Deputy Premier of Western Australia
Minister for Health

Our Ref: 25-46886

Ms Dawn Wright
Manager Listings
Office of the State Coroner
Level 10, Central Law Courts
501 Hay Street
PERTH WA 6000

Dear Ms Wright

Thank you for your letter of 3 June 2015 in relation to the inquest finding for Amanda Dana TAUAI, which informed me of the three recommendations made by Coroner Linton.

The Department of Health's Coronial Liaison Unit coordinates WA Health's response to the State Coroner on action taken with respect to the recommendations arising from coronial inquests. As part of this process, the Coronial Review Committee reviewed these findings on 23 June 2015 and relevant stakeholders subsequently provided a response against each of the recommendations.

Recommendation 1 – I recommend clinicians in remote settings consider their capacity to resuscitate patients with sepsis when assessing a patient's clinical presentation and the threshold for the administration of broad spectrum antibiotics, following the taking of bloods for diagnostic purposes.

The WA Country Health Service (WACHS) has undertaken to inform their clinical workforce of this matter by utilising a new publication called "Patient Safety Matters". This publication is intended to share lessons from adverse events, communicate outcomes and emerging trends; and, prompt reflection and discussion amongst clinical staff. The August 2015 edition asks clinicians in remote locations to consider lowering the threshold for treatment with broad spectrum antibiotics to account for the reduced capacity to resuscitate patients with septic shock. It will be distributed widely to all medical officers via the Regional Medical Directors.

Recommendation 2 – I recommend additional education and audits on the use of the Adult Observation and Response Chart in Paraburdoo to ensure appropriate use of those charts.

With regard to the adult observation and response chart, WACHS implemented an audit program in 2013. Audits are conducted monthly at all WACHS sites including Paraburdoo, where all presentations are audited because of the low number of separations at that site.

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The purpose of the audit program is to inform and generate improvements in:

- the recording of physiological observations as specified in the patient's monitoring/care plan; and
- the appropriate recognition and escalation when a patient's condition is deteriorating.

Audit results are monitored:

- at sites to identify any gaps in practise and assist with education of staff;
- at a regional level through clinical governance meetings and Regional Executive meetings; and
- at quarterly business performance meetings which are attended by the Regional Executive Team and selected members of the WACHS Executive.

Marked improvements in results are evident since this program was implemented. The most recent results from Paraburdoo demonstrated a high standard of recording, monitoring and appropriate escalation where required.

Recommendation 3 – I recommend user friendly flow charts summarising the guidelines and procedures in operation in rural and remote health services for the successful collection of bloods be placed in collections areas where they are not already in existence.

With regard to blood collection guidelines and procedures, PathWest has advised that since this death, wall chart information has been regularly and reliably updated in the Paraburdoo Hospital phlebotomy room. This information includes collection guidelines and instructions to be followed for different tests. PathWest's Online Test Directory also provides further information and instructions for collection and is accessible by WACHS staff. WACHS will investigate opportunities to improve access to PathWest online information via the HealthPoint home page.

Furthermore, in order to address quality and integrity issues of blood samples, PathWest has undertaken to provide training to remote PathWest staff in the preparation of fresh slide films and detection of clots in blood samples. Phlebotomy training is also available to any WACHS staff responsible for sample collection after hours.

Any further actions taken by WA Health services in relation to the recommendations will be included in the Coronial Liaison Unit's routine six-monthly reports to the State Coroner. I trust that this information will assist the Coroner to fulfil the annual reporting requirements to the Attorney General.

Yours sincerely

Dr Kim Hames MLA
DEPUTY PREMIER
MINISTER FOR HEALTH

9 SEP 2015