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Ms Lynne Cowan
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Via email: *lynne.cowan@sa.gov.au*

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Dear Ms Cowan

As you are aware, on 10th May 2022 I was asked by Minister Picton to undertake a review of the attendance of a patient, at the Lyell McEwen Health Service (LMHS) Emergency Department (ED) on the evening of Sunday, 8th May 2022. This was following media attention being given to her being made to wait outside the ED for quite some time, on a cold night. The Terms of Reference for the Review were conveyed to me on Friday, 13th May, by the Review Sponsor, Helen Chalmers. The Terms of Reference task me to provide my report to you.

I met, in person, with members of the Northern Adelaide Local Health Network (NALHN) Executive on 17th May, including the CEO, COO, Director of Nursing and Midwifery Operations, the Medical and the Nursing Divisional Directors of the Critical Care Division, the Executive Director of Nursing and Midwifery, Clinical Governance and Risk Services and the Acting Manager of Quality. During that visit I also met with the Chair of the NALHN Board. While there, I undertook a visit to the Emergency Department, including the external triage area, which was still in place but no longer in operation, and the Emergency Extended Care Unit (EECU).

I subsequently spoke with the co-convenor of the NALHN Consumer Reference Group on 20th May. I met with the son of the patient on Monday, 23rd May and on that day spoke with the medical clinician who cared for the patient when admitted on the 9th May at the LMHS.

I also consulted the Department of Health Chief Health Officer, the Chief Medical Officer and the Operational Lead, COVID-19 Testing and Surveillance, via Microsoft Teams on the 18th May.

I was met with candour and help for my task by all with whom I spoke and was furnished with all the material I requested.

I should note that the patient did not wish to take part in the Review so, as a result, I did not speak to her. I also note that a compliment from her to the LMHS was logged on the 9th of May stating that the ED nursing staff had "treated her like a queen", she was not unhappy with her wait, was not cold when she was outside the Emergency Department, as she had a warm dressing gown and other clothes on.

I should declare that I undertook a review of the Mt Gambier and Districts Health Service for emergency patients in December 2016, at the request of the then Chief Executive Officer of the SA Country Health Local Health Network, now CEO of NALHN, with my co-reviewer being the now NALHN Director of Nursing and Midwifery Operations, a role similar to that he held in 2016. I had a most productive working relationship with them both.

You are aware of the activities I have undertaken in my career, however you may not be aware that included in my current roles is membership of the World Health Organisation Independent Oversight and Advisory Committee on the World Health Emergency Programme. As you can imagine, that role has a heavy focus on the global impact of the COVID pandemic.

Presentation to the LMHS ED and subsequent care:

SAAS records show that her daughter phoned SAAS at 1803 hours and she was told that her mother had been prioritised to be seen within an hour, a Category 5 patient. SAAS called the family back, at a time recorded by SAAS at 1859 hours, to advise them that, given current workloads, she would not be able to be attended to by SAAS for an extended, and undefined, period due to their workload. The SAAS operator asked if there was someone in the family who could take their mother to hospital in a private car. This is what the family did.

The second discussion with SAAS concluded at 1905 hours. It is felt by her son that his mother arrived at the ED somewhere between 1915 and 1930, which is close to the time of her arrival that was subsequently estimated by the LMHS Executive. It is acknowledged that there was a wait for her to be triaged which is recorded as occurring at 1955. She waited outside, in the tent facility, where she was triaged, and where her Rapid Antigen Test (RAT) was taken at 1956 hours, the result of which was recorded at 2014. She was moved into the ED waiting room at 2049 hours and from there into a cubicle at 2155 hours and had the first recording of her observations listed there at 2210 hours. She did have observations taken at triage, which are recorded electronically on the ED computer system, and in the ED waiting room where her pain level was reported. After ED medical assessment, which is recorded as commencing at 0028, the patient was moved into the EECU at 0305.

The ED was very busy that evening, with 76 patients recorded as being in the ED and EECU at 2000 hours. There were staff absences due to sick leave including 3 doctors, one of whom was a consultant, and between 3-4 nurses.

She was transferred to the clinical Unit, under the care of the on-call clinician, the following day. He advised me that there were no acute problems identified on this admission as a result of the patients experience on her arrival to the LMHS.

The patient was transferred later in the week to Modbury Hospital.

My observations:

- NALHN reports that it has had no nosocomial (patient to patient) spread of COVID in its sites, due to the infection prevention and control systems and testing regime it has in place.

- The practice of pre-ED Rapid Antigen Testing (RAT) is a sensible clinical and public health practice. Pre-ED RAT is a practice which has had widespread use across Australia's EDs during this pandemic. While it was not mandated by SA Health, nor by the Chief Health Officer, the Covid Testing and Surveillance Workstream of SA Health provided information to Emergency Department Heads of Departments, including a flow chart, on 8th November 2021 to assist the practice, which was subsequently adopted by the LMHS. It made sense to me that NALHN adopted this practice, particularly as there was concern regarding the lower COVID vaccination rate in Adelaide's north when the LMHS ED RAT process was introduced.

- It is important to note that those patients who arrive by ambulance are tested in the ambulance and admitted to the relevant part of the ED when their result is known. It is also important to understand that all patients needing urgent medical care are taken directly into the ED where their treatment, and the RAT, are undertaken concurrently. Urgent care is not withheld because the result of a RAT is not yet known.

- The siting of the testing, whether inside or outside the ED, depends on a number of factors, including the built environment, in particular the capacity of the waiting room to test and appropriately segregate patients until a suitable treatment space can be made for them. That NALHN chose an external environment for the LMHS was understandable, given the small size of the ED waiting room and concerns regarding the suitability of the air flow in the ED to prevent the spread of COVID. At times, especially overnight, patients may have to undergo very long waits in the waiting room. (That NALHN very uncommonly ramps ambulances outside the LMHS ED, in itself a most worthy, sought after and necessary practice, does mean that those who arrive by other means will be required to wait longer and spend longer in the waiting room in times of high demand.)

- The siting of the external facility at the LMHS is (or was) not ideal, but it appears to have been the only practical option. It could not be sheltered from some prevailing winds, the overhead shelter is very high, and it is adjacent to an area that serves as the ambulance ramp and as a construction site. I was advised that a windbreak could not be applied to the mesh fence as it could cause the fence to become unstable. There is no protection from extremes of ambient temperature. I have been advised that the LMHS has not, prior to this occasion, received complaints regarding the experience of those waiting outside the ED.

- External triaging and testing are currently employed in the EDs in Perth and WA regions, using modified shipping containers to house the RAT process and marquees for those subsequently waiting entry into the ED. The marquees in Perth do provide much more shelter for their patients than was possible at the LMHS. The process at the Fiona Stanley Hospital is explained in a 3 minute video which is made available to the public.

- There is a Business Continuity Plan at the LMHS for when the outside temperature is above 30 degrees (patients in that situation are to be moved into the ED where they are triaged and tested), but it appears that there was no plan for cold weather. That said, it was observed that a portable heater was placed over the external triage station on the evening of the 8th May whereas I am advised that no heaters were distributed or employed in the rest of the external, tented, area, nor were blankets provided unless specifically asked for by patients. The seating was described as quite uncomfortable.

- As of the 9th May, NALHN reinstated internal triaging with the ability to externally triage at extremely busy times. If, in such a situation where external triage is to occur again, the NALHN Executive has advised that this area would include improved heating, more comfortable seating and an additional nurse to attend to waiting patients' needs.

- Rapid Antigen Testing will continue to be undertaken internally when the LMH ED redevelopment Milestone 2 is opened next month.

- Time will tell if the current process of testing internally, accompanied by patients wearing N95 masks, will prevent nosocomial spread of the COVID virus and whether the modifications to the ED to undertake the internal Rapid Antigen Testing of patients will hinder patient flow there. The immediate result of the move to internally undertake a RAT for patients is that the ED has lost two cubicles adjacent to the waiting room for this process. These cubicles had been used by senior medical staff to provide a rapid assessment of attending patients in order to expedite patient flow, so this initiative has now been significantly impacted. All patients awaiting their RAT and those who are post RAT, but before the result is known, will be in the main waiting room, with the risk of some of them being COVID positive during that time. (There were 22 patients diagnosed with COVID in the ED on the 8th May.) The current requirement for all those in the waiting room to wear a N95 mask may assist in the reduction of the spread of COVID there but that will depend on the effectiveness, and the fit, of the mask and how (or if) it is worn by those waiting.

Conclusion:

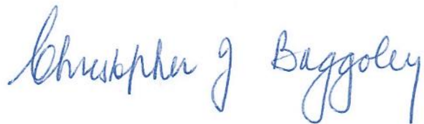
The policy that was adopted by NALHN at the LMHS ED to test patients for COVID prior to their entry into the ED was wise and in line with practice elsewhere in Australia. There were valid reasons for it to be undertaken externally, albeit in a physical setting that was not optimal for patient care and comfort. While the patient was complimentary of her care whilst outside the ED, I accept the observations of her family that she, and others, were significantly affected by the cold that evening and that insufficient attempts were made to address those needs. That a heater was being utilised at the triage station that night, but nowhere else, reinforces that conclusion. Portable heating for the waiting patients and the

pro-active provision of blankets to them on that cold evening would, most likely, have prevented the distress that has been described.

This situation was the result of an oversight by the LMHS, given that plans were in place to test patients internally in the event of hot weather, but not in the event of cold weather. It is unfortunate that this situation occurred, and it is reassuring that the Executive of NALHN has recognised this oversight and taken steps to ensure it does not happen again.

I do not believe that other steps, beyond those described above, need to be adopted.

Yours faithfully



Chris Baggoley

This is the publicly available version of Chris Baggoley's report. Some clinical and personal information has been removed from the original version to maintain patient confidentiality.