting frustrations over resource shortages and inadequate provisions for appropriate medicine management at [REDACTED] led its pharmacy director and deputy director to tender their resignation.

One source claimed understaffing, drug treatment and patient safety was "at the heart of the matter" and said [REDACTED] management had failed to act on those matters.

Claims that staff feared [REDACTED] patient safety was being compromised were confirmed by professional representative body Society of Hospital Pharmacists Australia.

National SHPA president Sue Kirsasaid [REDACTED] told [REDACTED] she was aware of concerns related to "a gap between staffing resources ([REDACTED]) and those recommended in the clinical pharmacy services standards of practice".

She said staff had also expressed concern about the number of errors occurring in the administering of medications at [REDACTED] recent years.

[REDACTED] chief executive [REDACTED] refused suggestions of unsafe practices, saying [REDACTED] followed "rigorous processes to ensure medication safety" and "data for the previous 12 months shows that there has been no increase in the number or severity of medication errors for (that) period."

It is unknown how many errors have been reported to the Department of Health in past years but Ms Kirsasaid [REDACTED] pharmacy staff believed their capacity to "raise concerns in the usual ways, in terms of incident reports" was restricted.

[REDACTED] countered those suggestions, saying [REDACTED] culture "strongly encourages reporting of any errors."

Ms Kirsasaid SHPA produced standards of practice used as "professional guidelines for pharmacists who operate through hospitals" and while they had "no legal standing in their own right" the standards were supported by the Pharmacy Board of Australia.

"Those standards have 'pharmacist to

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Staff resign over resources

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bed' ratios within them" Ms Kirsasaid, adding she was aware [REDACTED] pharmacy director had been "working over a period of time to be able to provide the resources required to adequately service the patients of [REDACTED] acknowledged the SHPA's ratios but said the level of funding was a "complex matter" that depended on the "acuity of the patients being cared for."

Ms Kirsasaid it was essential pharmacists be available at admission, preferably in the emergency department, to undertake "medication reconciliations", documenting "what medications a patient has been taking on the outside" to

prevent potentially dangerous drug allergies or interactions once in-hospital treatment commenced.

She said accurate medicine lists upon patient discharge also needed to be prepared for GPs.

"Pharmacists play a really important role at that interface and where it doesn't happen well, it is potentially very serious," Ms Kirsasaid.

Ms Kirsasaid [REDACTED] pharmacy directors had shared concerns that few recommendations had been adhered to, relating to "additional resources for the pharmacy so they could provide clinical services, particularly in the emergency department and mental health unit", arising from a 2012 independent review [REDACTED]

pharmacy services.

[REDACTED] said the review, undertaken "in light of an increasing demand on services" evaluated the hospital pharmacy against national benchmarks and "a number of recommendations" arose, "most of which were aimed at improving processes and efficiencies".

"From that, an action plan was drawn up and was finalised this month, with implementation to begin immediately," [REDACTED] said.

"We are disappointed that the pharmacy director and deputy director are leaving right as we are implementing these improvements but we wish them well in their future plans."

Ms Kirsasaid the SHPA was

considering its approach to the events [REDACTED]

She said the association had already warned health ministers about "what happens when the focus is directed solely on financial matters", in light of a recent UK review into hospital quality and safety issues.

The review, known as the Francis Report, "highlighted the sort of situation as we see happening [REDACTED]" Ms Kirsasaid.

"It showed where there is a lack of clinical staff and support for medicines used at the ground level, with pharmacists assisting nurses and doctors to safely manage (medications), it can result in significant errors."

Thursday, 30 May, 2013

Make sure you ask for protection

IT is with immense sadness that I read of the resignation of the director and deputy director of pharmacy at [redacted] Hospital.

Prior to my retirement, I worked as a clinical pharmacist [redacted] for almost 25 years, and was present when these two assumed those positions.

I observed the department move quite rapidly from a position of mediocrity to become a leader in its field through their efforts.

They built a team of enthusiastic and collegiate pharmacists and technicians who worked harmoniously and well above the call of duty.

It is generally difficult to attract health professionals to positions in rural areas, but as the reputation of the department grew, it attracted staff, students and interns of the highest calibre and subsequent graduates were snapped up for highly contested positions in the large city hospitals, due to the quality of their training.

Presentations at conferences and publications in professional journals enhanced the department's and therefore, [redacted] reputation, and led to other hospitals seeking advice to follow our policies and procedures, particularly the strong clinical focus which aimed at staffing all wards with a pharmacist to provide oversight and expertise at the bedside.

Hospitals are staffed by humans, and humans make errors.

This is acknowledged by hospitals and measures are taken to minimise the risk, and maximise detection of any errors, in which clinical pharmacists play a significant role.

However, the department was never staffed at the required level, and in latter years the pressure increased to levels causing serious concern.

The claim [redacted] there had been no increase in incidents has no value; if the pharmacists are not available to check for errors, they just slip through, so of course they are not reported.

Staff a ward with a pharmacist and the incident reports will rise, because of pharmacist intervention but the errors will not reach, and therefore, affect the patient.

The executive could not, or would not accept the need for adequate resources, despite reviews acknowledging this.

Every department accepts the need to compete for a share of limited resources but the pharmacy was subjected to pressure far above and beyond that.

In the face of intractable opposition, I can understand that these two women of unimpeachable integrity, despaired of ever being able to provide patients and staff with professional care in accordance with medication safety guidelines, and I can only imagine the heartbreak this decision cost them.

I ask [redacted] board why they allowed the destruction of a dedicated, expert and innovative team for want of adequate resources?

No doubt something will be done - "too little, too late".

May I suggest that the board actually visit the pharmacy and talk to all the staff to find the truth and prevent it happening again.

To future patients - if you do not see a pharmacist at your bedside every day, reviewing your medication chart, ask why you are denied this protection?

To the doctors and nurses, if you do not have a pharmacist to provide advice and expertise about increasingly complex drug therapy, ask why you do not have this safety net?

Hospital services continue to expand, drug therapy becomes more and more complex and expensive, if patient safety is paramount, pharmacy departments must have realistic pharmacist to patient ratios; a principle not confined to nurses.