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MOST OUTSTANDING
METROPOLITAN
HEALTH SERVICE

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Frankston
Hospital

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Rosebud
Hospital

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Psychiatric
Services

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Services

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Primary and
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14 June 2013

Team 1
Coroners Court
Level 11
222 Exhibition Street
MELBOURNE VIC 3000

Dear Sir/Madam

Inquest into the death of Rolden Ablis
Coroner's Reference: 2007 5025

We refer to the inquest held in relation to the death of Rolden Ablis before Coroner West on 4 to 7 March 2013.

Coroner West delivered his findings on 15 March 2013. At the conclusion of his findings, Coroner West made the following recommendation pursuant to section 72(2) of the *Coroners Act 2008* (Vic):

> *'That Peninsula Health give consideration to providing dedicated paediatric care (medical and nursing staff), to all infants, children and adolescents presenting to their Emergency Department.'*

We provide the following response to the Coroner's recommendation.

1. Peninsula Health recognises the value of having a dedicated paediatric space within its Emergency Departments (**ED**). It is currently constructing a new ED at Frankston Hospital (which is estimated to be completed in November 2014) that includes four dedicated paediatric treatment cubicles, a dedicated paediatric procedure room, a paediatric resuscitation cubicle and a paediatric waiting room. At present, Frankston Hospital ED has dedicated paediatric cubicles, while Rosebud Hospital ED has a dedicated paediatric waiting room and, where possible, children are treated in consultation rooms.

2. Peninsula Health is aware that not all infants, children and adolescents presenting to its hospitals' EDs necessarily require specialist paediatric care. Peninsula Health has, however, focused on enhancing the capacity of ED staff to identify those patients who require specialist paediatric attention and to respond quickly by arranging for them to be seen by a paediatric registrar in the ED, to be transferred to the Child and Adolescent Unit (**CAU**) at Frankston Hospital or to another Victorian hospital. Peninsula Health has been addressing this goal in the following ways:

   (a) Peninsula Health has augmented its system of rotating paediatric nurses from the CAU to the ED and vice-versa in order to increase the knowledge, skills and training of ED staff who care for paediatric patients in the ED. Currently, a Clinical Nurse Specialist from the ED rotates to the CAU one day a week and shares knowledge and experience gained in the care of paediatric patients by working as a team leader and providing

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mentoring and support to ED staff allocated to paediatric cubicles. In addition, a Clinical Nurse Specialist from the CAU will rotate to the ED one day a week and work in the paediatric area in a supernumerary capacity, providing one-on-one education and support to staff in that area as well as in-service education on the care of paediatrics to supplement the paediatric care education that is currently in place;

(b) Peninsula Health arranges for senior ED nurses to attend annual Paediatric Life Support (**PLS**) simulation training at the Peninsula Health Simulation Centre;

(c) Peninsula Health also requires all Junior Registrars in the ED to attend PLS training and all Senior Registrars and Senior Medical Staff to attend and be current with Advanced PLS;

(d) the Nurse Unit Manager of the Frankston Hospital CAU is a member of the Department of Health's state-wide steering committee that is designing an Early Warning Tool for Paediatric Patients, which will facilitate early recognition and response to the deterioration of paediatric patients; and

(e) Peninsula Health requires ED staff to follow its Clinical Practice Guideline titled, *Emergency Department Triage Procedure* (copy enclosed). This Guideline requires all neonates presenting to the ED to be assigned a Triage Category 2, so they are seen as a priority, a senior clinician sees and assesses them within 10 minutes of triage, early investigations and medical management of them is initiated, and their access from the waiting room or ambulance trolley to the relevant area of the hospital is expedited. Further, the Guideline requires all children (other than neonates) to be seen and assessed within an hour of presentation to the ED, and assessment, investigations and medical management of paediatric patients to be initiated promptly.

3. Peninsula Health is confident the above initiatives and changes it has implemented will ensure those patients who present to its hospitals' EDs and require specialist paediatric attention will obtain both timely and appropriate treatment and management.

We trust that this is of assistance to the Court.

Please do not hesitate to contact me if you have any queries.

Yours sincerely

Dr David Rankin
Executive Director, Medical services
Peninsula Health

Enclosure: Peninsula Health, *Emergency Department Triage Procedure*

CLINICAL PRACTICE GUIDELINE

EMERGENCY DEPARTMENT TRIAGE PROCEDURE

Peninsula Health

1. INTRODUCTION

The term 'triage' is derived from the French word 'trier' meaning to pick or sort.[1] Triage systems were first used to prioritise medical care during the Napoleonic wars of the late 18th Century.[2] Subsequent wars have led to the refinement of systems for the rapid assessment and removal of mass causalities to a place where definitive medical treatment commences. In modern day emergency departments, the triage process is underpinned by the premise that timely access to definitive care improves patient outcomes. With this in mind, the Australasian Triage Scale (ATS), formerly the National Triage Scale (NTS), was implemented in 1993.[3,4,5]

2. PURPOSE

The purpose of this document is to provide guidance to the staff of the emergency department on their role and responsibilities in the provision of consumer care upon arrival to the emergency department and while the consumer is waiting in the emergency department waiting room.

3. DEFINITIONS

Australasian Triage Scale = The Australasian Triage Scale (ATS) is designed for use in the acute hospital setting. It is a scale for rating clinical urgency based on the triage nurses' assessment and observation. The triage nurse also employs locally based clinical guidelines to expedite consumer care with each consumer receiving a rating of 1 to 5 depending on their clinical picture or presenting signs and symptoms.[1, 2]

Description of Australasian Triage Scale

ATS Category	Treatment Acuity (Maximum waiting time)	Performance indicator threshold
ATS 1	Immediate	100%
ATS 2	10 minutes	80%
ATS 3	30 minutes	80%
ATS 4	60 minutes	80%
ATS 5	120 minutes	80%

4. RELATED POLICIES/ CLINICAL PRACTICE GUIDELINES

- Peninsula Health Policy 5.4.02 – Hand Hygiene & Aseptic Technique
- Emergency Medicine Clinical practice Guideline - Emergency Department Admission and Assessment.
- Emergency Medicine Clinical Practice Guideline - Emergency Department Waiting Room Policy and Procedures
- Emergency Medicine Clinical Practice Guideline - Emergency Department Discharge and Transfer

5. RESPONSIBILITIES

5.1. EMPLOYER – Peninsula Health supports adherence to the Clinical Practice Guideline through education and departmental policy and procedures.

5.2. DEPARTMENTAL – To ensure compliance with Clinical Practice Guideline and facilitate associated activities with physical resources.

5.3. **DEPARTMENTAL HEAD/MANAGER** – To monitor compliance to the Victorian Privacy Act and to ensure optimal clinical practice by nursing and ED clerical staff, and regular audits that looks at triage category against wait times, mortality and patient DRG.

5.4. **EMPLOYEE** – It is the responsibility of all staff to ensure that the Clinical Practice Guideline is followed at all times ensuring that consumers are triaged and assessed on arrival to the Emergency Department.

6. CLINICAL PRACTICE GUIDELINE

- Triage is the first point of public contact with the Emergency Department. The triage assessment should take no more than two to five minutes involving both observational and clinical assessment – i.e. the consumer's general appearance combined with physiological observations that include the consumer's blood pressure, heart rate, respiratory rate, temperature and assessment of the consumers pain scale and, where relevant, the consumer's neurological status.
- All consumers presenting to the emergency department (ED) must be triaged by a specifically trained and experienced registered nurse utilising the ATS (see above). The aim of triage is to provide timely care to consumer's who present to ED on the basis of the triage nurses' primary clinical assessment, observation and clinical judgement.[3,4,5]
- The triage nurse applies an ATS category in accordance to the time to treatment criteria attached to the ATS categories (see above). These categories describe the maximum time a consumer can safely wait for medical and nursing assessment and treatment.[3,4,5] For example, a consumer who presents with chest pain will be assessed as requiring medical and nursing care within 10 minutes and, therefore, should be triaged as a Category 2. Likewise, any consumer identified as ATS Category 1 should be taken immediately into a Resuscitation cubicle.
- Once the triage primary assessment and ATS category is allocated, the Triage Nurse in conjunction with the Waiting Room Nurse should ensure continuous reassessment of consumers waiting to see a doctor. The triage nurse should raise any concerns with the Waiting Room Nurse. All consumers should be advised to represent to the triage desk if there is any change in their condition. Should the consumer's clinical features change, the triage nurse must reassess the patient and where appropriate, modify the consumer's triage score and inform the ED Floor Manager on ext. 7264, of his/her clinical decision and concerns.
- The triage nurse may also initiate investigations or timely access to analgesia according to the organisations clinical practice guidelines[3, 4]. Alternatively, the consumer may be appropriate for referral to the Medicentre – this must be the consumers' choice and all referrals require a written referral note from the triage nurse. The Medicentre can be contacted on ext. 8522.
- In the event of a queue at triage waiting to see the Registered Nurse, patients should be instructed to take a seat on the designated red 'waiting for triage seats' which are in close proximity and easily viewed by the triage nurse. At no time should the triage nurse take a list of names of people waiting to see the triage nurse.

PAEDIATRICS

All neonates (under 28 days) are to made a Category 2.

All children should be seen within an hour of presentation. If a child is waiting for greater than one hour this needs to escalated to the Floor Manager on ext. 7264 or the Consultant of the day on ext. 7196.

Initial Assessment and Treatment of ED Consumers
"STAT Team" ("See Treat Admit Transfer" Team)
Aim

- Ensure that all category 2 consumers are seen and assessed within 10 minutes of triage by a senior clinician.
- Initiate early investigations and medical management of category 2 consumers.
- Expedite access of category 2 consumers from the waiting room or ambulance trolley to an appropriate cubicle, Fast Track or EDS
- Assess all Paediatric presentations within an hour of presentation and initiate investigations and medical management as appropriate
- Assess all other presentations in time of arrival order and initiate investigations and medical management as appropriate.
- Facilitate appropriate and timely identification and transfer of a patient to EDS.

Notification

Triage nurse assesses patient and assigns a patient a triage category of 2. Triage nurse will call **STAT Doctor on extension 8807 and STAT Nurse on extension 8808**

Triage nurse

- Assesses consumer from the waiting room or on an ambulance trolley
- Assigns triage Category 2 to patient
- Notify "STAT" Team.
- If no doctor attends within 5 minutes notifies floor manager or Consultant in Charge
- Receives (from previous shift) and carries 8807 all shift unless otherwise directed by CIC
- Category 2 patients should be seen as a priority
- Commence early assessment and initiation of management for Paediatric patients then all others in time of arrival order.
- On receiving call walks to Triage area and contacts Triage nurse to identify which is the Category 2 patient
- Assesses patient. This should be a rapid basic assessment of the patient only. (no more than 5 minutes) The patient should not be formally managed by them at this stage. May initiate blood tests, medication and/or radiology
- If the patient is potentially unstable, the Floor Manager and the Consultant in Charge should be contacted so a cubicle can be found as a priority
- If a more thorough/private assessment or an urgent ECG is required this can be performed in cubicle 25 and 26
- If more than one Category 2 patient needs assessment or the doctor is busy, the "STAT" Doctor should contact the Consultant in Charge who will assign an appropriate SMS to assess the patient
- Enter time patient was seen in initiation of management in iPM
- At handover ensures 8807 is handed to oncoming STAT Doctor

STAT Nurse

- Category 2 patients should be seen as a priority unless otherwise directed by NIC.
- Commence early assessment and initiation of management for Paediatric patients then all others in time of arrival order.
- On receiving call walks to Triage area and contacts Triage nurse to identify which is the category 2 patient.

- Assesses patient. This should be a rapid basic assessment of the patient only. (no more than 5 minutes) The patient should not be formally managed by them at this stage. May initiate blood tests, medication and/or radiology
- If the patient is potentially unstable Floor Manager and the Consultant in Charge should be contacted so a cubicle can be found as a priority.

CLINICAL CONSIDERATIONS

Triage is based on clinical judgment, when concerned clinicians should err on the side of caution. There are some "golden rules of triage" that must be observed these include:-

- Consideration of Mechanism of Injury , the following presentations are high risk and must be Category 2
    - All pedestrians –vs.- car
    - All cyclists –vs.- car
    - All falls ≥ 1 metre
    - All MVA ≥ 60klm
    - Any consumer aged ≥ 65 years involved in an MVA
- All trauma patients and attempted hangings should be considered to have a spinal injury until this is excluded by the Medical Team in accordance with CPG Management of Spinal Injury
- All consumers with chest pain must be assigned a Triage Category 2.
- All males presenting with sudden onset testicular pain must be assigned a Triage Category 2.
- All consumers presenting with penetrating eye injuries must be assigned a Triage Category 2.
- Any consumers with onset of stroke symptoms within the previous 3 hours, facial droop, inability to lift both arms or slurred speech are a Triage Category 2. The Stroke Team should be activated immediately.
- All neonates ≤ 28days must be assigned a Triage Category 2.
- All patients with vital signs within MET criteria (this includes "staff concern") should be made a Category 2

7. EVALUATION

- A range of tools will be used to evaluate policy compliance. These include incident reports, complaints, Time to Treatment Performance Indicators and customer feedback via VPSM Feedback should be linked with Clinical Practice Guideline review process.

8. REFERENCES

[1] Kennedy K, Aghababian RV, Gana L, Lewis PC. Triage: Techniques and Applications in Decision Making. Annals of Emergency medicine, 1996; 28(2): 136-144.
[2] Schom A. Napoleon Bonaparte. New York: Harper Collins; 1997.
[3] ACEM – Hospital ED services for Children. In Policy Document – Hospital Emergency Department services for Children. At http://www.acem.org.au/ Accessed 11/10/2009.
[4] ACEM – Responsibility for care in Emergency Departments. In Guidelines on responsibility for care in Emergency Departments. At http://www.acem.org.au/ Accessed 12/10/2009.
[5] ACEM – The Australasian Triage Scale. Policy Document – The Australasian Triage Scale. At http://www.acem.org.au/ Accessed 12/10/2009

9. KEY PERFORMANCE INDICATORS/OUTCOME

- Triage allocation against guidelines, triage category, average waiting time, admission rate and mortality rates in each triage category.
- DHS mandatory Victorian Emergency Minimum Data Set Key Performance Indicators.