CORRUPTION AND CRIME COMMISSION

MISCONDUCT HANDLING PROCEDURES IN THE WESTERN AUSTRALIAN PUBLIC SECTOR: WA HEALTH

TABLED IN THE PARLIAMENT
OF WESTERN AUSTRALIA
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This report and further information about the Corruption and Crime Commission can be found on the Commission Website at www.ccc.wa.gov.au.

Corruption and Crime Commission

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CORRUPTION AND CRIME COMMISSION

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Dear Mr President
Dear Mr Speaker

In accordance with section 84 of the *Corruption and Crime Commission Act 2003*, the Commission presents the Corruption and Crime Commission report on *Misconduct Handling Procedures in the Western Australian Public Sector: WA Health*.

Yours faithfully

The Hon. LW Roberts-Smith, RFD, QC
COMMISSIONER

9 April 2010

ABBREVIATIONS AND ACRONYMS

AIMS	Advanced Incident Management System
CAHS	Child and Adolescent Health Service
"the CCC Act"	*Corruption and Crime Commission Act 2003*
Chief Pharmacist	Chief Pharmacist of the Department of Health
"the Commission"	Corruption and Crime Commission
"Corporate Governance"	Corporate Governance Directorate of the Department of Health
DD	Dangerous Drugs (Schedule 8)
"the Department"	Department of Health. (Refers to the management arm of WA Health, located at Royal Street, East Perth.)
"the Director General"	Director General of the Department of Health
DMRP	Disaster Management, Regulation and Planning Directorate of the Department of Health
DoE	Department of Education
ED	Emergency Department
FCCC	Fraud and Corruption Control Committee
FTE	Full-Time Equivalent
GP	General Practitioner
HCN	Health Corporate Network
HR	Human Resources
ICU	Intensive Care Unit
NMAHS	North Metropolitan Area Health Service
ORC	Operational Review Committee
PMH or "Princess Margaret Hospital"	Princess Margaret Hospital for Children
"the Poisons Act"	*Poisons Act 1964*
"the Poisons Regulations"	*Poisons Regulations 1965*
PSB	Pharmaceutical Services Branch of the Department of Health
"the review"	Review, by the Commission, of the Department of Health's management of misconduct across WA Health.

RPH	Royal Perth Hospital
Schedule 4 Drugs	Means those drugs designated as Schedule 4 substances in Appendix A of the *Poisons Act 1965* with reference to the Standard for the Uniform Scheduling of Drugs and Poisons issued by the National Drugs and Poisons Committee and available from the Therapeutic Goods Administration. The term "Schedule 4" is defined in section 20 of the *Poisons Act 1964* as: "poisons that should, in the public interest, be restricted to prescription or supply by a medical practitioner, dentist, veterinary surgeon, or nurse practitioner".
Schedule 4 Drugs "of interest"	The term Schedule 4 drugs "of interest" was used colloquially by the managers interviewed to refer to drugs including the benzodiazepine group, analgesics and anaesthetics. These drugs are more likely to be abused than other Schedule 4 drugs because of their effects.
Schedule 8 Drugs	Means those drugs designated as Schedule 8 substances in Appendix A of the *Poisons Act 1964* with reference to the Standard for the Uniform Scheduling of Drugs and Poisons issued by the National Drugs and Poisons Committee and available from the Therapeutic Goods Administration. The term "Schedule 8" is defined in section 20 of the *Poisons Act 1964* as: "poisons to which the restrictions recommended for drugs of dependence by the 1980 Australia Royal Commission of Inquiry into Drugs should apply".
SHEF	Senior Health Executive Forum
SMAHS	South Metropolitan Area Health Service
WA Health	"WA Health" refers to the whole of the WA public health system, particularly the Area Health Services and their sites.
WACHS	Western Australia Country Health Service
WACHS-Kimberley	Western Australia Country Health Service-Kimberley

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EXECUTIVE SUMMARY

[1]   This report presents the Corruption and Crime Commission's ("the Commission") review ("the review") of the Department of Health's ("the Department") management of misconduct[1] across WA Health.[2]

[2]   From June 2007 to October 2009 the Commission conducted 304 interviews; examined the policies, procedures and structure of 14 work sites; and conducted a survey of WA Health staff.

[3]   The site-based reviews were conducted at Princess Margaret Hospital for Children (PMH), WA Country Health Service-Kimberley (WACHS-Kimberley) and Royal Perth Hospital (RPH).

[4]   The Commission also undertook a thematic review of the management and handling of Schedule 4 and Schedule 8 drugs[3] in hospitals and the management of drug-related misconduct.

[5]   The findings of the various phases of the review can be broadly summarised as detailed below.

> (1)   Serious, identifiable misconduct risks exist in WA Health. These pose a risk to patient safety and have financial impacts.
>
> (2)   There is limited practical capacity within WA Health to deal with misconduct, and no real improvement has occurred over the period of the review.
>
> (3)   Notwithstanding the work undertaken by WA Health during the period of the review, there is no evidence the Department has established a misconduct management mechanism.
>
> (4)   There is no high level ownership or direction of misconduct management within WA Health.

[6]   A series of drug-related case studies relating to the handling of pharmaceuticals support these findings.

> (1)   A nurse working at a remote area nursing post and at a regional hospital stole and self-administered Schedule 8 and Schedule 4 drugs over a two-and-a-half month period.
>
> (2)   A nurse from an intensive care unit stole the Schedule 8 drug fentanyl from the hospital and was found slumped in the toilets. Work colleagues were reluctant to report the behaviour. The theft

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[1] Refer section 4 of the *Corruption and Crime Commission Act 2003* for definition of "misconduct".

[2] In this report, "the Department" refers to the Department of Health situated at Royal Street, East Perth, and is the executive or management arm of WA Health. "WA Health" refers to the whole of the WA public health system.

[3] Refer p.vi (Executive Summary) and p.7 of this report for definitions of Schedule 8 and Schedule 4 drugs.

and use of drugs was not seen as a misconduct issue. Some staff who made statements as part of the investigation of the incident were victimised by colleagues.

(3) There was mismanagement, and cover-ups, relating to a young doctor who stole drugs and drug-administering equipment from several hospitals. The doctor displayed a lack of attention to patients, and was seen staggering around and staring at medical equipment.

(4) The number of Panadeine Forte tablets used annually in one ward fell from 16,000 tablets to 200 tablets, after a counting requirement was introduced.

(5) Anecdotally, the Commission was told of staff substituting saline water for drugs, various other drug thefts, and doctors allegedly over-prescribing and offering to deliver drugs to patients' houses.

[7] Although the review addresses drugs as a particular issue, there is a range of other characteristics particular to hospital environments that also present misconduct risks. For example:

- offers of gifts, benefits and hospitality (particularly for doctors) create conflicts of interest;

- large sums of money are spent on developing, improving and maintaining property, and on purchasing fixed and consumable assets; and

- the working environment is closed and characterised by a power imbalance in the relationship between staff and patients.

[8] The reviews of PMH, WACHS-Kimberley and RPH revealed WA Health did not place sufficient weight on managing misconduct. These sites did not have effective misconduct management mechanisms, although elements of such mechanisms existed. WA Health agreed with these conclusions and highlighted the need for a "whole-of-Health" approach to managing misconduct.

[9] The drugs review revealed there are misconduct risks associated with Schedule 8 and Schedule 4 drugs in public hospitals. Drug theft by staff was one such risk. The Commission formed the opinion the Department was not adequately managing the misconduct risks associated with the day-to-day management and handling of Schedule 8 and Schedule 4 drugs.

[10] The Commission also arranged for the conduct of an independent survey of WA Health staff. The survey focussed on employees' knowledge and understanding of misconduct, and how their workplace dealt with it. Over half the respondents considered themselves to be poorly informed or not sure about misconduct risks in their workplace.

[11]   The Commission examined the Senior Health Executive Forum and Corporate Governance Directorate of the Department to determine the ownership and direction of misconduct management within WA Health. The Commission found neither one had a clearly articulated responsibility in that regard.

[12]   The Commission has formed the opinion that WA Health is currently unable to adequately account to the wider community for the way it manages misconduct risk and related occurrences of misconduct in a demonstrably fair, reliable and transparent way.

[13]   The Commission makes the following recommendations.

Recommendation 1

That the Department of Health articulate and promote its commitment to managing misconduct throughout WA Health.

Recommendation 2

That the Department of Health, through the Senior Health Executive Forum, identify and commit to a strategy for managing misconduct, including a plan to give practical effect to that strategy.

Recommendation 3

That the Department of Health, through the Senior Executive Health Forum, commit sufficient resources to that strategy to make it work.

Recommendation 4

That the Department of Health work with the Commission to achieve progress.

[14]   The Commission has established a team within the Corruption Prevention Directorate to assist WA Health.

[15]   The review was conducted in cooperation with the Department.

[16]   The Commission is grateful to the WA Health staff who gave their candid opinions in interviews, responded to the survey, and assisted administratively.

CHAPTER ONE
INTRODUCTION AND OVERVIEW

1.1 Background

[1] Section 7A of the *Corruption and Crime Commission Act 2003* ("the CCC Act") specifies the main purposes of the Corruption and Crime Commission ("the Commission"), and section 7B specifies how these purposes are to be achieved. One purpose of the Commission is "to improve continuously the integrity of, and to reduce the incidence of misconduct in, the public sector". One of the ways the Commission does this is by helping public authorities to increase their capacity to prevent, identify and manage misconduct, and by requiring authorities to notify the Commission when misconduct occurs. The Commission may conduct reviews to assess this capacity and has done so in the case of several authorities. In June 2007 the Commission commenced a review of WA Health (which refers to the whole of the WA public health system, while the Department of Health is the executive and management arm of WA Health), under sections 17 and 18 of the CCC Act. The review by the Commission was completed in April 2010.

[2] WA Health is a major organisation within the Western Australian public sector. The nature of its business, its size, its 37,000 employees and its importance to the wider community means it is an organisation the Commission must consider in executing its responsibility for assisting public sector agencies to prevent and manage misconduct.

1.2 Jurisdiction of the Commission

[3] The Commission is an executive instrument of the Parliament (albeit an independent one). It is not an instrument of the government of the day, nor of any political or departmental interest. It must perform its functions under the CCC Act faithfully and impartially. The Commission cannot, and does not, have any agenda, political or otherwise, other than to comply with the requirements of the CCC Act.

1.3 Definitions

1.3.1 Misconduct

[4] The term "misconduct" has a particular and specific meaning in the CCC Act and it is that meaning which the Commission must apply. Section 4 of the CCC Act states that:

> *Misconduct occurs if —*
>
> > *(a) a public officer corruptly acts or corruptly fails to act in the performance of the functions of the public officer's office or employment;*

> (b)   a public officer corruptly takes advantage of the public officer's office or employment as a public officer to obtain a benefit for himself or herself or for another person or to cause a detriment to any person;
>
> (c)   a public officer whilst acting or purporting to act in his or her official capacity, commits an offence punishable by 2 or more years' imprisonment; or
>
> (d)   a public officer engages in conduct that —
>
>> (i)   adversely affects, or could adversely affect, directly or indirectly, the honest or impartial performance of the functions of a public authority or public officer whether or not the public officer was acting in their public officer capacity at the time of engaging in the conduct;
>>
>> (ii)   constitutes or involves the performance of his or her functions in a manner that is not honest or impartial;
>>
>> (iii)   constitutes or involves a breach of the trust placed in the public officer by reason of his or her office or employment as a public officer; or
>>
>> (iv)   involves the misuse of information or material that the public officer has acquired in connection with his or her functions as a public officer, whether the misuse is for the benefit of the public officer or the benefit or detriment of another person,
>
> and constitutes or could constitute —
>
>> (v)   an offence against the "Statutory Corporations (Liability of Directors) Act 1996" or any other written law; or
>>
>> (vi)   a disciplinary offence providing reasonable grounds for the termination of a person's office or employment as a public service officer under the "Public Sector Management Act 1994" (whether or not the public officer to whom the allegation relates is a public service officer or is a person whose office or employment could be terminated on the grounds of such conduct).

[5]   Misconduct, as defined in section 4 of the CCC Act applies only to the conduct of public officers.

1.3.2   Public Officer

[6]   The term "public officer" is defined in section 3 of the CCC Act by reference to the definition in section 1 of *The Criminal Code*. The term

"public officer" includes any of the following: police officers; Ministers of the Crown; members of either House of Parliament; members, officers or employees of any authority, board, local government or council of a local government; persons holding office under, or employed by, the State of Western Australia, whether for remuneration or not; and public service officers and employees within the meaning of the PSM Act.

1.4 Reporting by the Commission

[7] Under section 84(1) of the CCC Act the Commission may at any time prepare a report on any matter that has been the subject of an investigation or other action in respect of misconduct. By section 84(3) the Commission may include in a report:

> (a) *statements as to any of the Commission's assessments, opinions and recommendations; and*

> (b) *statements as to any of the Commission's reasons for the assessments, opinions and recommendations.*

[8] The Commission may cause a report prepared under this section to be laid before each House of Parliament, as stipulated in section 84(4).

[9] Section 86 of the CCC Act requires that before reporting any matters adverse to a person or body in a report under section 84 the Commission must give the person or body a reasonable opportunity to make representations to the Commission concerning those matters.

[10] Accordingly, a number of persons were notified by letter dated Tuesday 19 January 2010 of possible adverse matters which it was proposed to include in this report. They were invited to make representations about those and other matters about which they might wish to make representations by Friday 12 February 2010. Approval was given to one person to make representations by a later date.

[11] As a body, the Department of Health ("the Department") was notified by letter, to the then Director General, Dr Peter Flett, dated Wednesday 13 January 2010 of possible adverse matters which it was proposed to include in this report. Representations were received by the Commission on Tuesday 2 March 2010 from the Acting Director General of the Department, Mr Kim Snowball.

[12] The Commission has taken all representations into account in finalising this report.

1.4.1 Representations Received from the Department

[13] In its representations to the Commission, which were comprised of 68 pages, dated 2 March, the Department indicated that it agreed with the recommendations proposed by the Commission in its draft report (a copy of which, including appendices, was attached to the letter of 13 January 2010), but did not agree with all Commission findings. Essentially there

were three fundamental issues raised by the Department in its representations. These issues, and the Commission's responses, are detailed below.

- The Department disputed the Commission's finding that the Department lacks a strategy for managing misconduct.

  The Commission maintains that what the Department calls a "strategy" is a conceptual framework, unsupported by a practical implementation plan.

- The Department maintained that because the Commission review of WA Health took place over an extended period of time, the findings can no longer be justified.

  The Commission maintains that review findings are valid and that there is no evidence of a misconduct management strategy or mechanism.

- The Department claimed the Commission has failed to acknowledge work undertaken by the Department during the period of the review, and disputes that no real improvement has occurred.

  The Commission acknowledges the Department's ongoing efforts to promote integrity in the public health sector (see Appendix 1 to this report). However, the Commission maintains that there is little evidence these efforts have resulted in fundamental change or significant improvement in managing misconduct at the hospital level.

[14] In response to the above, the findings contained in this report represent a modified version of the findings contained in the draft report provided to the Department in January 2010. The findings have been modified to clarify the Commission's views.

1.5 Commission Review

[15] The task of reviewing WA Health was a large one. It involved conducting 304 interviews, reviewing the policies, procedures and structures of 14 work sites, and analysing the survey responses of 920 people. The following was undertaken:

(1) preliminary assessment of the structure and the misconduct risk profile of WA Health (see Section 1.6.1);

(2) interviewing 74 managers and directors, and reviewing relevant legislation, policies, procedures and the organisational structure of Princess Margaret Hospital for Children (PMH) (see Section 2.2);

(3) interviewing 35 managers and directors, and reviewing relevant legislation, policies, procedures and the organisational structure of the Western Australian Country Health Service-Kimberley

(WACHS-Kimberley), including Broome and Derby hospitals (see Section 2.3);

(4) interviewing 126 managers, pharmacists and executives across 10 metropolitan and country hospitals, and central Department offices about the control and security of Schedule 8 and Schedule 4 drugs (see Section 2.4);

(5) interviewing 30 executives, and reviewing relevant legislation, policies, procedures and the organisational structure of Royal Perth Hospital (RPH) (see Section 2.5);

(6) conducting 39 interviews and reviewing the relevant legislation, policy, procedures and organisational structure of the Corporate Governance Directorate of the Department (Corporate Governance), Senior Health Executive Forum (SHEF) and associated bodies (see Sections 3.1-3.4); and

(7) conducting a survey of 2,956 WA Health employees, of which 920 (31.1%) responded (see Section 5.1).

[16] The Commission provided working papers to, and received comment from, WA Health on the reviews of PMH, WACHS-Kimberley, Schedule 8 and Schedule 4 drugs, RPH, Corporate Governance and SHEF.

[17] Quotes taken from interviews are used throughout this report and the working papers without revealing the identity of those involved. The Commission has used quotes where they represent a consensus view, or where a comment is particularly relevant. The interviews in which these comments were made were intentionally informal in order to engage in open and meaningful dialogue. Verbal (and written) quotes are italicised or placed in inverted commas, and are referred to in the context of the relevant discussion.

[18] The Commission thanks all of those people from WA Health involved in the review, including those who gave their candid opinions in interviews, those who responded to the survey, and those who helped the Commission reviewers administratively.

1.6 What Did the Work Reveal?

[19] The findings of the various phases of the review can be broadly summarised as detailed below.

(1) Serious, identifiable misconduct risks exist in WA Health.[1] These pose a risk to patient safety and have financial impacts.[2]

(2) There is limited practical capacity within WA Health to deal with misconduct, and no real improvement has occurred over the period of the review.[3]

(3)   Notwithstanding the work undertaken by WA Health during the period of review, there is no evidence the Department has established a misconduct management mechanism.[4]

(4)   There is no high level ownership or direction of misconduct management within WA Health.[5]

1.6.1   Misconduct Risk

[20]   There is a range of characteristics particular to hospital environments that contribute to misconduct risk.[6] Some of these characteristics are detailed below.

(1)   The working environment is closed, and characterised by a power imbalance in the relationship between doctors and nursing or support staff and between staff and patients. This environment results in the following specific risk factors:

(a)   nursing and support staff may not feel able to report or deal with apparent misconduct by doctors;

(b)   patients may be vulnerable to a variety of predatory and opportunistic behaviours, including sexual contact, theft and violence; and

(c)   it may appeal to people who wish to take advantage of such circumstances.

(2)   Addictive drugs are lawfully dispensed, used and available within the workplace.

(3)   Large sums of money are expended on developing, improving and maintaining property, and on purchasing fixed and consumable assets.

(4)   Offers of gifts, benefits and hospitality (particularly for doctors) create conflicts of interest.

(5)   The wider community places great trust in hospitals and their staff.

(6)   Hospitals draw staff from many walks of life and a variety of professions and trades.

(7)   Staff often work in highly pressured and emotional circumstances and can form close relationships with patients and their families, sometimes over many years.

(8)   There is a high level of staff movement (both clinical and non-clinical) through all areas.

(9)   In regional and remote areas, there are also specific risks, including:

(a) limited support and supervision of staff, many of whom work and live in remote locations;

(b) a transient workforce with high turnover;

(c) difficulties in attracting suitable staff and maintaining optimum staffing levels;

(d) cultural and familial influences on indigenous staff engaged in service delivery; and

(e) the nature and extent of services, funding and materials provided to remote communities.

[21] Drug-related misconduct in hospitals became a focus for the Commission because of matters raised at the first two sites reviewed (PMH and WACHS-Kimberley) and drug-related notifications received by the Commission. The management of drugs and drug-related misconduct were approached as a thematic review.

[22] The drugs considered in the review are divided into two categories. Section 20 of the *Poisons Act 1964* ("the Poisons Act") defines Schedule 8 drugs as "poisons to which the restrictions recommended for drugs of dependence by the 1980 Australian Royal Commission of Inquiry into Drugs should apply". Schedule 8 drugs are addictive and may be abused or misused, and include drugs such as opioid analgesics (for example, morphine and pethidine) and amphetamines (for example, dexamphetamine).

[23] Section 20 of the Poisons Act defines Schedule 4 drugs as "poisons that should, in the public interest, be restricted to prescription or supply by a medical practitioner, dentist, veterinary surgeon or nurse practitioner". Schedule 4 drugs include the benzodiazepine group (for example, temazepam and midazolam), anaesthetic drugs (for example, propofol) and analgesics (for example, Panadeine Forte).

[24] There are a number of misconduct risks associated with Schedule 8 and Schedule 4 drugs.

(1) Illegal drug users use Schedule 8 drugs of addiction and Schedule 4 prescription drugs, and they have a "street value" in the illegal drug market.

(2) Even though drugs "of interest"[7] exist within Schedule 4, the storage, security and accountability of these drugs in hospitals are not controlled by law or regulation.

(3) Drugs are held in hospitals in large quantities.

(4) Drugs are generally widely distributed across hospital sites.

(5) Out of necessity drugs are readily accessible (albeit subject to storage and access restrictions).

[25]   The review shows these workplace characteristics and misconduct risks pose a risk to patient safety and clinical service delivery, as well as negatively impact the finances and resources of WA Health.

1.6.2   Action by WA Health

[26]   While it may not be possible to eliminate all of these risks, it is possible to manage and reduce them. WA Health ought to be able to account to the wider community for the way it manages these risks, as well as related occurrences of misconduct, in a demonstrably fair, reliable and transparent way, i.e., the Department ought to have in place an effective misconduct management mechanism, as part of an organisational framework that is misconduct resistant.

[27]   There is both an ethical and legal basis to this expectation. The ethical basis is grounded in the Department's obligation to the community that, as a government agency, it will conduct business and deliver services with integrity. The legal basis is found in the CCC Act. Under section 28 of the CCC Act, the Director General of the Department ("the Director General") must notify the Commission of all matters that the Director General reasonably suspects concerns or may concern misconduct, i.e., a misconduct management mechanism should exist across WA Health to reliably inform the Director General of such suspicions.

[28]   Further, pursuant to sections 7B(3) and 33 of the CCC Act, the majority of matters notified to the Commission are referred back to the Department for investigation. Sections 40 and 41 of the CCC Act require the Department to report on its investigations to the Commission. The Commission reviews the adequacy of these investigations, i.e., a system needs to exist within the Department which reliably investigates and reports identified misconduct suspicions.

[29]   An adequate misconduct management mechanism is a cohesive and coordinated system with sufficient reach to ensure effective and appropriate action across an entire organisation. Such a mechanism ensures that each hospital site is able to identify misconduct risks, including the nature and location of such risks, and apply measures to prevent or at least minimise any related misconduct from occurring. The mechanism should also identify, manage and report misconduct when it does occur. Developing such mechanisms involves accepting that promoting professional conduct, and preventing misconduct, is a fundamental element of an agency's core business.

[30]   Part of the Commission's review process involved establishing whether WA Health has responded to its identifiable misconduct risks by implementing an effective misconduct management mechanism.

[31]   There can be no doubt that WA Health has told the Commission it is willing to both account for the way it manages misconduct risk, and to implement an effective misconduct management mechanism to do so. In support of this, Corporate Governance has been active in providing training to staff and has provided the Commission with every available

assistance to complete its review. Moreover, in response to the various issues raised in the working papers provided to the Department during the review, the former Director General has:

> (1)   acknowledged the existence of significant misconduct risks within WA Health;
>
> (2)   stated that the organisation aims to implement a misconduct management mechanism to deal with them; and
>
> (3)   accepted all recommendations made by the Commission.

[32]   Notwithstanding the work undertaken by WA Health during the period of review, there was no evidence the Department has established a misconduct management mechanism. The following factors are currently preventing WA Health from establishing such a mechanism.

> (1)   No broad statement of intent and commitment to creating and implementing a misconduct management mechanism has been made and announced to the wider organisation.
>
> (2)   Complete copies of working papers provided by the Commission to WA Health during the course of its review on PMH, WACHS-Kimberley, scheduled drugs and RPH have not been widely circulated within SHEF for discussion and decision-making purposes.
>
> (3)   If Corporate Governance has responsibility for owning and directing misconduct management, it has neither sufficient influence within WA Health or SHEF, nor sufficient resources to do so. Plainly stated, to the extent that it is pursuing some strategy on this front, the Commission was either unable to identify it or could not understand what was explained.
>
> (4)   If SHEF has responsibility for owning and directing misconduct management, SHEF members spoken to were unaware of it, notwithstanding that they agreed it ought to be their responsibility. In terms of the Commission's message to WA Health about managing misconduct, they believed their responsibility was effectively limited to co-operating with Corporate Governance.

1.6.3   Practical Capacity

[33]   Although WA Health has a desire for a competent misconduct management mechanism, there is limited practical application of that desire.   Little improvement was achieved during the period of the Commission's review.

[34]   The review at PMH from June 2007 to December 2007 found that misconduct was dealt with on an ad hoc basis. Relevant policies and procedures were of little assistance to direct managers in identifying, managing and reporting misconduct (see Section 2.2). The findings of a

subsequent review at WACHS-Kimberley from December 2007 to April 2008 were almost identical (see Section 2.3).

[35] In both cases recommendations by the Commission were accepted by the Department, which added that the issues needed to be addressed on a "whole-of-Health" basis.

[36] In that context, a review at RPH from January 2009 to July 2009 (see Section 2.5), which started 12 months after the PMH review was completed, found that recommendations made by the Commission and accepted by the Department in relation to misconduct risks associated with Schedule 8 and Schedule 4 drugs had resulted in some positive practical change. But the general position articulated in the reviews of PMH and WACHS-Kimberley was almost identical at RPH. For example:

(1) managers' understanding of and approach to managing misconduct was limited and varied;

(2) executives were unclear on what behaviours constitute misconduct;

(3) except for the control of Schedule 8 and Schedule 4 drugs, and security of patient data, a formal misconduct risk identification process had not been undertaken;

(4) some information from the Department about misconduct was being received by the RPH executive (for example, the need to report misconduct and some focus on drugs management), but the messages were inconsistent and there was no strategic message being delivered about developing a misconduct management mechanism within WA Health; and

(5) Similarly, confidence in how misconduct was managed at RPH varied across the executive group, from those who were certain misconduct was managed well, to those who thought it was not managed at all.

1.7   Why is this the Case?

[37] The misconduct management problems in WA Health stem from the disconnection between a stated desire to resolve its problems on the one hand, and the translation of that desire into a practical solution on the other (notwithstanding the work undertaken by WA Health during the period of the review). There are arguably many reasons for this, as detailed below.

(1) **Size:** WA Health is enormous. It has over 37,000 employees, an annual budget of around $4 billion, and workplaces in all parts of the State, ranging from remote nursing posts with a staff of one, to metropolitan teaching hospitals with thousands of employees and volunteers. Therefore, the size of the task should not be underestimated.

(2) **Complexity:** WA Health is very complex. It is made up of a number of semi-autonomous entities, all of which are large employers in their own right. It employs people from a variety of professions and occupations, all of which have their own agenda and cultures.

(3) **Scrutiny:** WA Health is an organisation that is under constant public scrutiny. There are ongoing pressures about issues such as its budget, the availability of hospital beds, surgical waiting lists and emergency department waiting times.

[38] Although the impact of these factors is significant, they do not adequately explain why WA Health does not have a misconduct management mechanism – indeed they emphasize the importance of having one, as part of its core business.

[39] These issues are not unique to WA Health, albeit that WA Health is a unique organisation. For example, the Department of Education (DoE) is a large and complex organisation, although its education districts are not neat equivalents to the large semi-autonomous entities within WA Health. But DoE has managed to develop a misconduct management mechanism in a relatively short amount of time.

[40] Western Australia Police is an organisation that is also under constant public scrutiny. It has a long standing, generally highly effective misconduct management mechanism.

[41] The review illustrated that WA Health has not implemented a strategy to give effect to its stated desire to manage misconduct. This missing strategy means that:

(1) an overarching message about preventing and managing misconduct has not been communicated across the organisation;

(2) a model to prevent and manage misconduct in the context of the organisation's size, complexity and scrutiny has not been developed; and

(3) reliable systems and adequate resources to give effect to such a model on a day-to-day basis throughout the organisation do not exist.

Consequently, WA Health principally relies on the general knowledge and individual motives of staff to identify and respond to misconduct issues.

1.8 What Needs to be Done?

1.8.1 WA Health

[42] WA Health needs to identify and commit to a strategy for managing misconduct including a model to give practical effect to that strategy.

Central to this is the need to communicate the strategy across the organisation.

[43]   In recent years DoE has tackled this issue by developing a centrally controlled and resourced Standards and Integrity Directorate that forms part of the Professional Standards and Conduct Division. This Division answers directly to the Director General of DoE and has the promotion of proper conduct and prevention of misconduct as its primary objectives.

[44]   In WA Health, Corporate Governance is a central unit with some similar responsibilities. However, its capacity to deliver change is effectively blocked by the fact that it has neither the resources nor influence within WA Health to deliver change on this scale.

[45]   On the resources front, it compares to DoE as follows:

    (1)   DoE's Professional Standards and Conduct Division has 32 Full-Time Equivalent (FTE) positions. In similar roles, WA Health's Corporate Governance Directorate (Ethical Standards) has 17 FTE positions (plus three casual FTE positions).[8]

    (2)   A sophisticated, on-line case management system has been implemented by DoE allowing for greater visibility, accountability and oversight of the management of complaints and misconduct matters; the WA Health case management system is in its infancy.

    (3)   DoE's Professional Standards and Conduct Division has high-level representation in DoE's Executive; the same is not true for Corporate Governance in WA Health.

    (4)   Corporate Governance has the added responsibility of providing an audit service for the whole of WA Health.

[46]   On the influence front, Corporate Governance does not have a voice on SHEF. This is significant because members of SHEF regard the management of misconduct as their responsibility, both collectively and individually within their particular business units or Area Health Services.

[47]   An alternative to the DoE model is the decentralised model of district responsibility, in which district managers take responsibility for this issue. This model is followed by Western Australia Police.

[48]   At some level this approach is consistent with WA Health's structure in which members of SHEF are responsible for business units or Area Health Services. Collectively, SHEF does not understand the nature and scope of the issue, and does not have an individual or collective strategy to deal with it.

[49]   This compares with Western Australia Police as follows:

    (1)   all Western Australia Police districts have governance officers (or similar), whose role is to oversee the conduct of internal investigations and deal with behavioural issues in each district;

(2) there is a sophisticated internal quality assurance process at the centre of the organisation that seeks to ensure equitable outcomes, and attends to policy and procedural issues highlighted by internal investigations;

(3) the central quality assurance process is sufficiently resourced and maintains sufficient information to identify trends and issues; and

(4) Western Australia Police initially commenced with a centralised model similar to DoE, and evolved to the decentralised approach at a point when their misconduct management mechanism was mature enough to do so with confidence.

[50] It is important to note that in both of these cases, the executive made a clear statement to the organisation, and more widely, that it was embarking on managing misconduct in this particular way.

1.8.2 Commission

[51] The Commission has established a team within the Corruption Prevention Directorate whose primary objectives include assisting WA Health to address the issues identified in this report. The team will:

(1) monitor and evaluate the progress of the implementation of recommendations contained in this report (see Section 6.4) and those of the working papers provided to the Director General, which may include conducting further thematic and site reviews, and WA Health staff surveys;

(2) provide feedback to assist WA Health improve systems for preventing and managing misconduct through the assessment, monitoring and review of WA Health misconduct notifications and investigations;

(3) engage local managers at WA Health workplaces in the context of evaluating progress against the recommendations, and building WA Health's capacity to manage misconduct; and

(4) provide ongoing advice to WA Health.

[52] The assistance outlined above should not be seen as definitive, and the Commission welcomes other approaches and ideas from the Department.

CHAPTER TWO
COMMISSION REVIEW

2.1   Scope of the Commission Review

2.1.1   Background

[53]   The review was conducted under sections 17 and 18 of the CCC Act which, among other things, authorise the Commission to analyse systems used by public sector agencies to prevent misconduct and monitor the way agencies take action in relation to allegations and matters referred to them by the Commission. The review was conducted to assess the capacity of WA Health to identify misconduct risks and deal with misconduct suspicions, and to form an opinion as to the adequacy of policies, procedures and structures with regard to the overall management of misconduct.

2.1.2   Methodology

[54]   A sufficiently diverse yet representative range of hospital sites was selected to enable a reliable view to be formed about misconduct management across WA Health. Size, location (metropolitan and country) and service delivery were all considered. The sites were:

    (1)   PMH;

    (2)   WACHS-Kimberley, including Broome and Derby hospitals;

    (3)   10 metropolitan and regional sites for the thematic review of the misconduct risk associated with the day-to-day handling and management of Schedule 8 and Schedule 4 drugs ("drugs review"); and

    (4)   RPH.

[55]   For the general misconduct management reviews, hospitals ranged in size from the regional and remote Derby Hospital with 39 beds and approximately 140 staff, to metropolitan RPH with around 580 beds and 7,000 staff. WACHS-Kimberley was chosen as being an example of a regional and remote health service. PMH and RPH were chosen as discrete, metropolitan hospitals.

[56]   For the drugs review, sites ranged from small to large metropolitan and country sites, with various service delivery specialties. The 10 hospitals chosen were: King Edward Memorial Hospital for Women; PMH; Fremantle Hospital; Kaleeya Hospital (East Fremantle); Rottnest Island Nursing Post; Swan Kalamunda Health Service (Swan and Kalamunda Campuses); South West Health Campus (Bunbury Hospital); Margaret River Hospital; Albany Hospital; and Katanning Hospital. Executives at the Department were also interviewed.

[57] The Commission also arranged for the conduct of an independent survey, which was sent to 2,956 WA Health employees. The responses of 920 respondents to the survey were analysed.

2.2 Princess Margaret Hospital for Children (PMH) Review (June 2007 - December 2007)

[58] The first of the WA Health reviews was of PMH. The Commission conducted 74 interviews with managers (including "frontline" managers, such as nurse managers) and directors at PMH. Relevant legislation, policies and procedures, and the organisational structure were reviewed.

[59] The process involved the following:

(1) identifying the site's business objectives and structure;

(2) identifying the site's approach to misconduct management and prevention;

(3) considering relevant legislation, policies, procedures and practices with respect to staff conduct/misconduct, including complaint, grievance and performance management systems;

(4) analysing relevant documents and files;

(5) interviewing management, both clinical and non-clinical, in key areas;

(6) establishing what misconduct issues exist, whether they are properly identified and managed, and how they are recorded; and

(7) assessing whether what was observed at PMH (in terms of managing misconduct) related to an overarching strategy or mechanism in place across WA Health.

2.2.1 Policies and Guidelines

[60] The policies and guidelines at PMH addressed aspects of behaviour and, in some cases, elements of misconduct. However, the policies and guidelines were not coordinated in a systematic way to deal with misconduct, and provided little information to direct managers in identifying, reporting or managing misconduct. The way in which misconduct was addressed also left staff with an inadequate understanding of, and ability to, identify and report misconduct.

2.2.2 Training and Education

[61] Limited reference to conduct or misconduct was included within training delivered at PMH. Not all hospital staff received all of the available training. Many staff interviewed commented that very little formal training on misconduct (or management more generally) was available, which made them particularly vulnerable. For example:

> *… there is no specific training on conduct or misconduct … we barely get any information …*

> *… there needs to be more education/training at my* [manager] *level for how to manage situations …*

[62] Corporate Governance had commenced delivery of misconduct awareness sessions across WA Health at the time of the PMH review. A cross-section of North Metropolitan Health Service employees, including human resources personnel who provide services to PMH, had been involved. The sessions focused on the role of Corporate Governance and accountability issues. General information on misconduct and the requirement to notify the Commission of suspected misconduct was covered. It did not address the issue of managing misconduct, nor the concept of a whole of agency misconduct management mechanism, nor identifying misconduct risks. There was no evidence that these sessions had had any effect at PMH.

[63] There appeared to be no compulsory education and awareness training provided to doctors at PMH that focused on the issue of misconduct. One medical manager commented that:

> *… ethics training might be contained in documentation, but it's not formally taught …*

> *… I don't have any corporate training – I'm a doctor. You learn as you go, and you're very vulnerable. I try to act as a manager and tell people what to do if they're underperforming in some way, and then you're accused of bullying … I'm afraid to even say anything to staff that's negative …*

[64] Overall, the misconduct-related training and education sessions run for PMH employees were delivered in a fragmented way, without addressing misconduct in an organisational context. There was insufficient importance placed on the issue. Many staff commented about the inadequacy of training offered, not only in misconduct but in management skills more generally.

2.2.3 Risk Management

[65] There was no overall risk management plan for PMH. Misconduct risks, particular to each of the diverse work areas in the hospital, had not been formally identified.

[66] The hospital's Safety and Quality unit was responsible for developing the hospital's risk management plan. Work had commenced in this regard. In discussions about the risk management process, one manager commented that they:

> *… would now consider misconduct as a risk, and what it might look like …*

2.2.4 Fraud and Corruption Control

[67] Fraud and corruption are aspects of misconduct. Corporate Governance has developed a *Fraud and Corruption Control Plan*. This Plan was released in January 2007, and once fully implemented was intended to "provide an appropriate strategic framework for managing and preventing fraud and corruption across WA Health".[9] This was not reflected in developments at PMH.

2.2.5 Identifying Misconduct

[68] PMH did not have policies or procedures that formally focused the attention of managers and their staff on misconduct. There were, however, several processes within the hospital's structure that involved receiving and dealing with information that may contain evidence of, or references to, misconduct. While these processes had no particular policy focus on misconduct, or on misconduct management responsibility, they did provide "windows" through which the organisation might gain a view about possible misconduct across the agency, and may provide the opportunity to address the issues identified both individually and collectively. These "windows" included the customer complaints process, the Parent Advocate, the Advanced Incident Management System, the Child Protection Unit, Mediation and Legal Support Services, and the performance management process.

[69] The Commission believes that if these "windows" were integrated to inform PMH about misconduct risks, including the types, frequency and severity of occurrences, the hospital would be better able to identify, report and ultimately prevent misconduct.

2.2.6 Recording Misconduct

[70] There was no system in place at PMH to routinely and reliably record misconduct issues. Such records that did exist were kept at the discretion of individual managers. Record keeping depended largely on each manager's personal practices, their perception of the nature and seriousness of the issue, who the subject of the allegation was and the particular circumstances. This resulted in inconsistent practices with varied recording arrangements at the local level. Some matters were recorded, some were not; some were recorded on a manager's computer, some were kept as hardcopies on a physical file. None of the records found their way onto a central database of misconduct issues.

> *… there is a recurring theme that issues are not recorded well from area to area …*

[71] Each of the processes outlined at "Identifying Misconduct" above had its own database for recording relevant information. The exception was the performance management process, which did not have a database or central register of staff that were, or had been, subject to performance management conditions. Only the customer complaints process dealt with

identified misconduct, which it categorised as "professional conduct". One manager commented that:

> … *we need to think about where such conduct-related information and reports could be gathered, as information is gathered all the time …*

2.2.7 "Managing as Best you Can"

[72] As an overall proposition, interviews of managers across PMH revealed that they managed misconduct "as best they could", i.e., they knew little, if anything, about misconduct or how to manage it. Therefore, when they encountered misconduct they did the best they could to deal with it, among other competing priorities and without support from a system. Perhaps predictably in the circumstances – and significantly – they did not consider managing misconduct as being part of their core business responsibilities.

> … *health culture is very different from the rest of the public sector* – [we're] *so focused on "making people better" that people can forget about systems, codes etc. …*

> … *the cultural view of misconduct management is that it is extra work … staff are busy, under-resourced and are trying to do the right thing …*

[73] There was uncertainty about what misconduct or misconduct risks looked like in the context of the services delivered at the hospital, or in the business activities associated with this service delivery. A significant number of managers and directors stated that misconduct had not been a management issue for them and that "never having to deal with misconduct" in their work area was to some extent a matter of "luck". They often acknowledged, however, that they and their staff might not know what constituted misconduct.

2.2.8 PMH Workplace Culture

[74] The PMH staff interviewed generally held the view that as professionals, they and their colleagues were ethical. In their view, therefore, misconduct was unlikely to occur. This was particularly so for clinical staff, where:

> … *professions have codes of ethics and conduct, and minimum standards already built in …*

[75] Similarly, it appeared there was a reticence by staff to turn their minds to the possibility of a colleague acting inappropriately with a child. One manager commented that hospital staff were generally "unsuspecting" of colleagues, that they did not want to think inappropriate conduct was possible and that staff awareness for identifying a child abuser was as low as for the rest of the community.

… I think it's very difficult for a paedophile to get into the PMH system, but if they did, I don't think any of us would even know …

… [staff] think "that'd never happen here" *…*

[76] The consistent view expressed by managers was that they would find out if misconduct was occurring in their work area because others would inform them, by "knowing" when and what to report:

… I rely on supervisors and managers to look out for behaviour – they are my eyes and ears …

[77] Many staff indicated that there was a "silo mentality" in the hospital environment, and that the medical area was particularly insular when confronting and dealing with misconduct:

… staff close ranks …

… medicine is an old boys' club … there's a culture of "don't dob in your mates" …

… there is a culture in medicine not to tell the truth … you'd manage someone until they become someone else's problem …

2.2.9 Management Discretion

[78] Management discretion influenced whether misconduct was reported to the next tier of management or was dealt with at a local level. It was evident that when hospital management became aware of important information relating to an employee's behaviour, there was a reluctance to pass that information on to others with management responsibility for the individual concerned.

[79] The following list details the most commonly expressed influences on managers and directors in the exercise of their misconduct management responsibilities.

(1) **Devolved management style:** the expectation that managers should deal with issues at their operational level and not refer matters (including misconduct matters) or seek advice unless it is essential.

… problems may occur if they [managers] *think they have to sort everything out at their level … they might see it as a failure if they fail to keep something under control or in-house ...*

(2) **Compromise/conflict:** operational and clinical impacts were considered in deciding how to respond to a misconduct issue and what action to take, particularly with regard to discipline and how seriously to treat a matter.

… with it being so hard to find and hold onto staff, it [a situation involving misconduct] *may not be managed as*

impartially as it should be if I [had] *a formal process* [to use] *…*

(3) **Inexperience:** personal experience in dealing with misconduct matters specifically, or of management generally, shaped how managers would act in future.

> *… I use my experience, rather than a set process … I would be better able to handle the situation* [involving misconduct] *if it arose again, purely because I have had to manage it before …*

(4) **Limited understanding of misconduct:** there was a generally acknowledged lack of awareness of the nature of misconduct in the hospital setting.

> *… we know the difference between what we should and shouldn't do clinically, but behaviourally, not so much … the level of misconduct awareness is low …*

(5) **Lack of management skills:** several managers stated that they were not managers but clinicians – "one day you're a doctor or a nurse, the next day you're a manager" – and as such they were not properly equipped to deal with management-related tasks, misconduct management being one of those.

> *… there is no manual, nothing to show me what to do …*

(6) **Peer views:** advice about what action to take was often sought from those that have had misconduct management experience.

> *… you rely on peer support and advice … you hope it's one good doctor talking to another …*

(7) **Perceptions:** how serious an issue was perceived to be influenced how managers reacted to it.

> *… nothing is written to say "here's the bar" and below it is a management issue and above it it's something else … it's based on a manager's assessment …*

(8) **Values:** an individual's own "sense of right and wrong", and their own ethical standards, influenced how a situation was defined (being misconduct or not) and consequently how it was managed.

> *… clearly my own standards guide me …*

> *… people have different moral compasses …*

(9) **Management associations:** with an effective working relationship, managers were more likely to report to and engage with senior management when dealing with misconduct. If there was a tenuous working arrangement, managers were more likely to "manage in" and not report misconduct.

> *… behaviour of staff, and finding out about problems, relies heavily on staff and director relationship with managers …*

(10) **Relationship with and perception of the role of the human resources (HR) and industrial relations (IR) offices:** managers who had a positive experience with HR/IR were more likely to engage them during the process of managing an allegation of misconduct. This was also true for those managers who saw the role of HR/IR being one of people management.

> *… it's how I approach HR – if I approached them differently, the relationship would be different …*

(11) **Application of the performance management process:** management of "substandard performance directly attributable to the employee" using the performance management process encouraged managers to consider a range of explanations for behaviour other than misconduct, and to deal with issues in isolation.

> *… you might deal with it* [a person's behaviour] *as a performance management issue … it's not necessarily picked up as "misconduct" …*

(12) **Familiarity with the disciplinary process (dealing with misconduct):** Some managers said that in the event of misconduct occurring they would familiarise themselves with the disciplinary process – a reactive measure. Few managers appeared to have used this process.

[80] Several managers and directors referred to the management of misconduct within the hospital as being ad hoc, and that:

> *… different managers deal with* [misconduct] *issues in different ways – no question of that …*

[81] PMH is a large hospital that delivers an extensive health care system to children. It faces significant misconduct risks, both in terms of the likelihood of misconduct occurring and the consequences of misconduct.

[82] PMH did not have an effective misconduct management mechanism in place to deal with these misconduct risks. Critical weaknesses in PMH's approach to dealing with misconduct included the following.

(1) Misconduct was dealt with on an ad hoc rather than core business basis.

(2) Although policies and guidelines existed to address behaviour, and in some cases elements of misconduct, they were not coordinated and provided little assistance to direct managers in identifying, managing and reporting misconduct.

(3) Training and education programs were fragmented and, significantly, did not engage doctors.

(4) A risk management plan did not exist.

(5) Managers knew little, if anything, about misconduct and how to manage it. To the extent that they did try to manage misconduct, practices varied widely.

[83] On that basis, the Commission formed the opinion that PMH did not place sufficient weight on managing misconduct as part of its overall management strategy. PMH was unable to account to the wider community that it managed its significant misconduct risks in a demonstrably fair, reliable or transparent way, i.e., it did not have in place an effective misconduct management mechanism, albeit elements of such a mechanism existed.

2.2.10 PMH Recommendations

[84]

The Commission made the following recommendations.

(1) That PMH develop a misconduct management plan for the prevention and management of misconduct across the organisation.

(2) That PMH develop a risk management plan and clearly identify and detail the misconduct risks that exist.

(3) That PMH develop a whole of organisation misconduct management mechanism.

(4) That PMH develop a function within its structure that has standards of conduct as its primary responsibility, overseen by a senior executive directly responsible to the Executive Director.

(5) That PMH, in conjunction with the Commission, develop an education and training package about misconduct prevention and response. This package needs to raise and maintain awareness among all PMH staff and managers of their obligations and responsibilities when dealing with misconduct matters.

[85] The Department responded to the PMH draft working paper by highlighting the need for a "whole-of-Health" approach. Indeed, the Department suggested rewording the recommendations, so as to refer not to PMH but to WA Health, and to recognise PMH "in the context of the organisational structure of WA Health". The Action Plan provided in the response was created after consultation with PMH management, "in order to ensure that the recommendations will be able to be implemented across both the whole sector generally, and PMH specifically".

[86] The Commission supports a "whole-of-Health" approach to managing misconduct, and refers to the approach in each of its working papers to the Department.

2.3 WA Country Health Service (WACHS): Kimberley Review (December 2007 - April 2008)

[87] The second of the WA Health reviews was WACHS-Kimberley, including Broome and Derby hospitals. The review team conducted 35 interviews with managers (including "frontline" managers, such as nurse managers) and directors, and again looked at the organisational structure and relevant policy, procedure and legislation.

[88] The process involved the following:

(1) identifying the business objectives and structure;

(2) identifying the approach to misconduct management and prevention;

(3) considering relevant legislation, policies, procedures and practices with respect to staff conduct/misconduct, including complaint, grievance and performance management systems;

(4) analysing relevant documents and files;

(5) interviewing management, both clinical and non-clinical, in key areas; and

(6) establishing what misconduct issues existed, whether they were properly identified and managed, and how they were recorded.

2.3.1 Policies and Guidelines

[89] In the absence of a coordinated and cohesive system, there were various policies and guidelines relevant to managing misconduct at WACHS-Kimberley.

[90] Staff referred to the *WA Health Misconduct Policy*. This defined misconduct under the CCC Act, and directed individuals to report "incidents that were considered misconduct" to Corporate Governance prior to initiating any action. It did not outline a system or process for doing so, nor give examples of what might constitute misconduct specifically in a health setting.

[91] Policies provided to the Commission in the course of the review addressed aspects of expected behaviour, and in some cases elements of misconduct. However, they were not coordinated in terms of having a misconduct focus or system to use, and provided little information to direct managers in identifying, managing and reporting misconduct. The way in which misconduct was addressed also left many staff with an inadequate understanding, and ability to identify and report misconduct.

2.3.2 Training and Education

[92] Overall, there was very little conduct-related training delivered across WACHS-Kimberley. Like the PMH review, some managers expressed the view that because staff belonged to a particular professional group (for

example, nurses or doctors) their ethics training was an inherent part of their professional training, and therefore they should act ethically.

> *… medical training and collegiate associations have an ethical element attached …* [with respect to misconduct] *the colleague in me thinks "there but for the grace of God go I" … we all have our weaknesses …*

[93] However, other managers commented on the inadequacy of the formal training offered with respect to misconduct particularly, and management skills more generally.

> *… we need to look at an orientation for new managers …*

2.3.3 Risk Management

[94] Risk management planning at WACHS-Kimberley did not adequately deal with the identification and management of misconduct risk. Misconduct as a risk particular to the range of functions carried out at Derby and Broome hospitals, and more widely across the region, had not been formally identified. To the degree that there was any clear risk management focus within WACHS-Kimberley, this was directed only at clinical risk.[10]

> *… clinical risk is very well done … would it be fair to say government agencies treat misconduct risk as very, very low because they don't understand it? …*

[95] Discussion with managers about misconduct as a risk produced varied responses, from the quite surprising dismissal of the matter as an issue of no concern at all, and having the view of being too busy to be concerned – "we don't have any major misconduct risks" – to those who expressed serious concerns about the risk in the environment in which they worked, and about the prospect that misconduct was (or was likely to be) occurring within the health setting – "what about [misconduct risks like] blurring of professional boundaries, or inappropriate services, like [over] prescribing". This divergence of view seemed to reflect two distinctly different service areas within the health service. Those expressing greater awareness and heightened concern generally came from non-clinical areas.

2.3.4 Fraud and Corruption Control

[96] Fraud and corruption are elements of misconduct. WA Health has developed a *Fraud and Corruption Control Plan* to "provide an appropriate strategic framework for managing and preventing fraud and corruption across WA Health".[11] The Plan and its implementation is the responsibility of Corporate Governance. The Plan was released in January 2007. Formal implementation of the Plan was not evident in WACHS-Kimberley. Prior to the review, there had been an increased focus on the need for managers within WACHS-Kimberley to report incidents of misconduct and for the Commission to be notified of misconduct matters. It was not evident that this focus was linked to the implementation of the Plan. Rather, it seemed from staff comments to have been raised as a matter of compliance with the requirements of the CCC Act.

2.3.5 Identifying Misconduct

[97] WACHS-Kimberley did not have policies or procedures that formally focused the attention of managers and their staff on misconduct. There were, however, several processes within the service's operating structure that involved receiving and dealing with information that may have contained evidence of, or reference to, misconduct. While these processes had no particular policy focus on misconduct, or on misconduct management responsibility, as with the processes at PMH similar but different they did provide "windows" through which the organisation might gain a view about possible misconduct across the agency, and may provide the opportunity to address the issues identified both individually and collectively. These processes included the Advanced Incident Management System (AIMS), customer complaints, grievance resolution, performance management, and the WACHS corporate incident management process.

[98] The Commission believes that if these "windows" were structured in an integrated way to inform WACHS-Kimberley about misconduct risks, including the types, frequency and severity of occurrences, together with a heightened level of misconduct awareness across the service, it would assist WACHS-Kimberley to identify, report and ultimately prevent future misconduct.

2.3.6 Recording Misconduct

[99] There was no system in place to routinely and reliably record misconduct issues. There were inconsistent approaches to:

(1) what, if anything, was recorded by managers;

(2) where the records were kept; and

(3) how "formal" the records were.

[100] Practices varied widely, from records consisting of a manager's file note or diary entry kept at a local level, to a formalised database in the case of the AIMS and WACHS Corporate Incident Management processes. However, none of the records were consolidated in a centralised way to inform the service about the nature, location and types of misconduct occurring or allegedly occurring in the Kimberley health system.

> *… paperwork?* [Misconduct matters] *should be documented, but where, I don't know …*

2.3.7 Managers' Perspective

[101] In the circumstances at the time, there was no effective misconduct management mechanism within WACHS-Kimberley, i.e., there was no coordinated, cohesive approach to managing misconduct. As a consequence, awareness of the issue of misconduct – what it looked like, the risk of it occurring and where, and how to prevent it or deal with it – was low, and WACHS-Kimberley could not say with any certainty whether

misconduct was occurring or not. Predictably, opinions about misconduct as a management issue varied widely. It was important for the purpose of this review, and for understanding the Commission's assessment, to consider managers' views in more detail. Consequently, interviews with managers were conducted. Sections 2.3.7.1-2.3.7.4 below canvass matters that were revealed by managers during these interviews.

2.3.7.1   Do I Know what Misconduct Is?

[102]   In the main, managers were uncertain what "misconduct" meant, other than referring to it in the context of the behavioural expectations described in the Code of Conduct.

> … I think that's the problem, the problem with what misconduct "looks like" …

2.3.7.2   Are there Misconduct Risks?

[103]   Generally, the level of awareness and understanding of misconduct was low, and it was not considered to be a significant management issue.

> … there's no out and out dishonesty or pilfering …

[104]   Even with the low level of misconduct awareness, it was interesting that managers often described a wide range of misconduct risk factors and situations that were considered likely to impact on their business areas. Many of these were specific to the delivery of health services in the remote regional setting.

> … there's a potential for favouritism, with the hospital versus the community versus familial information … it's small town syndrome …

> … some of our staff work alone in remote areas …

[105]   There were several managers who had a strong view about misconduct being a clear risk, and that misconduct was occurring.

> … there's a lot I'm not comfortable with … I'm concerned greatly about what's going on …

> … people within the hospital could abuse the imprest with the amount and types of items available, for example, syringes …

2.3.7.3   How Would I Know Misconduct is Occurring?

[106]   The common view was that managers would find out about misconduct occurring in their work area because their staff would inform them or they would simply "sense" that something was amiss. A range of factors influenced managers' beliefs about this.

(1)   The teams were mostly small and members worked closely with one another.

> *… it's such a small hospital that 99%* [of misconduct matters] *come through* [to management] …

(2) Staff "knew" when to raise or report a matter.

> *… [the need to report] is informal, but it's known – the hierarchy of the reporting structure directs them, they know …*

(3) There were close and trusted relationships between managers and staff.

> *… being here longer you have personal relationships and know you can go to* [management to report] …

(4) Managers made it practice to be visible and approachable.

> *… people will tell me things, and I wander around and can "feel" what's going on …*

(5) In this environment there was heightened awareness and communication.

> *... people in a rural setting will talk more candidly, won't let it go …*

[107] Despite the consensus view, there were some managers who were not confident that they would find out about misconduct occurring.

> *… people experiencing concern, but who have to live and work in that environment, are scared to speak up for fear of what will happen …*

2.3.7.4 How Would I Deal with It?

[108] In the main, managers indicated that in responding to a misconduct matter, they would refer to one or all of the following for advice, and proceed on that basis – the regional human resources office, their line manager or, in a hospital setting, the hospital operations manager.

[109] A number of managers believed there was a process to follow but were unclear what it was. There were also those who would deal with a misconduct issue at their local level on the basis of their instinct and who would only escalate the matter or "manage up" if resolution could not be achieved, or in those instances where they considered the issue was sufficiently serious.

> *… sometimes a gut feeling tells you, you should react, but more senior people might say "no, just wait" …*

[110] Of those managers who had an awareness of the requirement to report misconduct (either internally or to the Commission), there was no sense that they understood the importance of reporting other than in terms of

compliance, or that they had any greater understanding of how to handle a misconduct matter.

> *… even those people who have been around for a long time like me aren't sure on reportable incidents, where I might take a really hard line on something someone else will say "jeez, that's not that bad" …*

[111] A range of factors were raised in discussion as influences affecting a manager's response to misconduct. Some of the more significant included those in the following list.

(1) The manager's level of management skill or experience.

> *… you can move from a clinical setting into a management setting and it's scary – often it's without any management training or experience …*

(2) The likely impact of their response on the delivery of the health service – the focus on and need to maintain service delivery, and the affect on health outcomes.

> *… resourcing issues mean that you might let something go …*

(3) The impact their response would have on their working and personal relationship with the staff member – there was often comment by managers that having a system and the intervention of an independent or third party in the process would assist.

> *... lots of people who work for me I'm friends with outside of work, so I prefer for someone else to investigate …*

[112] The review concluded that WACHS-Kimberley delivered a range of services to a large regional and remote area. It faced significant misconduct risks, both in terms of the likelihood of misconduct occurring and its consequences.

[113] WACHS-Kimberley did not have an effective misconduct management mechanism to manage misconduct and the misconduct risks. Critical weaknesses in WACHS-Kimberley's approach to dealing with misconduct included the following.

(1) There was little awareness of the nature of misconduct or of misconduct risk as an organisational or management issue.

(2) There was no risk management plan – misconduct was not identified as a risk.

(3) Training and education contained little reference to conduct or misconduct.

(4) Changes to the regional management structure and reporting lines for the various health service streams complicated the approach to misconduct management.

(5) WACHS-Kimberley did not have policies and procedures that formally focused the attention of managers and staff on misconduct.

[114] On that basis, the Commission formed the opinion that WACHS-Kimberley did not place sufficient weight on managing misconduct as part of its overall management strategy. The Commission's view was that WACHS-Kimberley was unable to account to the wider community that it effectively managed misconduct, that it handled the issue in a demonstrably fair, reliable and transparent way, or that it knew where it was vulnerable in relation to its misconduct risks, i.e., it did not have in place an effective misconduct management mechanism, albeit elements of such a mechanism existed.

2.3.8   WACHS-Kimberley Recommendations

[115]

> The Commission made the following recommendations.
>
> (1) WACHS-Kimberley develop a misconduct management plan for the prevention and management of misconduct across the service.
>
> (2) WACHS-Kimberley develop a risk management plan and clearly identify and detail the misconduct risks that exist.
>
> (3) WACHS-Kimberley develop a whole of service misconduct management mechanism.
>
> (4) WACHS-Kimberley develop a function within its structure that has standards of conduct as its primary responsibility, overseen by a senior executive directly responsible to the Regional Director.
>
> (5) That WACHS-Kimberley, in conjunction with the Commission, develop an education and training package about misconduct prevention and response. This package needs to raise and maintain awareness among all WACHS-Kimberley staff and managers of their obligations and responsibilities when dealing with misconduct matters.

[116] WA Health responded to the WACHS-Kimberley working paper by again referring to their "whole-of-Health" approach to managing misconduct. The response noted that:

- *the organisation has an existing misconduct management mechanism;*

- *improvements have been made to that mechanism, but the effects are only beginning to become apparent;*

- *the organisation, its component entities and administrative units are continuing to participate in the process of reforming public health in Western Australia;*

- *the framework of policies relating to conduct, misconduct, fraud and related subjects is being reviewed and revised to affirm a whole-of-agency approach;*

- *there has been a consolidation and improvement in complaint administration processes;*

- *a revised education and misconduct awareness program has begun being rolled out;*

- *steps have been taken to reinforce risk management's role in preventing and identifying misconduct; and*

- *there has been a significant increase in misconduct reporting.*

[117] The response went on to say:

> *… [a]s noted in previous correspondence, WA Health, in responding to the CCC's draft report on PMH, developed an Action Plan that reviewed all recommendations made by the CCC and established timelines for implementing appropriate action. We believe that the majority of items identified in the Action Plan are consistent with those that seem likely to arise from the CCC's review of WACHS-Kimberley …*

[118] Again, the Commission supports a whole-of-agency approach to managing misconduct. However, the only way to assess the effectiveness of a misconduct management mechanism across an agency is to test it at the site level.

2.4 Drugs Management Review

2.4.1 Background and Purpose of Drugs Review

[119] The PMH and WACHS-Kimberley reviews in Sections 2.2 and 2.3, in combination with notifications[12] made to the Commission, highlighted the lack of a cohesive approach to managing misconduct, and within that, a significant misconduct risk relating to the management and handling of Schedule 8 and Schedule 4 drugs. The Commission determined a thematic review into this issue was required. The review "Misconduct Handling Procedures in the Western Australian Public Sector: the Management and Handling of Schedule 8 and Schedule 4 drugs within WA Health" ("drugs review") was completed in January 2009.

[120] The drugs review used information gathered from 10 WA Health hospital sites and the Department centrally to determine:

(1) the management and handling of Schedule 4 and Schedule 8 drugs in hospitals; and

(2) the management of drug-related misconduct.

[121] There were three methodologies used in the drugs review:

<blockquote>

(1) interviewing managers with responsibilities for managing, dispensing and administering Schedule 8 and Schedule 4 drugs at each site;

(2) identification of management practices and procedures; and

(3) observation of storage, access and accountability arrangements.

</blockquote>

[122] In order to gather sufficient information to form a representative view, the following metropolitan and country hospitals were visited:

<blockquote>

(1) King Edward Memorial Hospital for Women;

(2) PMH;

(3) Fremantle Hospital;

(4) Kaleeya Hospital (East Fremantle);

(5) Rottnest Island Nursing Post;

(6) Swan Kalamunda Health Service (Swan and Kalamunda Campuses);

(7) South West Health Campus (Bunbury);

(8) Margaret River Hospital;

(9) Albany Hospital; and

(10) Katanning Hospital.

</blockquote>

[123] Meetings were also held with the Department's Director, Disaster Management, Regulation and Planning (including the Pharmaceutical Services Branch) and with the Department's Chief Pharmacist.

[124] In the course of this review, 126 interviews were conducted. These were held with:

<blockquote>

(1) executive directors;

(2) regional directors;

(3) directors of nursing;

(4) directors of a range of medical/clinical service areas (including anaesthetics);

(5) managers and coordinators in wards, theatres and emergency departments;

(6) pharmacists; and

(7) where appropriate, managers with corporate responsibilities relevant to the review.

</blockquote>

[125]   The review focused on actual practice, as opposed to written policies or procedures.   These practices were considered from a misconduct management and misconduct risk perspective.

2.4.1.1   Legislation

[126]   Schedule 8 drugs are dangerous and addictive and include opioid analgesics and amphetamines.   Schedule 4 drugs include the benzodiazepine group, anaesthetic drugs and analgesics.   The management and control of Schedule 8 and Schedule 4 drugs is regulated by the Poisons Act and the *Poisons Regulations 1965* ("the Poisons Regulations"), although there is limited reference to the public health system or to public hospitals.   Nonetheless, adequate regulation and control of drugs is intended through this legislation.[13]

2.4.2   Management of Schedule 8 and Schedule 4 Drugs

[127]   The responsibility for day-to-day management of scheduled drugs in hospitals appeared to be informally shared between pharmacists and nurse managers.   Pharmacists and nurse managers exercised this responsibility to varying degrees, on the understanding that certain aspects of security, control and accountability were, or would be, dealt with by the other (whether or not this was actually so).

[128]   For example, some pharmacists believed discrepancies involving drugs should be brought to their attention by nurse managers, who they believed were responsible for drugs once they left the pharmacy.   Conversely, the detection of excessive use of drugs was considered by many nurse managers to be a primary responsibility of pharmacy – should there be unexplained increases these would be identified through pharmacy processes and brought to their notice.

> *… nurses for us are our greatest ally … they're the ones who will tell us about discrepancies …*

> *… pharmacy would draw attention to it if there were questions of usage …*

[129]   There was little evidence that nurse managers and pharmacists consider broader management responsibilities, or have any wider focus on the issue of drug management within the hospital setting, other than is relevant to clinical service delivery and their immediate area of activity.

[130]   The arrangement of informal, shared responsibility, and the absence of a misconduct risk approach to managing scheduled drugs, created undesirable and unacceptable security issues. It created a situation where there were often vague and inconsistent practices within and across hospital sites that left the way open for system abuse and misconduct by staff.[14]

[131]   The lack of certainty surrounding who is and should be responsible also existed at an executive level of the Department. As a consequence, there was a lack of clear direction and focus in relation to practices, and a lack

of awareness of misconduct risks. There was no coordinated and cohesive management strategy in place.

2.4.3   Practices

[132] The four main functional areas with respect to drugs in hospitals are general wards, theatres, emergency departments and pharmacies. The following sections outline the practices in these areas for the management of Schedule 8 and Schedule 4 drugs. The "clinical" areas (wards, theatres and emergency departments) will be considered together. Pharmacy areas and practices will be considered separately.

2.4.3.1   Wards/Theatres/Emergency Departments

Storage

[133] In all sites assessed, Schedule 8 drugs were stored securely and in accordance with the provisions of the Poisons Regulations. At most sites the Schedule 8 cupboard was "double-locked" (either a cupboard had two separate external locks, was a locked cupboard within a locked cupboard, or was a locked cupboard within a locked room).

[134] Schedule 4 drugs were generally stored in lockable cupboards, although due to operational requirements, these cupboards were sometimes left unlocked.

[135] At several sites, it had become practice to store Schedule 4 drugs considered to be "of interest"[15] with Schedule 8 drugs, in double locked storage. This usually resulted from some experience with these drugs, such as:

(1) suspicious breakage, damage or tampering with drug packets/ampoules;

(2) drugs being unaccounted for or lost (due to theft, being misplaced, use not being recorded, accidental destruction etc.);

(3) increased use in a little-used drug, or of a drug with a small stock holding; or

(4) concern about excessive use of a drug (particularly drugs such as Panadeine Forte and benzodiazepine drugs).

[136] The practice of locking a Schedule 4 drug "of interest" had, in some cases, only been a short-term reactive measure to discourage inappropriate access.

> *… a few years ago we had problems with Panadeine Forte and in each area it was required to go into the cupboard and be recorded … it stopped the activity … it was in one area initially but that person moved around and the other areas were affected … eventually they left …*

> *… we started counting* [Panadeine Forte] *like Schedule 8 and the problem* [of unaccounted use] *stopped*

> *… certainly the incident with the doctor* [stealing and using Schedule 4 medications] *made us change our protocol where some Schedule 4s are treated differently …*

Access/Security

[137] At a number of sites, managers expressed concerns about the location of their Schedule 8 and Schedule 4 cupboards that were either relatively isolated, making observation of staff access difficult, or situated where public access was possible. Particular arrangements for storing scheduled drugs depended on the physical layout and structural limitations of hospital areas, and on individual hospital policies.

> *…* [Schedule] *8s are locked in a cupboard but it's in a public thoroughfare … it's not legal …*

> *… plenty of people can just wander in after hours or during the day and access the drugs room … there's no security swipe on the doors, anyone could go in …*

> *… there are two doors into the ICU* [Intensive Care Unit] *and if all the nurses have their backs to the doors then anyone can come in and grab stuff and disappear down the fire escape …*

[138] Schedule 8 cupboard access required the attendance of two nurses. In theatres it was not uncommon for only one person, either a registered nurse or anaesthetic technician, to obtain Schedule 8 drugs requested by the anaesthetist.

> *…* [the anaesthetist] *asks through me and I* [anaesthetic technician] *ask the nurse … the nurse gets the drugs …*

[139] Only one nurse was required to dispense Schedule 4 drugs from a storage facility.

[140] In theatres both Schedule 8 and Schedule 4 drugs were sometimes placed on top of the anaesthetic trolley for the anaesthetist to access. Theatre and resuscitation trolleys were not always lockable units, and those that were, were not always locked. In some instances, it appeared that the trolley was left unattended and unsecured for a period of time.

[141] Anaesthetists may order (verbally or in writing) scheduled drugs on an individual patient basis. These drugs may be issued immediately prior to each separate procedure, or in multiples according to a procedures list for a theatre session, or in large doses.

> *… instead of getting five or six ampoules one at a time, they'll get one big multi-dose vial … it saves times … it's laziness …*

[142] The specific nature of emergency departments meant Schedule 4 drugs may be stored on open shelves for ease of access. Schedule 8 drugs

may also be drawn and set out in the treatment area in advance of a patient arriving at the emergency department.

> *… we might have to get drugs up for someone who hasn't even rocked up yet, which sounds crazy out of context, but in the* [emergency department] *context it's not …*

[143]   Control of keys for access to Schedule 8 cupboards in general wards and emergency departments was generally strictly managed, with one senior nurse manager or coordinator for the shift holding and assuming responsibility for the keys. In the main there was only one set of keys available, but there were some exceptions where two and three sets were in use. To some extent key control practice depended on individual ward circumstances, and a large degree of trust.

> *… I was shocked when I first started that someone asked for "another copy" of the DD* [Schedule 8] *key … there was more than one! …*

[144]   In theatres, key control for Schedule 8 drug cupboards was significantly different to the predominant practice in wards and emergency departments. In theatre areas, there was often more than one set of keys in use and a number of different persons accessing the same cupboard.

> *… there are four theatres … there's a* [Schedule 8] *cupboard between each theatre and one in recovery …*

> *… there's a big drug room in the middle that's accessed by all the theatres …*

[145]   At all sites reviewed, key control for Schedule 4 drugs was the responsibility of nominated registered nurse(s) but there was sometimes more than one set of keys in use amongst the registered nurses on duty. Keys changed hands each shift.

[146]   In some locations Schedule 4 drugs were kept locked in the patient's bedside cabinet (all drawers in a ward are keyed alike) and the nurses allowed to access and administer drugs held the key.

Registers/Checks

[147]   Registers were used by all hospitals to record Schedule 8 drug holdings and daily usage. This recorded: drugs requested; drugs removed; the return of unused drugs; the daily count of drugs on hand; drugs resupplied by pharmacy; and the patient's own drugs. The recording of the actual amount of drug(s) administered to patients and the amount of drug discarded was not always recorded in the register.

[148]   Schedule 4 drug holdings and daily usage were only recorded at the discretion of the nurse managers.

[149]   Checks on Schedule 8 drugs were limited and relied almost solely on the daily counts conducted by nursing staff (this is not a comment about

checks on the clinical aspect of administering drugs to patients). While nurse managers were confident daily counts were carried out, there were no separate, independent checks conducted to verify that the Schedule 8 holding was correct.

> *… to be honest, I don't know if* [the pharmacist] *checks routinely … I can't say I've noticed her checking with someone … whether she should be checking … maybe she is? …*

> *… I think pharmacy sometimes audits the books but I don't know … I'm not aware of other management checking …*

> *… no* [we don't have random checks] *only because we don't have a problem with them* [Schedule 8 drugs] *going missing …*

[150] Some nurse managers conducted their own checks of whether the registers were completed during the shift, but did not record those checks. Some nurse managers were concerned about the delay in detecting discrepancies, due to counts usually being conducted only once in 24 hours.

[151] In theatres, dispensing of a Schedule 8 drug might not have been recorded on the register immediately, especially when more than one theatre accessed a single drug cupboard. Likewise, the amount of drug destroyed/discarded (when known) may or may not be recorded in the register.

> *… there's one register so things would be happening simultaneously* [in different theatres] *and then filled in* [the register] *…*

[152] Anaesthetists may take an unused or partly used theatre-issued drug with them if they escort the patient to the recovery area. While the amount of drug administered in the recovery area was usually recorded on the patient medication chart, it was unlikely to be recorded in the theatre Schedule 8 register.

Disposal/Discarding of Drugs

[153] Discarding partly used Schedule 8 and Schedule 4 drugs was generally considered the responsibility of the nurse or doctor who drew the drug, although this was not a clearly assigned responsibility. The amount of drug destroyed/discarded (when known) may or may not be recorded in the register. The discarding process may or may not be witnessed.

> *… we like it to be witnessed when it's thrown away … but it doesn't always happen …*

> *… waste disposal is the big risk … it gets joked about … "who wants half" …*

... if you draw 10 mL of morphine and only administer 5 mL, who's to say what happens to that? ... someone could say and sign off "I administered 10 mL" ... how do you control that? ...

[154] The procedure for discarding was unclear. Depending on circumstances, the nurse or doctor may put the waste drug – either syringe or ampoule – in a "sharps" container, or empty the contents into a sink.

... I don't know what to do with leftover syringes, whether to throw them into the bin or into the sharps ...

[155] Some doctors did not advise how much of a scheduled drug was used during treatment and/or how much was discarded. Some nurses indicated they would not question the doctor.

... we [nurses] presume that if [the anaesthetist] draws 10 mL and uses 5 mL that 5 mL is discarded ... it's cumbersome [to record] in theatres ... that's where the misuse can occur ...

Transport/Transfer of Drugs

[156] Drugs were "loaned" between wards, theatres and emergency areas. This was mostly after hours or on weekends, when pharmacy staff were unavailable. Movement of Schedule 8 drugs was recorded. Different hospitals approached this process differently. Transfers were made by either moving registers, medication charts or both to the "loaning" ward.

[157] Physical transport of Schedule 8 drugs from one ward to another was a concern, given the strict controls required for dispensing and administering.

... one person can bring the drug in a brown paper bag, but two people have to sign and administer ...

[158] The processes for transferring Schedule 4 drugs were much less controlled. The drug type, amount, wards transferred to and from, and the patient details were not usually recorded by nursing staff involved in the process. As a result, neither nursing nor pharmacy staff could track the movement of Schedule 4 drugs within hospitals.

... with Schedule 4s there's almost no process [for giving drugs to other wards], it'd just be "have you got X?" and "yeah, come and grab it" ...

... there's nothing to stop someone saying "I need 5 for ward X" when really it's for them ...

... pharmacy can't track Schedule 4s between wards ...

[159] At some of the sites reviewed, scheduled drugs were couriered externally (either by contractors or staff) from:

(1) suppliers in Perth to hospitals;

(2)   regional to district hospitals and nursing posts as general supply;

(3)   between hospitals as "loan" items (where a drug cannot be supplied by the hospital pharmacy); and

(4)   the emergency department at one hospital to another, when transferring a patient being treated using scheduled drugs.

[160]   Drugs were labelled so as not to draw attention to the fact that medications were inside.

>*… it says "Urgent Medical Supplies" on the box, not "drugs" …*

[161]   In regional areas, staff often transported the medicines, either during their shift or on their way to or from work. This process was not documented. The hospital needing the drug telephoned the other hospital, asked for the drugs required and gave the name of the person collecting them.

>*… usually we tee up with staff who live close with picking up or dropping off … a patient care assistant might go in a car and get the drugs and bring them back …*

>*… if I was loaning something from* [another hospital] *I'd call and talk to* [the nurse manager] *and say "we'll get someone to pick it up" … it could be the kitchen hand or whoever …*

[162]   When couriers were used, drug parcels were sometimes left with hospital stores "just before" the courier was due to collect the drugs. Stores staff did not sign for the package from pharmacy. Pharmacy kept a copy of the consignment note to say that the drugs had been taken by the courier although this was not signed or sighted by pharmacy. Stores did not keep a copy of the consignment note.

[163]   Schedule 4 drugs were sometimes borrowed from the local community pharmacy if the hospital ran out (usually on a weekend, or because the drug was unusual and not held in stock). Some hospitals did not record loans, others used a whiteboard to temporarily record what drugs were "owed" to the community pharmacy and vice versa, and others kept records in a book.

2.4.3.2   Pharmacy

Hospital Pharmacies

[164]   Hospital pharmacies are the central point of drug holding and distribution in hospitals. Pharmacists and pharmacy staff do not administer drugs to patients. Pharmacists discussed their role and responsibilities for drug management in hospitals in terms of getting the "right drug" to the "right patient", i.e., they talked about giving advice to medical and nursing staff, conducting medication reconciliation and giving advice on legal issues surrounding drugs.

[165]   In pharmacy areas, access to Schedule 8 drugs was restricted, but varied between sites. Access was given to the:

(1)   head pharmacist only;

(2)   head pharmacist plus their staff;

(3)   relevant nurse manager in district hospitals; or

(4)   registered nurses in district hospitals, where the ward supplies come directly from the central pharmacy Schedule 8 stock.

[166]   Security of drugs in the immediate pharmacy area was raised by all pharmacists as being their responsibility.   However, discussions about responsibilities for storage and security of drugs across the hospital site, outside of the pharmacy area, revealed varying viewpoints.

[167]   Some pharmacists believed they were responsible for the security of all drugs in hospital sites, as they held the Poisons Permit.   Other pharmacists said that because their physical control ceased once drugs left the pharmacy, responsibility for drug security was transferred to the nurse manager of the area in which the drugs were held.   Others viewed security as a shared responsibility of nursing and pharmacy staff.

[168]   There was no evidence that management arrangements were discussed or agreed upon between nurse managers and pharmacists, or between pharmacists.

[169]   Security of Schedule 4 drugs in pharmacy areas ranged from being locked in safes, to being left on open shelves with the pharmacy door left unlocked or ajar, allowing relatively free access.   Schedule 8 drugs were locked.

[170]   Pharmacists resupply drug stocks throughout hospitals.   Drugs were supplied on the basis of either a special request from medical or nursing staff, or as part of the routine maintenance of stock through the imprest system.   Checks were done on the imprest levels either by nursing staff, or if available, pharmacy staff.   These checks were not an audit of use against what remains in supply.   They were a count of how much/many drugs need resupply.   Schedule 8 drugs were counted in and signed off by a pharmacist/technician and a nurse from the area to which the drug was being resupplied.   A count was only conducted on the supplied Schedule 8 drugs at that time.   Schedule 4 drugs restocked by pharmacy were not counted in or signed for.

[171]   Some sites had rolling, semi-regular or targeted audits conducted by pharmacy on Schedule 8 and Schedule 4 drugs throughout the hospital, including pharmacy stocks.   This was done to pick up discrepancies in stock holdings, and to look at trends in usage. Because these audits were relatively infrequent, discrepancies could be many months old before they were picked up, thus making it very difficult for the discrepancy to be investigated.

> … [auditing] *happens informally quite regularly …* [pharmacy]
> *have a staff meeting to say "audit this at this time for this drug"*
> *… we check the drugs sent and those used correlates to the*

> *medication chart … sometimes it doesn't correlate … for example, with* [Schedule 4] *Temazepam, we were using 100 boxes a week on a 40 bed ward, using way more than was on the medication charts, so we made ward packs up of 5* [tablets] *each, and now we use 20 packs* [100 tablets] *a week …*

[172]   Many pharmacists believed they and/or their technicians would pick up overuse in the hospital because they "know" what drugs are being used and how many. This was based on aspects like:

(1)   "knowing" the patient profile of an area/hospital and being active on the ward;

(2)   the fact they were responsible for restocking imprests; and

(3)   by keeping imprest levels of drugs low.

[173]   None of these processes was <u>focused</u> on picking up discrepancies; pharmacists would simply "notice" overuse, even though it was not the purpose of the process. Significantly, there was no tie between drugs prescribed and used, even when medication reconciliations were conducted by pharmacy. One example given was that a part-bottle of a Schedule 4 drug may be placed in a patient's drawer. When the patient leaves, the bottle was checked back into pharmacy, but there was no count on what remained in the bottle, to compare it to what was administered according to the chart.

[174]   Several pharmacists interviewed said their pharmacy was unable to detect discrepancies because the stock control database (used for the central drug inventory) was unable to record or report on the required information.

> *… the stock control system is very outdated …*

> *… the records don't show "this much being ordered" versus "this many patients on it" …*

> *… we've all known this* [lack of a pharmacy computer system] *is a huge shortcoming … we've had a couple of serious problems over the years and it took ages to find out …*

[175]   In emergency departments, high volume use of drugs made detection of abnormal usage by pharmacy even more problematic than in other clinical areas. Unless usage was an extreme variation over a short-term period, an unusual increase in use of a little-used drug, or the elevated use of a drug that was held in limited supply, identification, particularly early identification, was difficult.

[176]   Regional and district hospitals presented unique circumstances in relation to pharmacy and drug supply. In regional hospitals, the pharmacist had a dual role, being both the hospital's pharmacist and the region's pharmacist. At the smaller district hospitals reviewed, there was no pharmacist on site. Practical responsibility for drug ordering and control was given to a registered nurse.

[177] The regional pharmacist checked the Schedule 8 registers in district hospitals' pharmacies. Random checks may be done on registers throughout hospitals, although this depended on the individual regional pharmacist's view of their role, responsibility and whether they felt it was necessary to do spot checks.

> … I check the main narcotic [Schedule 8] *book and safe at each regional hospital … I can't check all the wards but I do random checks … I've taken over positions where there's been a good pharmacist, but they've never done checks …*

[178] At sites where a registered nurse had responsibility for drugs on site, there was a perceived lack of advice and support, especially as the role was learned "on-the-job". There was no formal training or explanation provided of the requirements. One nurse commented that it was difficult at small, district hospitals, where "I feel like it's left up to me" to be responsible for drugs. This was in comparison to larger hospitals that the nurse had worked at, where a pharmacist was on hand to check the drugs directly, and was routinely available to discuss issues.

[179] At another district hospital, the nurse manager in charge of pharmacy said that although it was a core hospital service, there was little focus on pharmacy and drug management. Limited information about pharmacy issues, particularly in relation to misconduct, was received. The nurse manager also felt unsupported in terms of having responsibility for pharmacy.

> *… I've learnt what to do for myself, or off the person before me … there's not any training for running a pharmacy … we just do what we think we know …*

Chief Pharmacist

[180] The Chief Pharmacist[16] administers the Poisons Act and Poison Regulations on behalf of the Director General. The Poisons Act and Poison Regulations have wide application covering public and private hospitals, doctors, pharmacists, veterinarians, and industrial, commercial and agricultural clients.

[181] The Chief Pharmacist gives effect to his/her responsibilities through the functions of the Pharmaceutical Services Branch (PSB). The PSB forms one of five units that make up the Disaster Management, Regulation and Planning directorate (DMRP). The Chief Pharmacist and PSB are therefore responsible to the Director, DMRP.

[182] The stated purpose of the PSB is to "protect public safety by maintaining appropriate controls over medicines, therapeutic products and poisons as well as provide independent, expert advice on these and all aspects of pharmacy".[17] The role of the PSB is primarily a regulatory one, together with responsibility for policy and funding. The PSB is divided into three operational areas: a Drugs of Dependence unit; a Legislation and Licensing unit; and the Office of the Chief Pharmacist (the Chief

Pharmacist plus support staff). The PSB is relatively small and operates with 20 FTE employees.

[183] Historically, the Chief Pharmacist has had little focus on the handling and management of drugs in the public hospital system. The private sector was considered the area of greatest risk because of the particular nature and wide distribution of poisons/drugs in use. Further, drugs used in the public hospital system were seen to present a less serious risk (i.e., hospital medications compared to industrial chemicals), and public hospitals were seen to provide a significantly more structured and secure drug management environment.

> *… the private area is far more dominant … we have until now focused on it … there's bigger risks in terms of the public health view, because of the poisons involved, like cyanide and phosphine gas … you could kill thousands of people with it in the wrong hands … the risk of diversion of drugs in the public sector is low, they're more likely to be dobbed in by someone rather than the system picking it up …*

[184] Given this view, and the fact that the private sector had the majority of the poison permit and licence holders, the Chief Pharmacist's attention and PSB's limited resources had been directed at managing and controlling poisons/drugs in this environment.

[185] It was said that this position had changed, and there was an increased focus on the public hospital system. Two factors brought about this change. First was the Commission's work on misconduct management in WA Health, in particular drug-related misconduct matters. Second was the increase in audit activity from within Corporate Governance.

> *… when you* [the Commission] *came to us we looked back and said "this needs improving" …*

[186] In discussing the factors impacting on the Office of the Chief Pharmacist and influencing the relationship between it and hospital sites/pharmacists, a number of significant issues were raised.

(1) The Chief Pharmacist had limited authority to actually "direct" hospitals and pharmacists, locally and regionally, in respect of practices and procedures.

(2) This was relevant to providing a legal framework but left the development of a system to the hospitals and regions.

(3) There was a lack of a "forum" for discussion between the Chief Pharmacist and hospitals and pharmacists about drug management issues.

(4) There was a "disconnect" between hospital sites and the Chief Pharmacist.

     (5)   There were insufficient resources in the PSB given the nature and scale of responsibility.

2.4.4   Management of Drug-Related Misconduct

2.4.4.1   Executive, Security and Risk Managers

[187]   This section is based on interviews conducted with the following non-clinical management and executive areas of hospital and health service operations:

    (1)   the executive, security and risk managers; and

    (2)   the Chief Pharmacist and the Director, Disaster Management, Regulation and Planning of the Department.

[188]   It was generally held by this non-clinical management group that Schedule 8 drugs were relatively well managed because of the higher accountability levels associated with their use, but that because Schedule 4 drugs were not so tightly managed, there were associated misconduct risks. The managers said controls around Schedule 4 drugs were poor, and that a large amount of trust was placed in the staff that used or had access to them.

> *… the opportunity to get your hands on Schedule 8s is pretty low, but not Schedule 4s … it's a risk area …*

[189]   Central ownership of drug management at hospitals was acknowledged as being unclear. While those interviewed generally deferred responsibility to the hospital's pharmacist, there was nothing documented to support this assumption. Almost universally it was explained that, at the operational level, responsibility for drug management was shared between pharmacy and nursing staff.

[190]   While executive members indicated their reliance on receiving advice about drug-related misconduct issues from one or both of these areas, they generally confirmed that there was little in the way of formal processes in place to do so. There was an admission by many in the corporate group that while there was a strong clinical focus on drug use and risk, there was little or no focus on non-clinical aspects of drug management.

> *… it's hard for* [health] *professionals to look at something less immediate and less clinical* [like drug misconduct management] *… it's like "oh, the Schedule 8 count is out, but at least the patient isn't in pain" …*

[191]   Further, there was confusion about what, to whom and how drug issues should be reported.

> *… we desperately need advice on how to manage misconduct, especially when we've narrowed it down* [to a person of interest]

> *… I've checked our policy and procedures and it basically says "report up" …*

[192] The approach to dealing with drug-related misconduct issues was largely reactive; if drug use could not be accounted for, the relevant drug was locked up. In responding to incidents involving Schedule 4 drugs, it seemed that neither appropriate risk assessments nor investigations were carried out in order to decide on a course of action.

> *… I've had managers who've said "gee, we use a whole lot of X, and nurse so-and-so is having trouble sleeping, I might have to have a talk to her" … or we'd bring it up at a staff meeting and scare the shit out of everyone … or we could take it off the ward …*

[193] At those sites where matters were referred to hospital security staff (this did not occur at all sites), it appeared to be an informal and inherited responsibility. There was a lack of clarity, process, direction and oversight. The adequacy of resourcing and training were also obvious concerns.

> *… [what guides us in Security to handle an allegation] … nothing really, we do it instinctively … it's probably not right to, it's just evolved that way …*

> *… we're doing this blind … we don't have the 1-2-3-4 of here's what you do with reporting or investigating …*

[194] The issue of drugs and their management as an area of "non-clinical" misconduct risk did not appear to be a focus of the risk assessment process at the hospital level.

> *… [our hospital service] has set up clinical risk really well but it has taken people away from the corporate risk area …*

[195] Managers responsible for "risk" were required to assess misconduct risk generally, and to include it in the hospital risk management plan. There appeared to be some confusion about the concept of misconduct and its management, what behaviour comprises misconduct, and how the process of misconduct risk assessment might be undertaken.

> *… the issue of misconduct is so broad, and it's so different in different settings …*

> *… it's so important to define misconduct … it depends on the work area and relationships … people's "moral compasses" are very different …*

[196] Managers seemed unaware that this risk assessment exercise was part of a larger strategy within WA Health to develop an organisation-wide mechanism for managing misconduct.

… basically Health says you need to have a "Fraud and Corruption Control Plan"… it was never delivered in the context you spoke of [being part of something bigger] *… I'd say there wouldn't be a system anywhere in Health …*

[197] As a result, it was not surprising that formal assessments of drug-related misconduct risk had not been carried out, and risk managers tasked with doing so said they required assistance in order to perform the task.

… I think we're the same as most places and we haven't identified misconduct as a risk …

… there's no overriding direction … we're aware of what needs to be done, but we don't know how to do it …

… we'd be happy to put in better structures and guidelines to help us …

2.4.4.2   Drug-Related Misconduct Concerns

[198] The drugs review intentionally focused on managing Schedule 8 and Schedule 4 drugs at the operational level. As a consequence, the Commission engaged primarily with nurse managers responsible for managing the various operational areas within the selected hospitals. The views expressed and the comments quoted in this part of the report come from discussions with these clinical managers (as opposed to the non-clinical perspective from the previous section). Many gave direct and anecdotal accounts of instances of Schedule 8 and Schedule 4 drugs being stolen.

[199] The Commission recognises that, collectively, nurse managers are professional in their approach to their management responsibilities and are committed to the well-being of patients within their care. They exhibit considerable strength and dedication to this task, generally working under intense pressure and dealing with a wide range of complex clinical and administrative situations.

[200] There was a range of concerns held by managers about the handling of Schedule 8 and Schedule 4 drugs. Even those who expressed at the start of discussions that there was no problem, or that they had not experienced problems, identified issues as they discussed and described the way in which drugs were handled in the course of daily activities.

… [have you had any issues?] … not that I can remember … we had Panadeine Forte go missing when they were in the normal cupboard, also diazepam …

[201] In the main, managers believed that Schedule 8 drugs were relatively secure and well managed. Problems centred on the handling and management of Schedule 4 drugs. The basis for this was that Schedule 8 drugs had a high level of accountability attached to their storage and use. Managers believed these requirements were well known and adhered to by nursing staff. Schedule 4 drugs had little accountability.

... there probably is scope for abuse, Schedule 8s are pretty tight, Schedule 4s you can help yourself really …

… as far as Schedule 4s are concerned, it's a much more open system, [nurses] *don't see it as such a legislated thing, it's a bit more low-key, it wouldn't be seen as such a strict thing …*

[202]   While managers were reasonably confident with Schedule 8 drugs management, concerns were still expressed that those with the clear intention to steal drugs in this category could manage to do so.

… if you draw 10 mL of morphine and only administer 5 mL, who's to say what happens to that? … someone could say and sign off "I administered 10 mL" … how do you control that? …

… even with you standing right next to me, I [anaesthetist] *could still draw something up and pocket it and you'd never know …*

[203]   Some managers were concerned about the delay in detecting discrepancies, due to counts usually being conducted only once in 24 hours.

… Schedule 8s we check daily on a night shift … whether they should be checked shift-by-shift is something I'd question … when something goes missing, it's a long time [frame] *to check …*

2.4.4.3   Awareness of a Drug-Related Misconduct Focus in WA Health

[204]   Some clinical nurse managers had a heightened sense of awareness that drugs were an "issue" within the hospital environment and that there was an increasing non-clinical focus on drug management. Some managers were conscious of the increase in reported incidents of loss, theft and use of certain drugs from within the Schedule 4 category, and that there was a growing interest organisationally in the handling of these drugs. Other managers were completely unaware of any focus on these issues.

[205]   Even managers with some awareness seemed relatively uninformed about what was driving the change in focus. They did not know of a formal strategy across WA Health, what the issues were or whether this change in focus should or would affect them in their management roles.

… the only thing I know at a management level is that misconduct goes through to the clinical governance unit … I don't know that the girls on the ward would know …

[206]   While managers' (and the health system's) focus on clinical risk was clearly demonstrated with references to relevant policy and practice, it was generally acknowledged that any awareness of, or formal focus on, misconduct risk – particularly misconduct risk associated with handling Schedule 8 and Schedule 4 drugs – was limited.

> *… we don't tell people* [about drug-related misconduct] *as such, we assume that if something's going on they'd tell us …*

[207]   To the extent that there was a level of awareness and focus, it was fragmented within and across the sites. It was often explained in terms of an individual manager's practice having had the "benefit" of an adverse experience. It usually remained an individual and localised action.

> *… personally I've had the experience … at least three nurses* [I've worked with] *have acquired drugs for a habit so I have a personal awareness …*

[208]   Managers advised that general misconduct management, or managing particular misconduct risk issues, such as the drug risk (in the non-clinical sense), was not a subject routinely raised or discussed, either with staff in the course of regular staff meetings, or at the management and executive level, unless there was a particular issue or incident to generate that discussion. As a consequence, changes to practices and procedures, and any increase in security arrangements that might result, were generally reactive measures and were more likely to have limited and local application, i.e., they were not part of a misconduct prevention strategy.

2.4.4.4   Awareness of Drug-Related Misconduct Occurring

[209]   Many clinical nurse managers explained that they would be aware of anything untoward occurring in respect of drugs because they were watchful and perceptive, and because they could rely on and trust their staff to inform them. This was said in the belief that staff:

(1)   were equally watchful and perceptive;

(2)   would know through their professional training and experience when something had gone or was going wrong; and

(3)   would know what action to take (for example, to advise their manager).

[210]   This view was held despite managers acknowledging that, culturally and professionally, nursing and medical staff found it very difficult to consider that colleagues might engage in inappropriate behaviour in the course of their work. There was a high level of trust between colleagues.

> *… when you talk to nurses about misconduct, you look at it from a patient perspective* [about stealing drugs]*, not your colleagues … you don't even think of the other side …*

> *… they're all professional so they know what's right … we all know what the expectation is, what's right and wrong, I don't need to say too much …*

[211]   Further, staff might not readily identify such behaviour or their responsibility to act in those circumstances, and the issue of misconduct (generally or in relation to drugs) was rarely discussed.

… I have a heightened awareness [because I've seen drugs stolen first-hand]*, but I don't want to be talking negatively all the time …*

2.4.4.5   Managing Drug-Related Misconduct

[212]   Clinical nurse managers gave varying explanations of how they would deal with a drug-related misconduct issue. In some instances there was a simple and confident response that pharmacy would be informed or that Security or Human Resources would be told. Some indicated that Western Australia Police and the Nurses and Midwives Board of Western Australia ("the Nurses Board") should be involved, and others simply explained that they would manage the matter "up" and inform their respective line manager or director. Some indicated an awareness of a reporting obligation to the Chief Pharmacist. Other managers stated that they would initiate their own action, including:

> (1)   making direct enquiries with staff;
>
> (2)   making an indirect approach by dealing with staff as a group;
>
> (3)   observing an individual or a particular location; and
>
> (4)   in a number of cases, by introducing prevention or detection measures.

[213]   Managers were generally vague about the system or procedure for dealing with these matters or the part they should play, even those who had clearly explained who they would report to.

> *… that's what I would do … I don't know if that is what everyone would do …*
>
> *… what system would I use? … would I report to my line manager? … okay, I guess I would report to my line manager …*

[214]   It was evident that there was a lack of direction for managers in how to deal with allegations of drug-related misconduct. As a consequence, this left them vulnerable and in need of support.

> *… someone came to me and said "the drugs are running out" … I went to my director … I immediately began recording the numbers of* [Schedule 4] *tablets at the beginning and end of each shift … I identified the common people on shifts where there were discrepancies … I was advised it wasn't appropriate to approach people directly … pharmacy got involved and locked the drugs up … I wrote to everyone who had access … said the drugs were missing … whether it was right I don't know …*

2.4.5   Observations

[215]   The most significant conclusions arising out of the drugs review are detailed below.

(1) There clearly were misconduct risks associated with Schedule 8 and Schedule 4 drugs in public hospitals.

(2) Drug theft by staff was clearly one such risk.

    (a) There may be other misconduct behaviours (to be identified by a risk assessment process), but that theft occurs was obvious from the incidents identified and reported.

    (b) It was reasonable to say that drug theft may lead to adverse outcomes for patients.

(3) The Department lacked a strategy to deal with these misconduct risks, including theft by staff.

(4) There was limited and varied awareness of the misconduct risks, how and why misconduct might occur, and how to manage and prevent such misconduct.

(5) A risk assessment process was needed to address the various circumstances in which misconduct behaviours might occur.

    (a) This included assessing the practices and physical security within wards, theatres and emergency departments (as described in Section 2.4.3 of this report), and any other areas where drugs were held and used.

    (b) Indicators of unidentified or undetected theft were not recognised. These included, but were not limited to, suspicious breakage, unexplained losses and unusual usage patterns.[18]

(6) There was no strategy for handling drug-related misconduct incidents, including investigating and conducting inquiries at a hospital level, and providing oversight and direction at both a local and executive level.

(7) The prospect of misconduct occurring (and occurring undetected) was heightened by the fact that a misconduct risk assessment in respect of Schedule 8 and Schedule 4 drugs in hospitals had not been undertaken.

(8) There were conflicting views expressed across the reviewed hospital sites and at an executive level about who was, or who should be, exercising primary responsibility for the management and handling of Schedule 8 and Schedule 4 drugs, at both a day-to-day level and overall.

(9) There were vague and inconsistent practices and inadequate storage security.

    (a) This was particularly relevant with regard to the lack of security and accountability for Schedule 4 drugs.

(b) The notion that the misconduct risk associated with Schedule 8 drugs was low because they are subject to stringent security was, on the evidence, mistaken.

(10) The physical security aspect of Schedule 8 and Schedule 4 drugs management was a significant concern. It was focused on the location of cupboards and rooms, and arrangements for locking and unlocking storage facilities.

(a) It would be fair to observe that such a process within a modern health system seems antiquated.

(b) A more sophisticated system, involving the application of today's technology to storage and access controls, would go a long way to improving security and simplifying access and recording procedures.

(c) Indeed, some managers made reference to swipe-card technology for controlling access to drug storage facilities, and the use of bar-coding to track drug movement as examples of how the system might be improved.

(11) The Chief Pharmacist was assigned the responsibility for administering the Poisons Act and Poisons Regulations on behalf of the Director General.

(a) At the time of the review, the Chief Pharmacist had little focus on the management of drugs in the public health system.

(b) The location of the Chief Pharmacist and Pharmaceutical Services Branch within the Department's structure seemed unrelated to the Chief Pharmacist's responsibilities surrounding the management of drugs in the public hospital system.

(12) The Poisons Act and Poisons Regulations contained limited reference to the management of drugs in public hospitals.

(a) In addressing the circumstances surrounding the management of drugs, the provisions of the legislation needed to be considered. The Commission is aware that a review of this legislation was underway at the time of the drugs review.

(13) The primary focus on drug management was a clinical one, to ensure that the right drug was provided to the right patient. This focus was understandable and to be expected in a hospital setting.

(a) A clinical focus should not override the need to have processes and procedures that address the misconduct risks associated with drug management and handling.

2.4.6 Drugs Management Review Recommendations

[216]

The Commission made the following recommendations.

(1) The Department carry out the initiatives related to drug management as outlined in its advice to the Commission referred to in the working paper.

(2) The Department develop and implement a "whole-of-Health" strategy for the management of Schedule 8 and Schedule 4 drugs in public hospitals, and the associated misconduct risks.

(3) The Department determine who exercises executive management responsibility for Schedule 8 and Schedule 4 drugs across the public hospital system.

(4) The Department determine who exercises primary management responsibility for the day-to-day drug management and handling of Schedule 8 and Schedule 4 drugs at the hospital level.

(5) The Department create specific and consistent minimum practice standards across public hospital sites for day-to-day management and handling of Schedule 8 and Schedule 4 drugs.

(6) The Department develop and implement a strategy for managing drug-related misconduct incidents, including investigating and conducting inquiries at a hospital level, and providing oversight and direction at both a local and executive level.

(7) The Department address the current limited reference to public hospitals in the Poisons Act and Regulations, to ensure that the provisions are adequate for day-to-day management and handling of Schedule 8 and Schedule 4 drugs in public hospitals.[19]

(8) The Department give immediate consideration to improving security and accountability measures surrounding Schedule 8 drugs, and particularly Schedule 4 drugs "of interest", i.e., the Department should consider the use of modern technologies to replace the current "lock and key" system for drug access and storage security.

[217] Shortly after the commencement of the drugs review, the Department informed the Commission that it had increased its focus on drug-related matters within WA Health. It stated that it was "aware of issues relating to the storage and use of pharmaceuticals and poisons, particularly the systems used to control access to and account for the use of Schedule 4 and Schedule 8 drugs".

[218] In response to these issues, the Department advised that it had:

(1) conducted audits of areas involved in the handling of drugs;

(2) endeavoured to improve communication between the Department's Chief Pharmacist and the Pharmaceutical Services Branch (referred to as "Pharmacy" below); and

(3) in respect of drugs and misconduct risks, initiated a process to have these risks noted and addressed in operational risk registers.

[219] The Department advised the Commission of a number of other intended initiatives:

(1) *an organisational review of Pharmacy be undertaken, focusing on its functions, current business practices and resourcing;*

(2) *an intensive review of incidents of alleged drug-related misconduct be instigated, aimed at obtaining a better understanding of why they occurred;*

(3) *the Chief Pharmacist and WA Health executive acknowledge the correlation of drugs and risk, and take steps to ensure it is considered for inclusion in all significant risk registers;*

(4) *the Corporate Governance Directorate and Pharmacy develop appropriate whole-of-Health risk management policies that support operational-level risk management strategies;*

(5) *pharmacy put greater effort into ensuring compliance in all operational areas;*

(6) *pharmacy implement a "cradle to grave" review system (i.e., one that permits tracing of drugs from manufacture or receipt by WA Health to dispensation or destruction), particularly with respect to Schedule 8 drugs;*

(7) *the Corporate Governance Directorate and Pharmacy develop and implement clear and reliable complaint-handling protocols;*

(8) *communication between all areas involved in the handling and monitoring of drugs be strengthened, with greater support being given to hospital security staff involved in the initial investigation of reported drug losses;*

(9) *targeted education programs for pharmacists, pharmacy staff and security staff be developed and delivered;*

(10) *attendance at the Administrative Investigation course currently being developed by the Corporate Governance Directorate become mandatory for those staff who will be investigating drug-related misconduct; and*

(11) *management respond as a matter of priority to any recommendations made in the draft audit reports that are soon to be released by the Corporate Governance Directorate.*

[220] WA Health responded to the working paper by agreeing with the outcomes (with some qualifications) and by stating that it had already started addressing some of the issues raised. The Department agreed with all of the Commission's recommendations.

2.5 Royal Perth Hospital (RPH) Review (January 2009 - July 2009)

[221] The Commission's review of RPH focused on assessing the Department's progress in developing and implementing a misconduct management mechanism across WA Health. The Department had indicated in response to the previous reviews that:

(1) it was progressing its misconduct management planning at a central, Department level;

(2) appropriate messages about the strategy for managing and preventing misconduct would filter down to the site level; and

(3) evidence of a misconduct management mechanism would become evident at the site level.

[222] In these circumstances, it was decided to limit interviews to executives[20] (i.e., "frontline" managers were excluded) on the basis that if the Department was making the progress indicated, it would be seen at senior levels of management.

[223] Thirty interviews were conducted. The RPH review focused on three key issues in order to determine the progress of the Department in implementing a misconduct management mechanism at RPH.

(1) What information or messages managers receive from the Department about misconduct.

(2) Whether managers were confident that misconduct was managed appropriately at RPH.

(3) Managers' perceptions of staff awareness and understanding of misconduct.

2.5.1 Policy, Guidelines and Codes

[224] There were many WA Health, South Metropolitan Area Health Service (SMAHS) and hospital level policies, guidelines and codes that related to conduct, misconduct or risk management at RPH. There was a uniformly high awareness of the existence of "conduct-related" policies across the senior management group interviewed. However, there were varied opinions on the content, effectiveness and accessibility of such policies.

The available policies, guidelines and codes addressed aspects of expected behaviour and in some cases elements of misconduct. However, they were not coordinated in terms of having a misconduct focus or system to use. The way in which misconduct was addressed also left many managers and staff with an inadequate understanding and ability to identify and report misconduct.

> *… most people aren't aware of the Code of Conduct … you can send out all the policies you want …* [staff are still] *not sure after wading through them* [what misconduct is or what to do] *…*

> *… the hospital sends out lots of correspondence via email, there's also Servio Online … the question is, do people access it? … probably not … do I know where to look? … probably not … there are protocol and procedure manuals across the hospital to support the policies … do people look at them? … probably not, but they're there …*

2.5.2 Understanding Misconduct at the Executive Level

[225] In the course of discussions, it was clear that there was varied understanding about misconduct. There was confusion about what misconduct looked like in a given work environment, and about what and when executives notified (either to Corporate Governance Directorate, executive management, Human Resources or Security), if staff report misconduct to them.

> *… the problem for us is there's been a lack of clarity …*

> *… I don't think I'm aware of all the things that fall under* [the definition of] *misconduct … I don't know what to notify the CCC on …*

[226] Several managers spoke specifically about their confusion surrounding the threshold for reporting misconduct, making reference to the "grey area" between inappropriate behaviour or performance management, and behaviour constituting misconduct.

> *… there're lots of grey areas around bullying versus performance management … I'm the contact officer and it's so obvious people don't get it … it's such a nebulous sort of thing …*

> *… I am aware of what I think misconduct is, the high-level stuff … other types of misconduct are very grey … people might not realise what they're doing is misconduct and it can then get them in a lot of trouble … is it misconduct if at the end of the day they are just trying to achieve the best outcome? …*

[227] Serious misconduct or criminal behaviour was said to be more easily identifiable and therefore would be managed appropriately.

> *… the higher end stuff* [such as criminal behaviour] *is easy* [for people to recognise and deal with] *… the other types of*

misconduct … I'm not even clear if it is misconduct … I don't think it goes past that [people recognising behaviour beneath the criminal threshold] *… it wouldn't even go to the head of department…*

[228] However, some of the managers interviewed were not confident that even criminal behaviour would be handled appropriately.

2.5.3   Is Misconduct Recognised as a Risk Generally?

[229] Some executives clearly expressed the risks they had identified in their area of responsibility. This identification, rather than being based on any formalised risk assessment process, was based on:

(1)   already having controls in place (for example, "I.T. runs checks quite regularly on internet usage"); or

(2)   experience with misconduct occurring in their area; or

(3)   awareness of occurrences of misconduct at other health sites/areas.

[230] Significantly, some opinions about the risk of misconduct occurring were diametrically opposed. This supports the Commission's view that a consistent message has not been received at RPH management level about misconduct risk. For example, "… helping yourself to the drug cabinet is over now … in the mid 80's helping yourself to drugs, sleeping tablets, was common …" versus "… staff need the downers to come off the highs …".

2.5.4   Is Misconduct Formally Recognised on Risk Registers?

[231] In discussion with senior managers at RPH, some with additional roles related to risk management, there was some debate about the need to add misconduct risks to formal risk registers.

> *… the risk register … we decide what goes on it … misconduct is not included … officially you don't recognise it* [staff stealing drugs] *because it's not supposed to happen … the risk* [register] *is publicly available … we know it happens and* [technically] *we've all done it ourselves* [take hospital medicines], *but we wouldn't have it in the risk register …*

[232] It was unclear whether a formal misconduct risk identification process had been undertaken, and if it had, at what level, based on discussions with some managers involved in the risk management process.

> *… we've been told by Corporate Governance we need the risk of fraud and corruption on the register … but how good is it? … I'm wanting to move away from just ticking the boxes, saying "yes, we've got it on there" … I'd rather be dealing with real things and dealing with the real issues …*

2.5.4.1 Risk Register Review

[233] The review team obtained and examined the RPH Organisational Risk Registers and the Executive Significant Risk Register.[21] The Organisational Risk Register was broken down into Clinical, Corporate and Other areas, and then by division as shown in Table 1.

Clinical Risk Registers	
Cancer and Neurosciences	Medical Specialties
Critical Care	Mental Health
Imaging	Rehabilitation and Orthopaedics
Laboratory Medicine	Surgical
Corporate Risk Registers	
Clinical Services	Human Resources
Corporate Nursing	Information Services
Executive	Infrastructure Support
Finance and Business	Occupational Health and Safety
Other	
Infection Control	

Table 1: RPH Organisational Risk Registers

[234] In the examination of these 17 registers, only two (Information Services and Clinical Services) had any reference to misconduct. These two registers and the relevant risks appear as follows.[22]

Information Services Risk Register

[235] This register included one misconduct-related risk:

> *… Patient data can be copied from secure applications on to unsecure external connected storage devices (CDs, USB Drives etc.) and removed from the system …*

Clinical Services Risk Register

[236] This register included two cross-referenced risks. Both risks were owned by the Pharmacy Department.

[237] The first misconduct-related risk[23] in the Clinical Services Risk Register was described as:

> *… Widespread loss of easily abused Schedule 4 drugs across public hospitals, including RPH.*
>
> *Easy access and lack of controls for this category of drug can result in staff dependence or illegal activities (such as on-selling).*
>
> *A culture of entitlement has developed which exacerbates this problem and the wider problem of generalised theft of drug stock.*
>
> *[Two] damaging audits have been submitted to Corporate Governance from [Hospital A and Hospital B] and the latter has gone to the CCC [the Commission].*
>
> *If the media were informed of the scale of abuse and theft, it would be damaging to the reputation of staff in the health system.*
>
> *The problem has been highlighted in an audit by Corporate Governance although the scale of the problem was underestimated …*

[238]   The implications are "organisational wide" and "area health" and the possible impacts are "Political … Patients/Clients … Reputation/Image … Staff/Contractors".

[239]   The treatment plan in part states RPH was to undertake the following.

   1. *Introduce new controls to prevent theft and a new reporting scheme, new policy, controlled storage and accountability, new reporting system and review.*

   2. *Chief Pharmacists forum recommendation to ORC* [Operations Review Committee] *for state-wide implementation.*

[240]   Comments on the progress of the treatment plan dated 15 December 2008 showed that no response had been received from the Chief Pharmacists Forum regarding the implementation of a state-wide policy, and that a draft proposal was with the Director Clinical Services RPH. Another comment dated three months later stated that extra controls were to be placed on the storage, ordering and accountability of "S4R" drugs (Schedule 4 restricted drugs "of interest"). This draft was distributed to the Medical Directors Forum and State Nurses Forum for feedback.

[241]   The second misconduct-related risk[24] on the Clinical Services Risk Register was cross referenced to the above risk, and was described as:

> *… SMAHS to adopt a risk management approach to the control of Schedule 8 drugs…*

[242]   The Initial Risk Assessment was that "Serious misconduct and misuse could occur in relation to Schedule 4 & 8 drugs [if] a risk management

approach is not adopted by SMAHS". The existing controls were described as inadequate.

[243] The treatment plan stated:

> *… SMAHS to review its current policies to ensure that appropriate risk management strategies are incorporated. SMAHS will also ensure that each site (RPH) reviews and identifies its risks in this area, enters those risk[s] on its risk register and develops appropriate risk treatments to manage the identified risks …*

[244] Comments on the progress of the treatment plan for Schedule 8 drugs, made in December 2008, mirrored those for Schedule 4 drugs above.

[245] Examination of the risk registers showed that Clinical Services was seemingly the only area to make documented progress on addressing the risk of theft of Schedule 4 and Schedule 8 drugs. This action seemed to have been a result of a ward audit and identified problems, not a result of action taken by SMAHS, "to ensure that each site (RPH) reviews and identifies its risks in this area, enters those risk[s] on its risk register and develops appropriate risk treatments to manage the identified risks".

Executive Significant Risk Register

[246] This register was cross-referenced to the risks identified in the Clinical Services Risk Register (outlined above), together with the risk of not complying with the Department's *Fraud and Corruption Control Plan*.

2.5.5   Executive View

[247] Discussions with executives focused on three key issues:

(1)   what information or messages they received from the Department about misconduct;

(2)   whether they were confident that misconduct was managed appropriately at RPH; and

(3)   their perception of staff awareness and understanding of misconduct.

2.5.5.1   Misconduct Messages from the Department

[248] In the course of the interviews, executives were initially asked about what kind of information they had received from the Department centrally, either from the Executive or from Corporate Governance, about misconduct.

[249] A few managers said that they had received very little information from the Department about misconduct.

> *… there's nothing we get direct from Corporate Governance …*

> *… minimal* [information], *not a lot comes out of the Department …*

[250] However, most believed that there was an increased focus on misconduct by the Department, particularly with respect to Schedule 8 and Schedule 4 drugs.

> *… there's a focus and expectation on misconduct …*

> *… [drugs-related] misconduct is a high priority issue …*

[251] The requirement to report misconduct was the primary issue discussed that related to the perceived increase in focus by the Department. Managers were not always sure who to notify.

> *… the hospital is quite clear on the requirement to notify of any issues, but I would have to guess as to where the appropriate place to refer it to is …*

[252] Those that said they had received information about misconduct from the Department were asked whether they believed that the type, amount and quality of the information was satisfactory. Some managers were satisfied with the types and amount of information that had come to them.

> *… [there is] consistent communication from Corporate Governance regarding ongoing improvement processes … in regard to what we think is criminal, we deal with it …*

[253] In some cases, managers had received information from the Department based on their involvement on committees and other groups, rather than by virtue of their manager role.

> *… I sit on the Fraud and Corruption Control Committee as the Area Health Service representative … we get updates on misconduct reporting, comparisons across health … that's how I knew about the [Commission's] reviews … [the PMH review] was matter of some discussion …*

> *… I receive information from the Risk Committee on what is happening …*

> *… there's been wide-ranging discussion on issues [within the Fraud and Corruption Control Committee] … some of the feedback was that this is such a big issue, there's fraud and misconduct across all areas in all different ways … clearly some of it is just good management …*

[254] The predominant method of information delivery described was the "global email" system. This was thought to be an appropriate method by only a handful of managers interviewed. Overwhelmingly, global emails were seen as ineffective in conveying messages to staff and managers. The volume of emails received by most of the managers interviewed meant that many of them simply did not read the emails.

> *… we get many global emails … there's certainly lots of awareness … do I think it's enough? … we all get dozens of*

emails each day … we're busy clinicians and do we have time? … many of us would only look at them when we have to …

… when staff receive emails and see "Global RPH" or "Global SMAHS" they delete them … the information is depersonalised … it's not the lack of effort but that face-to-face contact is needed …

… I get global emails and I must admit, I delete them … they send out so much rubbish …

[255] Significantly, there was no reference made to a "whole-of-Health" strategy for managing misconduct, nor to preventative or awareness-raising strategies, nor to implementation of a misconduct management mechanism.

… clear guidelines are needed and are desperately overdue …

2.5.5.2 Confidence in Misconduct Management at RPH

[256] Some managers were confident about how to manage misconduct. Some had experience in reporting misconduct to Corporate Governance directly, and felt that the matter was handled appropriately.

[257] Some interviewees described how they would respond to an allegation of misconduct against one of their staff. This was primarily based on what they believed to be the best way of dealing with it, or on having done so previously, rather than referring to a system for doing so.

… it depends on who the complaint goes to, how it's managed … how quickly you escalate is based on your experience … the policy guides you, the degree of severity isn't something you can easily define …

… senior [medical] staff meet behind closed doors and try and resolve things … if there's no luck they will go the Director Medical Services and then to the Medical Board …

… sometimes I report, sometimes not, when I don't think a satisfactory outcome will be reached …

[258] In some cases they relied solely on experience in the stated absence of a misconduct management mechanism.

… I received an anonymous phone call from someone saying that someone was dispensing valium at a party … until something happens there is no guidance on step-by-step process for dealing with misconduct, as you go along you learn what to do …

… there's no documented process of how you go through it [an allegation of someone stealing drugs]*, you just rely on your own knowledge* [and experience] *not a procedure …*

[259]   Most managers referred to Human Resources (HR) at RPH as being the primary contact for reporting misconduct. This arrangement was seen to be satisfactory by most of those who use it.

> *… you need good HR managers as a resource, you need training and experience … I think all managers would be contacting HR straight away …*

[260]   Especially where drug-related misconduct was alleged, there were differences of opinion about whether to notify hospital Security, HR or Corporate Governance first. Who should handle preliminary investigations in these cases was also unclear.

> *… Security give it* [the investigation] *to Corporate Governance, not to HR … HR know about it …*
>
> *… the relationship between Security and HR has evolved, probably needs to be arrangements in place … sometimes Security go and do what Security want to do … if there are HR issues, maybe they're not identified … then Corporate Governance come to HR and ask "what have you done about it?" …* [HR] *didn't know about it …*

[261]   The Health Corporate Network (HCN) was mentioned by several managers as having a role to play in the management of misconduct at RPH. This was primarily with respect to the process to follow for disciplinary procedures, and for general advice on handling human resources issues. HCN was generally viewed as being unhelpful. There was very little confidence expressed in the advice given by HCN on matters involving misconduct.

> *… they're HR "consultants" who only give advice on what to do, not tell you what to do, with HCN coming in … it's to protect themselves, to just give us "choices" … it's made it difficult for me* [as a manager] *…*
>
> *… you can get three different opinions from the same person …*

[262]   The perception that allegations or reports of misconduct must be made in writing was very strong with some executives. They believed that they could not act on verbal information alone. It appeared that some staff had expressly stated that they were reluctant to put allegations in writing. In some cases this meant that no action was taken.

> *… there's been a few "Chinese whispers" of misconduct, and I've encouraged staff to document it, but they won't … I can't act … there was an unfortunate event where someone said "can you document that* [allegation]*, because we're trying to get rid of them" … so that doesn't help … after that comment, people are unwilling to document …*
>
> *… staff report verbally on lots of incidents but will put nothing in writing … for example, last week, a nurse on night shift took two*

> *temazepam … I asked the staff member to give it to me in writing or nothing could be done about it … the nurse involved has a history … if incidents aren't reported in writing nothing is done …*

[263] Conversely, others expressed a belief that as managers they should and would act on a verbal account of an incident.

> *… [a drug-related allegation was made] … no-one wanted to put it in writing … [pharmacy] pulled the usage on the ward … I can't ignore information that comes to me, I need to act …*

> *… without it in writing some [managers] think they can't do anything, but I still have to act …*

[264] There was some discussion about how much preliminary evidence needed to be gathered before a manager could act on an allegation of misconduct. This also related to the confusion about the threshold for reporting misconduct.

> *… [when told there's a low threshold for reporting misconduct] … but it behoves you to be sure, not to just shoot from the hip … you can't just base it on nothing …*

> *… until I've got evidence I can't do anything …*

[265] Some managers interviewed were not confident that misconduct, if reported either to or by them, would be managed well at RPH.

> *… there was a theft of drugs from ward three years ago, police, warrants, searching … the Nursing Director at the time was inexperienced … I had to debrief staff … it was very unpleasant … did not get any support … three years on, I don't think we deal with those situations very well …*

> *… in my experience a lot of misconduct is very hard to prove … aside from asking staff the questions if I believe they have done something wrong, there's no process to allow me to go further … my experience is that nothing will happen …*

[266] Very few managers interviewed talked about incorporating misconduct prevention strategies when discussing managing misconduct at RPH. Those that did focused primarily on the existence of polices, guidelines and codes of conduct.

2.5.5.3 Perceptions of Staff Awareness and Understanding of Misconduct

[267] Managers were also asked about their perception of the awareness their staff had of misconduct, and of the misconduct risks in their work area. Managers spoke about whether they thought staff would recognise misconduct behaviours and report them (to line managers, HR, Corporate Governance, Security or the Commission directly).

[268] Some managers believed their staff would know what was acceptable behaviour (for themselves and for others), based on being professional or having an "in built" sense of appropriate behaviour.

[269] Some managers were very confident that their staff had an awareness of what behaviours constituted misconduct, and that they had the capacity to deal with it appropriately if they saw it happen.

> *… I'm confident of solid understanding of misconduct by staff …*

> *… there's quite a strong awareness of right from wrong …*

> *… they strive to do well … don't want to have to work alongside these types of people …*

[270] Others were not at all confident that staff would recognise misconduct if they saw it. They did not believe staff were attuned to the misconduct risks in their area of business.

> *… they haven't separated out grievances from misconduct … yeah, they need to know what misconduct looks like …*

> *… staff probably wouldn't know what to do if they witnessed misconduct … I would, but I certainly think that people at the "grass roots" level wouldn't have received any training on it …*

[271] Some managers gave reasons why they thought staff would not report misconduct, even if they did recognise it. This is also covered in the section on cultural issues.

> *… people become blasé … they think nothing will be done, or "if I make a complaint there'll be this and this and this to do, so I won't* [report it]*" …*

> *… [with regards to drug discrepancies]* *wards try to fix it* [rather than report it to pharmacy] *… they feel so ashamed* [that something's gone wrong] *…*

2.5.6   Other Issues

[272] In the course of discussions with senior managers at RPH, several additional issues pertinent to managing misconduct were raised. These issues were significant in that they highlighted the complexities of managing misconduct at RPH, in addition to implementing a misconduct management mechanism.

2.5.6.1   A "Culture of Entitlement"

[273] Of the interviews conducted, five areas had direct patient care as their primary role. Significantly, managers in four of these areas spoke about what they believed to be a "culture of entitlement" at RPH, i.e., they believe that there was a feeling among staff that because they worked long hours, for what are seen to be low wages, in an often hostile and difficult environment, and are not appreciated by management and others,

they were entitled to "take" from the hospital. This included stealing consumables and drugs, including those in the Schedule 4 and Schedule 8 categories, taking extra time off at breaks, and arriving to work late or leaving early.

> *… it's a mindset … it's like it's allowable for "unpaid overtime" … some are quite good about it, some are like they're kids in a lolly shop … yeah, it's like "they owe me" … even in my own experience, I got a rose thorn stuck in my finger and it got infected, so I asked for a script and a doctor and the pharmacist both said "just take something"! … there's limits on your own conscience …*

> *… a nurse gave a Patient Care Assistant Panadeine Forte … there is an "entitlement" attitude … if you work here you are entitled to get what you want … equipment and supplies going missing are regular, such as bandages, plasters, Panadol, antibiotics, non-prescription medication … there are no audits … it's viewed as a "perk of the job" … if each nurse* [in one area] *took one deodorant can a week, that'd be $5,000 a month gone out the door …*

[274] Interestingly, the notion of a "culture of entitlement" was included in the Clinical Services Risk Register, in relation to Schedule 4 drugs. The register stated that "a 'culture of entitlement' has developed which exacerbates this problem [of theft of Schedule 4 drugs] and the wider problem of generalised drug theft".

2.5.6.2 A Culture of Protection and Loyalty

[275] There was also reference made by some managers to a kind of "protectionist culture". This culture was demonstrated by different reactions to inappropriate staff behaviour.

(1) Allowances for people's behaviour being made (because there are medical or personal issues at play, or the person holds a "special" position in the hospital).

> *… market forces make specialists hard to find … allowances may be made for the behaviour of someone who is one of the only people with the medical skills needed by the hospital … I know this shouldn't change how we respond …*

> *… there is a terrible culture in WA* [Health] *where we feel sorry for them* [staff who have used drugs at work out of "need"] *… the nurse will cover* [their colleague] *… if it's good luck we get away with it - management only becomes aware of it if it hits the fan …*

(2) Not wanting to "tell on" a colleague, or get involved.

… the perception [is one] *of "dobbing in" co-workers … it's about not wanting to get involved … there was a staff member who lost their registration, there was an incident here … it was appalling …*

(3) Complications arising when there are members of the same family or cultural group involved in certain work areas.

… RPH loyalty, the family culture, if you talk to someone they will be related to eight or nine people across the hospital … before they tell the first sentence they will say "promise me you won't do anything" …

2.5.6.3 A Fear of Reprisal

[276] Throughout the review, comments were made by managers in relation to the fear staff had of the repercussions of reporting acts of misconduct. Their comments were also influenced by some having witnessed particular events.

… staff know that if you "blow the whistle" you know they won't make life easy for you … staff would put their head in the sand … there's a fear of retribution when it comes to reporting misconduct …

… staff might be fearful of retribution [for reporting misconduct] *…*

[277] The cultural issues (described above) appeared to affect the way misconduct was managed at RPH.

(1) Whether behaviour was recognised as misconduct or seen as "how things are done here".

(2) Whether behaviour recognised as being misconduct was reported and/or dealt with appropriately.

(3) Whether the individual reporting the misconduct was dealt with fairly and appropriately.

[278] Significantly, these cultural issues not only influenced the management of misconduct at the time of the review, but may directly affect the Department's future endeavours to implement a misconduct management mechanism at RPH (and presumably wherever such cultures exist across WA Health).

2.5.6.4 Removal of the RPH General Practitioner Clinic and a Lack of Clarity around "Acceptable" Use of Resources

[279] There was a view strongly held by many of the managers interviewed that due to the on-site General Practitioner (GP) clinic being removed from the hospital, staff had no alternative but to use the hospital's drug supply. This relates in part to the "culture of entitlement" as discussed above.

> *… the hospital has got rid of the GP from the clinic … from the cleaner to the Executive Director people need access to a doctor, and now there's no-one to get an assessment from … we actually set our staff up to fail …*

> *… if they're [hospital management] going to address "benzos"[25] [by locking them up] they'll need to have a clinic on site … they need to facilitate a service for that [so that staff can get them] …*

[280] The executives interviewed said that this situation was particularly confusing in the absence of any defined policy on what was acceptable use of hospital drugs (if any use at all).

> *… if someone has had a really hard shift and they ask for a couple of temazepam to help them get to sleep … if I give them some, is that misconduct? … we have no proper directions … we certainly would welcome some workable directions … we don't have any practices, processes or procedures in place [with regards to staff accessing drugs] … there are no clear guidelines for what is and isn't appropriate … I guess everyone will have their own threshold …*

[281] This view seemed, at least in part, to be based on the fact that because the drugs were available and accessible RPH staff should be able to use them. When comparisons were made with other agencies whose staff do not have access to drugs as an "agency resource", it was argued by some RPH executives that it was easier for the staff of other agencies to visit a GP than for RPH staff (i.e., RPH staff might be on night shift, or cannot get time off because the hospital is understaffed).

2.5.6.5   Inadequate Management Skills

[282] Across RPH, and particularly in clinical areas, many managers said they did not have specific management skills or capacity. Even at senior levels of management, it was clearly expressed by many that they felt unsupported when it came to managing the behaviour of staff. These managers used their experience, rather than formal training, instruction or support when dealing with issues of staff behaviour, some of which may constitute misconduct. Those senior people who were relatively new and/or inexperienced felt particularly vulnerable.

> *… I think the information is there but the support is lacking … senior managers have had more experience but for middle managers there isn't the support … the first line is the manager or supervisor and they don't have the support and training … there's no training on managing, they go with the flow, they learn on the job … the support mechanism is lacking … I think people know they can go somewhere … people are often scared, afraid of repercussions … in the public system, you get a sense of that they think things don't get done, it's a very long-winded process, so they don't want to get involved … there's a*

fine balance between natural justice and dealing with an issue … I feel for new supervisors …

[283]   There was a collegial relationship between clinicians in senior management roles that also had clinical responsibilities on the same level as other doctors. This added a perceived level of complexity when dealing with people who were both subordinates and equals. Further, people were often placed in senior positions with very little understanding of their true responsibilities and accountabilities, from a public sector, hospital and people management perspective. One manager stated:

> *… doctors and nurses manage with no experience in people management … I "fell into" management … a lot of time you don't want to know what other people* [staff] *are doing* [because you don't know how to manage it] *… you talk about it* [misconduct] *privately, not in public … most people like to deal with misconduct internally* [in their division/work area] *…* [as a director] *I know nothing about public sector guidelines … you are put in a managerial or administrative role without any training … one unit head was involved in a lot of impropriety … he may not have known that some of what he was doing was wrong … everyone focuses on the clinical part* [of their senior role] *and not on the other aspects of being a head* [of department] *… this year they're the manager, next year they might just be another staff member* [because positions rotate every three years] *… people think "do I really want to rock the boat?"* [and get involved in investigating an allegation of misconduct] *… it stops people from fully exercising their powers and responsibilities …*

2.5.7   Conclusions

[284]   Messages from the Department were "received" inconsistently, i.e., some executives were happy with the type, amount and quality of messages about misconduct they received from the Department; some executives had received no information at all. Most managers believed there was increased focus on drugs management, particularly around reporting drug losses. There was confusion about what behaviours constituted misconduct, and the threshold for reporting.

[285]   In terms of misconduct risk, only two of the 17 hospital risk registers included misconduct-related issues. Also, it appeared that a formal risk assessment had not been undertaken with respect to misconduct risks.

[286]   There was a strong perception on the part of executives interviewed that allegations of misconduct from staff must be made in writing before management can act. There was uncertainty about how much "evidence" of misconduct must be gathered before reporting or acting on an incident. Some managers believed they did not have the skills required to manage staff behaviour, and therefore misconduct, properly.

[287] Executives had varying views on the awareness and understanding of staff about misconduct. Some managers believed their staff would know what was acceptable behaviour (and therefore what was not) based on their assumption that staff were "professional" and "know" the right way to behave. Some managers were very confident their staff would recognise misconduct and had the capacity to deal with it, but some managers were not at all confident their staff knew what misconduct "looked like" or what to do when it occurred.

[288] "Culture of entitlement", protection and loyalty, and a fear of reprisal were raised by several of the executives interviewed, which affected how people reacted to misconduct. These cultural issues will continue to affect how misconduct is managed at RPH (and across WA Health wherever such cultures exist), and may have an adverse effect on the implementation of any mechanism for managing misconduct in the future, if they are not addressed.

[289] Notifications from RPH to the Commission increased in the period since the review of WA Health commenced (from 10 pre-review to 151 post-review). The majority of these were drug-related (124 out of 151). The increased focus by the Department on drug management was the likely reason. Some of the increase was explained by a bulk notification of old, previously unreported losses that may or may not be misconduct. Should the Department and RPH increase the focus on other misconduct risks, it seems likely that these numbers would also increase. Areas that warrant such attention may include:

- theft of other items such as food, small but expensive assets, patient belongings and consumables (toiletries, dressings etc.); and

- conflicts of interest (particularly in relation to medical staff).

[290] The Department was achieving some success (in terms of executive and staff awareness) with regards to the control and security of Schedule 8 and Schedule 4 drugs at RPH. As no formal misconduct risk identification had been carried out, there was little or no success in relation to the other misconduct risks that likely exist at RPH. Risks such as the theft and use of other hospital resources (linked to the "culture of entitlement") had not been addressed.

[291] On the basis of the above observations, the Commission formed the opinion that the Department was not adequately managing misconduct at RPH.

[292] The review at RPH did not find evidence of a strategy on the part of WA Health for managing misconduct at the site, or more widely.

2.5.8   RPH Recommendation

[293]

The Commission therefore made the recommendation detailed below.

(1)   That the Department improves the effectiveness of its implementation of a misconduct management mechanism at RPH by developing strategies to deal with the issues identified in this report, including the following:

- methods of delivering information to executives (noting the ineffectiveness of "global emails" and Servio Online);[26]

- low level awareness and understanding of misconduct across the site, including at executive level;

- confusion about the threshold for reporting misconduct;

- need for identification, recording and management of all misconduct risks;

- confusion about acting only on allegations made in writing;

- culture of entitlement, leading to theft of resources;

- culture of protection and loyalty;

- fear of reprisal amongst staff for reporting misconduct; and

- inadequacy of management skills especially in terms of managing staff behaviour.

[294]   WA Health responded to the RPH working paper by accepting all of the recommendations, some of which were being actioned by the time of the response (particularly the "awareness raising" aspects). The Department again reiterated the need to link the misconduct handling procedures at RPH to the overall "whole-of-Health" approach.

CHAPTER THREE
ISSUES RELEVANT TO THE REVIEW:
SENIOR HEALTH EXECUTIVE FORUM AND THE
CORPORATE GOVERNANCE DIRECTORATE

3.1   Senior Health Executive Forum

[295]   The Senior Health Executive Forum[27] (SHEF) is the most senior management tier of WA Health. It includes representation from all main functional areas. SHEF is the principal advisory body to the Director General of the Department, and is tasked with assisting the management of WA Health through discussion of, and provision of advice to, the Director General on strategic service, policy and administrative issues.

[296]   SHEF is comprised of the:[28]

    (1)   Director General;

    (2)   Executive Director Innovation and Health System Reform;

    (3)   Chief Executive North Metropolitan Area Health Service (NMAHS);

    (4)   Chief Executive SMAHS;

    (5)   Executive Director Child and Adolescent Health Service (CAHS);

    (6)   Chief Executive Officer WA Country Health Service (WACHS);

    (7)   Chief Medical Officer;

    (8)   Executive Director Mental Health Division;

    (9)   Executive Director Finance and Corporate;

    (10)   Executive Director Public Health;

    (11)   Chief Finance Officer;

    (12)   Chief Information Officer;

    (13)   Director Office of Aboriginal Health; and

    (14)   Director, Director General's Division.

[297]   The Operational Review Committee (ORC) is a subcommittee of SHEF. The ORC comprises the heads of the Area Health Services,[29] Finance and Corporate, and Innovation and Health System Reform. As the name suggests, it focuses more on operational issues.

[298]   The review team interviewed members of SHEF. The issue of what misconduct management messages are being delivered across WA Health is of utmost importance when looking at the implementation of a misconduct management mechanism. According to SHEF members

interviewed, they have neither received from Corporate Governance, nor delivered to their staff, a strategic message about managing misconduct in WA Health, i.e., an overarching message about why managing misconduct is important to staff in a context relevant to the health setting has not been articulated.

[299] Neither have the various initiatives being implemented by Corporate Governance (for example, policy, training, investigations and risk management requirements) been identified as part of a strategy for developing an overall mechanism for managing misconduct across WA Health.

> *… I think we could be sending a more strategic message … now we're ready to be more strategic … that strategic learning and reinforcement isn't happening …*

[300] Many members of SHEF expressed concern they had not directly dealt with the Commission to discuss WA Health's approach to managing misconduct. They felt they were not clear on the Commission's approach to managing misconduct, beyond the need to notify the Commission of suspected misconduct. SHEF members interviewed said the time had come for the Commission to directly discuss the issues raised in the review to date with them, rather than with Corporate Governance. Some wanted a more direct working relationship with the Commission, in terms of notifying the Commission directly about suspected misconduct, asking for prevention advice etc.

> *… it'd be good for you to come and talk to SHEF …*

> *… from my point of view it'd be helpful* [for the Commission to talk to SHEF] *… maybe at a point in the near future you can take that step …*

> *… I want a better, more direct relationship with the CCC … that would help us* [an Area Health Service] *and it would help you …*

[301] SHEF members were asked about their level of exposure to the review working papers. It seemed that summaries or only partial details had been provided. This was thought to be due to a reticence on the part of the subject hospital or health service to divulge the full details of the relevant working paper, or to "air their dirty linen".

> *… I briefed SHEF on* [the working paper] *… not everything, but I briefed them on the main issues …*

> *… no, it wasn't in great detail … we weren't all given a copy of* [the working paper] *…*

> *… the* [Area Health] *Chief Execs, yes, they knew, but the rest of SHEF not so much, not the detail* [of the working paper] *…*

[302] Despite this, SHEF members acknowledged in discussion that although the working papers focused on individual hospitals or health services, the

issues raised and recommendations made applied broadly across WA Health. This view was shared by, and often said to the Commission by, Corporate Governance over the course of the review. It was also reinforced in WA Health's response to the Commission's working papers on reviews at PMH, WACHS-Kimberley, RPH and of drugs. SHEF members felt that they would benefit from reading the draft working papers in full. Some also agreed that the use of case studies would be helpful to illustrate the types of misconduct-related incidents that occurred, and that in some way case studies and statistics describing types of misconduct should be made available to staff.

> *… some case studies would be very motivating for people …*

> *… how do you get the message to a person that* [misconduct] *is happening two doors down from them? … by telling them so! …*

[303] When asked about Corporate Governance and its role in managing misconduct across WA Health, SHEF's overriding opinion was that Corporate Governance is not in a position to do this on its own, i.e., SHEF members believed that as the heads of the main functional areas across WA Health, they are responsible for managing the conduct of their staff, and for developing any form of strategy or mechanism, for managing misconduct.

> *… I think each Area Health Service should run the operational stuff …*

> *… the worst thing we can do* [as SHEF members] *is say "so, Corporate Governance, what are you doing about this?" … it's <u>our</u> health service! …*

[304] Indeed, it was suggested that Corporate Governance did not have the status or authority within WA Health required to deliver the strategic message about managing misconduct in a systematic, cohesive, "whole-of-Health" way, or to implement the necessary mechanism.

> *… in an organisation like ours, the corporate governance function should be elite, and well resourced, and here it's not elevated to the level it should be …*

> *… what credibility do Corporate Governance have when they're delivering to the Areas? ... what do they know about service delivery? …*

[305] There was acknowledgement that the breakdown in getting messages (both strategic and operational) through to staff was an Area Health Service problem, not the fault of Corporate Governance. Indeed, there was much support from SHEF for Corporate Governance's approach, particularly to their proactive training programs and their meeting with staff face-to-face. However, there was an understanding that with almost 40,000 staff to reach, and with a very high staff turnover in some areas, Corporate Governance could not reach a critical mass of staff through training programs and face-to-face meetings.

> *… it's not* [Corporate Governance's] *fault if it goes no further at the Areas …*

> *… Corporate Governance can't possibly do it themselves … Corporate Governance can develop the plan, but they can't deliver it …*

[306]   The actual/practical autonomy of Area Health Services, even down to the hospital level, was raised as another reason why SHEF members believed that they, and not Corporate Governance, were best placed to deliver messages (particularly the strategic message) to their staff. SHEF members indicated there was agreement for Corporate Governance to be the support for Area Health Services to maintain consistency across WA Health, but ownership should reside with the Area Health Services.

> *... I don't think Corporate Governance is the delivery model … they were asked to develop the tools for others to use …*

[307]   For example, SHEF members said that training material creation, and guidelines for reporting and investigating misconduct should be developed and monitored by Corporate Governance, but delivery and dissemination to staff should be by functional area.

> *…* [delivery of the message] *needs to be from the DG* [Director General] *to the CE's* [Chief Executives] *and the role for Corporate Governance is to be the back-up …*

> *… Corporate Governance isn't "delivery", it's "advisory" …*

[308]   There was universal agreement that the Director General at the time of the review was serious about managing misconduct across WA Health, and that he had kept misconduct management on the agenda since taking up his position in 2007.

> *… there's a very strong imprimatur from the DG … it's that this is absolutely important …*

> *…* [the Director General] *is very interested …*

> *… the DG has consistently made it clear that this is very important stuff …*

[309]   Against that, several members commented that misconduct management was no longer the priority it once was, and that the appetite to act had diminished over the last 12 months. This decrease in focus was due to increasing pressure on the WA Health budget and resourcing issues.

> *… currently, to be honest, with everything that's going on, it's less important than it was a year ago …*

> *… the timing of this no one could change, but the last 12 months the focus has been about money …*

[310]　Several SHEF members raised the similarities between introducing a misconduct management mechanism and a clinical governance framework. WA Health has a clinical governance framework in place, as a result of extensive consultation and implementation over many years. For clinical staff, use of this framework has become a routine part of their service delivery. Several members discussed the possibility of linking corporate governance – specifically misconduct management – into the existing clinical governance framework.

> *… there's a parallel that needs to happen now between ethical practice and clinical practice …*

> *… there's a very useful partnership existing with the clinical governance framework … there's a useful alignment if we can get that link between the clinical and the behavioural …*

[311]　Some members agreed there were direct links between managing misconduct (or not) and clinical outcomes. Decreasing the theft of hospital resources, better management of contracts and tenders, and reducing or eliminating the misuse of drugs by staff were all raised as significant misconduct risks with negative clinical and/or financial outcomes. This again led to discussion about the need for the strategic message to staff to be about misconduct management as core business, and the need to link it to positive business outcomes.

> *…* [managing misconduct is] *about improving performance, improving practice, and improving product, and that leads to better outcomes for patients …*

3.2　Corporate Governance Directorate

[312]　Corporate Governance was established in 2001, as an amalgamation of internal audit units from various health services, along with a number of other governance-type roles. Several functional and budgetary reviews occurred in the period 2001-2007.

[313]　In 2008, a major review was undertaken, resulting in the structure at the time of the Commission's review. There are 40 approved FTE positions, with funding for 33. There are three business areas: Ethical Standards; Internal Audit; and Risk Management.

[314]　The Ethical Standards area consists of Accountability, and Education and Research. Accountability has responsibility for complaints management, the conducting or oversighting of investigations, and notifying the Commission of suspected misconduct. The Education and Research area has responsibility for the creation and delivery of governance education and misconduct prevention training, policy development, freedom of information services on behalf of the Department (and those of a complex or politically sensitive nature from across WA Health) and criminal record screening.

[315] The Internal Audit area is divided into Strategic Audit and Operational Audit. Strategic Audit focuses broadly on financial and compliance audits, while Operational Audit broadly looks at operational, clinical, legislation and policy audits.

[316] The Risk Management area acts as a consultancy service for WA Health. Officers liaise with risk managers from the areas to assist them in managing their risk registers, and to provide tools and advice.

[317] Twenty-one interviews were conducted with people in the following responsibility areas and/or positions:

(1) Director;

(2) Ethical Standards – Assistant Director, Principal Policy and Research Officer, Ethics Education Coordinator, Senior Policy Officer, Senior Analyst, Senior Screening Officer and Investigators (Principal and Senior);

(3) Audit – Assistant Director, Operational Audit (Manager, Principal and Senior Auditors) and Strategic Audit (Manager, Principal and Senior Auditors); and

(4) Strategic Risk Management Manager.

[318] During the review, management and staff of Corporate Governance were interviewed about several matters.

(1) The role and function of Corporate Governance in WA Health.

(2) The structure and reporting lines, at an individual staff member level and more strategically.

(3) How their individual role relates to misconduct management across WA Health.

(4) What, if anything, blocks Corporate Governance from achieving its aims.

[319] Of greatest significance with respect to Corporate Governance's approach to implementing a misconduct management mechanism was whether or not a strategic or big picture message – about misconduct management being core business, and about the mechanism for managing misconduct being an integrated, cohesive, "whole-of-Health" system – had been rolled out across WA Health. No such message had been delivered by Corporate Governance (or by SHEF as detailed above). However, many initiatives had been rolled out across WA Health, including policies, procedures and training.

[320] The majority of Corporate Governance staff interviewed said the biggest hurdle to them achieving their goals as a directorate was a lack of resources. Some staff believed that while the senior executive of WA Health were supportive of Corporate Governance in theory, there was a lack of support in terms of properly resourcing the area.

> *… sure, budget always plays a part … it's the prime blocker at the moment …*
>
> *… so* [SHEF] *said "yes, but it comes out of your budget" …*

[321] This was said in the context of most Corporate Governance staff believing they were the owners of misconduct management for WA Health, and as such there was an expectation they would be the ones to bring about change. Very few of the staff interviewed spoke of the Area Health Services as having a responsibility to assist, or indeed to manage misconduct themselves, beyond reporting requirements.

[322] A common view was that Corporate Governance was relatively powerless to act with respect to the Area Health Services. For example, Ethical Standards staff needed to be invited in to do training at hospitals, and sometimes had difficulty in gaining access to documents or information during the conduct of investigations.

> *…* [Ethical Standards] *need to be invited in by the Area Health Services … it's that they have to invite us in …*
>
> *… you need to finesse some people to get the information, because we can't demand it …*

[323] These issues caused frustration for Corporate Governance staff, and they felt WA Health was paying them lip service. There was a belief that if WA Health was serious about Corporate Governance's role, it would be resourced appropriately to deliver its function. Some of those interviewed commented that the Area Health Services only got interested in engaging Corporate Governance's services after a particularly serious event or a Commission review.

> *… I think* [Corporate Governance] *gets moral support … the ideas are supported as being reasonable, but there's not the financial support there …*
>
> *… there's a group out there who are interested, but only because something happened …*
>
> *… Royal Perth wants training, but why? … because you* [the Commission] *were there* [and reviewed them] *…*

[324] Despite the good intentions and diligence of Corporate Governance, it appears to be incapable of delivering a misconduct management mechanism to WA Health.

3.3 Fraud and Corruption Control Committee

[325] The Commission review team also spoke to members[30] of WA Health's Fraud and Corruption Control Committee (FCCC). The FCCC "... falls within the ambit of the overall risk management activities of WA Health, but has a specific orientation towards fraud and corruption control and the

responsibilities of management to implement effective prevention strategies and control measures ...".[31] The FCCC is the peak body, below SHEF, that has a focus on fraud and corruption (and misconduct more generally).

[326] FCCC includes representatives from:

(1) Office of the Director General (Chair);

(2) NMAHS;

(3) SMAHS;

(4) WACHS;

(5) Mental Health;

(6) Health Finance;

(7) Innovation and Health System Reform;

(8) Development Division;

(9) Health Workforce;

(10) Health Information; and

(11) Health Corporate Network.

[327] When asked what the FCCC did, members variously said it was for information sharing, listening to initiatives being progressed by Corporate Governance, offering feedback on such initiatives, acting as an advisory body and letting members take information back to their workplace for dissemination as appropriate. Two of the members said they were "not sure" what the role or purpose of FCCC was. Some members said there was the opportunity for them to bring issues from their own work areas to the FCCC for discussion or action, but that in practice only one of the members did so.

[328] Most of the members interviewed held a very high opinion of Corporate Governance, and were impressed by the proactive training and education that was being rolled-out across WA Health. Corporate Governance was seen as the owner and deliverer of misconduct management by most of the members.

> … they're proactive and have high quality products …

> … it's the lead branch and accountable area …

[329] However, a few of the members expressed a belief that Corporate Governance had neither the resources nor the responsibility to manage misconduct across WA Health, and that Area Health Services were responsible for governance issues.

> … it's up to the managers out there to manage …

> *… I don't know that it's* [Corporate Governance's] *role to filter the information down … there's an expectation that they do all of that stuff … the way I see it in* [my Area Health Service] *is that we here have the responsibility for transferring that information down …*

[330] Those members who believed Corporate Governance did have the responsibility to deliver misconduct management across WA Health spoke about the issues blocking Corporate Governance from doing so. These included: cultural reasons, such as WA Health staff thinking "we've always done things this way, and we won't change" or "we're all good people so no one will do the wrong thing"; a lack of support from the Area Health Services; and a lack of resources (as mentioned above).

3.4 Discussion

[331] In the context of the preceding chapter dealing with reviews of hospitals and the misconduct risk associated with Schedule 8 and Schedule 4 drugs, comments made by SHEF members, Corporate Governance staff and FCCC members are illuminating.

[332] Although Corporate Governance is familiar with the contents of the working papers on reviews of hospitals and the misconduct risks associated with drugs management, SHEF is only aware in broad terms. It is not possible to see how WA Health can develop the necessary strategy and mechanism for preventing and managing misconduct while this situation remains. The only thing that can happen is ad hoc responses to particular issues (such as the Schedule 8 and Schedule 4 drugs issue) and the delivery of training. The training described is delivered without context, without the support and authority of some overriding strategy, and, from a staff perspective, is not delivered to address any particular problem or identifiable issue. It is, therefore, not surprising that the review at RPH identified only limited practical application of misconduct resistance and management, despite the issue having been on the table for the preceding 18 months.

[333] Such ad hoc responses appear certain because the responsibility for managing misconduct and developing the means to do so is unclear, and SHEF and Corporate Governance each have a different view about this. One of them needs to be made responsible. Whichever one is made responsible needs to be fully apprised of the issues and engage the wider organisation in resolving those issues in a strategic, coordinated way.

[334] WA Health must therefore identify a workable strategy, and identify who is responsible for ownership and delivery of the mechanism. Whether this is SHEF, Corporate Governance or a joint body (or another body) they must be resourced appropriately and hold enough power to implement change. This strategy and ownership must also be clearly articulated to the whole of WA Health.

CHAPTER FOUR
CASE STUDIES

4.1 Introduction

[335] The following case studies and anecdotes are used to illustrate the difficulties faced by those responding to misconduct. The matters were raised by staff during the course of the review, and refer to contemporaneous issues and to older cases. These case studies show the complexity of managing misconduct in the absence of a mechanism for doing so. The fact the case studies and most anecdotes refer to drug-related issues highlights a clear misconduct risk within WA Health.

4.2 Case Study One

[336] This case involved the loss of Schedule 4 temazepam from an emergency department (ED). The ED had recently introduced the practice of storing Schedule 4 drugs "of interest" (including temazepam) in the locked Schedule 8 cupboard, and to record and count them as per Schedule 8 drugs. The department had introduced the practice because there had been "significant numbers of drugs going missing".

[337] At 9:30 p.m. during the first week of locking and counting Schedule 4 drugs "of interest", two nurses accessing the temazepam in the drug cupboard discovered 21x10 mg tablets of the drug missing. All of the drugs in this cupboard had been checked as correct at 1:30 p.m. that day.

[338] Some informal inquiries were made by the shift nurse manager with staff on duty, and hospital Security was notified. Limited inquiries were made by Security staff and although an empty temazepam box was found, no conclusion about the missing drugs was reached. On the basis that there was a "lack of any further information being obtainable", the matter was closed by the hospital.

[339] This particular case was raised by a nurse manager from the ED during a discussion with the Commission's review team. She expressed her concerns about the way in which the matter was handled by the hospital. Her concerns were:

- she was uncertain about the process for dealing with the matter;

- there was little information provided about the action being taken;

- there was no assistance or direction in respect of how she should proceed; and

- she was unsure how to deal with staff affected by the incident.

[340] There are a number of issues about the managing of drugs in hospitals that are relevant to this case.

- The Schedule 8 cupboard in which the missing temazepam was kept was located in a small room adjacent to the ward, in an isolated area.

- The drug room was lockable, but was left unlocked for access.

- A number of registered nurses held the keys for the Schedule 8 cupboard during each shift.

- Counting drugs in the Schedule 8 cupboard was undertaken only once per day and in this case took place during the morning shift. The drugs were discovered missing on the evening shift (two shifts later).

4.3   Case Study Two

[341]   This case involved the loss of a 15 mg ampoule of Schedule 8 morphine from a hospital theatre area. At 8:00 a.m. (during the morning shift) nurses conducting a check of a theatre Schedule 8 drug cupboard discovered a discrepancy in the morphine stock. According to the drug register morphine had last been dispensed for a theatre procedure at 6:15 p.m. the previous evening.

[342]   Some informal inquiries were conducted by the theatre area nurse manager with staff, and patient records were checked. Her conclusion was that there was a recording error. Further inquiries were conducted by hospital Security. In their discussions with the nurse manager at the time, it was evident that key control was an issue. The nurse manager stated that she had not issued keys for that particular theatre cupboard, and that these keys (and others) were locked in a central safe (there were a number of theatres and drug cupboards in operation). Despite this, drugs were accessed from the cupboard. Security reached the conclusion that there was no error and, therefore, the ampoule had been stolen. However, as no person of interest was identified from these inquiries, Security closed the matter.

[343]   Corporate Governance did not investigate further and offered no view about the adequacy of the action taken at the hospital. Corporate Governance informed the Commission that the matter was closed. The Commission referred the matter back to the Department for review and further inquiries.

[344]   The Department's subsequent review of the hospital's investigation confirmed there was a discrepancy in the amount of morphine on hand, but concluded that there was insufficient evidence to say that the drug had been stolen. There were conflicting accounts between the anaesthetist and the theatre nurse (responsible for obtaining the drug for the anaesthetist) about how much morphine was requested and provided. The anaesthetist claimed he asked for one ampoule, the nurse claimed he asked for two. The register shows one ampoule was removed but two were subtracted from the total. The anaesthetist and the nurse both signed the register.

[345] This case raised a number of issues relating to drug management and handling procedures in theatres that may have been contributing factors to the loss.

- Both the anaesthetist and nurse were new to the hospital and uncertain of drug handling procedures.

- Drug counts of Schedule 8 cupboards were undertaken only once per day.

- Only one person (the theatre nurse) accessed the drugs from the Schedule 8 cupboard.

- The anaesthetist recorded the issuing of the drugs in the register, even though the nurse (and not the anaesthetist) had obtained the drugs.

- The theatre nurse manager on the night shift, responsible for keys to all theatre cupboards, did not issue the keys for the theatre cupboard in question.

4.4 Case Study Three

[346] This case relates to the management of reported misconduct, involving a young doctor (Dr A). Dr A displayed unusual behaviour at three different hospitals, two metropolitan and one regional. At each hospital, his behaviour was witnessed and reported by concerned staff.

[347] Dr A was seen at all three hospitals with stolen hospital equipment, including: an insulin syringe and an alco-wipe; a medical bag containing syringes and butterfly needles; medications; a "burette and a giving set"; and "a bag of IV [intravenous] fluid and IV giving set" (these are items used for taking drugs intravenously).

[348] Dr A was inattentive to patients in an emergency department, displayed a lack of thoroughness to assessments (including misdiagnosing a patient), and was absent from his work area for periods of time.

[349] Dr A was observed at one location:

> *… walking aimlessly around a lot … found on several occasions to be staring at hospital equipment and medications* [including in the resuscitation room] *… on some occasions was unable to be located … standing outside the department on several occasions … stated he felt tired and nauseated … was constantly eating including half a pineapple, a double pack of "Tim Tams"* [chocolate biscuits]*, an entire Turkish bread and dip … he made a coffee but when pouring the milk missed* [the cup] *completely and didn't notice …*

[350] A registrar who witnessed the above behaviour checked the drug stocks and found there was no midazolam (a Schedule 4 anaesthetic) in the

resuscitation room. There had been two 15 mg vials of the drug in the room earlier, and no midazolam had been administered since. The same registrar searched the toilets and found the broken top of a glass drug vial, broken glass on the floor, and a venepuncture circle bandaid with a blood spot in the toilet.

[351] An emergency department doctor described Dr A's behaviour in relation to his treatment of a patient at about 2:30 a.m. one shift, saying:

> … I became suspicious that he wasn't just merely tired [he had complained of being tired]. He wasn't acting tired, he was constantly eating, his pupils were dilated and he had a "glazed" look to him. I found him in the tea room and asked him to see a patient that was waiting. Instead of seeing the [patient] he came and stood in front of me while I was reviewing a [patient], he was staring blankly and when I asked what he wanted he didn't respond. I had to instruct him to see the [patient]. I subsequently went to talk to him about the [patient] he had reviewed but was unable to find him. I spoke to the nurse involved who said that [Dr A] had said the [patient] had asthma although he gave no instructions regarding management. The nurse was concerned and she stated it was very obviously not asthma. I then reviewed the [patient] briefly and ascertained that it wasn't asthma. I got another doctor to complete the care of the [patient] and went looking for [Dr A]. He was outside the department … When [I] confronted him he said that he was just tired and felt unwell …

[352] Dr A was allegedly seen by nursing staff entering the male toilets and was "staggering" when he emerged.

[353] Intravenous materials and a broken ampoule were found in the same toilets, and some two weeks previously nursing staff had found similar items of equipment used in drug administration and blood stains in the toilet when Dr A was on duty.

[354] At another location, Dr A was:

> … disoriented and confused … a nurse saw him throw [an] ampoule in [the] bin … didn't report it … drugs went missing when [Dr A] was at work … [when he was] on leave it stopped … nursing staff knew he wasn't right and wanted to protect him …

[355] The missing drugs were midazolam and propofol (a Schedule 4 anaesthetic), both kept in the emergency area of the regional hospital. It was established through a daily audit that an ampoule of propofol had been taken during a short period Dr A had been attending the emergency area. Police were called. Dr A was later found by a member of the public semi-conscious in his car in a public car park, in the process of administering the propofol.

[356] Subsequently, Dr A admitted to having taken anaesthetic-type drugs from the hospital on a number of occasions. He explained that he had done so because he was not taking his prescribed medication for his mental condition and he was progressing towards a "manic state".

[357] The management response to the incidents attempted to be therapeutic in nature, i.e., while the mental health issues associated with Dr A's behaviour were addressed (to varying degrees and with varying effectiveness), the management of the misconduct elements of his behaviour (including theft of drugs and equipment) was not addressed at all. Decisions were made at an executive level to maintain confidentiality about Dr A's mental health and misconduct, and vital information was actively withheld from those who had responsibility for his management.

[358] Several managers involved commented that they had not been given information they considered to be crucial in managing and working with this doctor.

> *… should I have been made aware? Absolutely …*

> *… I don't think it* [sharing information] *is done well. The dilemma is that if you say "you're getting a doctor with a problem" they won't want them …*

[359] Only the final incident in the car park was reported to the Commission (by Western Australia Police), and to the Medical Board.

[360] There was no mechanism for dealing with misconduct at the locations where Dr A worked. The case illustrates how serious the consequences may be (for example, misdiagnosis of patients and self harm by the individual) when not enough importance is placed on managing misconduct.

4.5 Case Study Four

[361] This case relates to a registered nurse who stole and self-administered Schedule 8 and Schedule 4 drugs. These events occurred over a period of two and a half months, while she was relieving at a remote area nursing post and working at the area regional hospital.

[362] The problem came to attention when the regional pharmacist noticed that an unusually large amount of pethidine (a Schedule 8 painkiller) had been ordered by the nursing post during the nurse's 22-day relieving period. Two boxes of 5x10 mL ampoules were ordered from the regional pharmacy, and 5x100 mL ampoules were also obtained from the Royal Flying Doctor Service. No pethidine had been supplied to the nursing post in the previous two years. At the time the ordering was noticed, the nurse was back working at the area regional hospital. After her return, there had been a series of events involving increased and unexplained breakage of pethidine ampoules at the hospital. There had also been an incident at the hospital's nurses' quarters where the nurse was found unconscious. When being treated by emergency staff, she requested pethidine.

[363]   Local level inquiries were made into the earlier matter of pethidine being ordered at the nursing post. These inquiries concluded that there was "insufficient evidence" to prove misuse of the drug by the nurse. The incident was reported to the Nurses Board, but the Commission, Corporate Governance and Chief Pharmacist were not notified. The Nurses Board advised that the nurse had previously been suspended for misconduct, but provided no further information for confidentiality reasons. The nurse was subsequently reinstated to work at the regional hospital, subject to supervision.

[364]   Two events followed the nurse's return to work. The first was an unexplained loss of five ampoules of pethidine from the hospital emergency department. The second was that the nurse was found in the hospital disoriented and threatening self-harm. She had two empty ampoules of midazolam (a Schedule 4 drug "of interest") and a syringe in her handbag. A search of the nurse's work area found a further three used midazolam ampoules. There had been no prescribed administering of midazolam in this area. A local level investigation was conducted and the matter was reported to both the Western Australia Police and the Nurses Board.

[365]   In respect of the nursing post incident:

- daily checks and balances on drug use failed to identify issues with the abnormal amount of pethidine being ordered and administered; and

- Schedule 8 drugs were able to be obtained at the nursing post from a source other than the regional pharmacy, without accountability.

[366]   In respect of incidents at the regional hospital:

- pethidine was able to be accessed;

- the drug midazolam is a Schedule 4 drug "of interest", and Schedule 4 drugs are not stored securely, have no recording procedures for access and dispensing, and are, therefore, easily accessible;

- the misconduct risk (particularly in the regional and remote area context) associated with Schedule 8 and Schedule 4 drugs "of interest" had not been identified; and

- a misconduct management process was not in place to ensure that an overarching management view was formed about the relationship (if any) between the nurse's drug use, the various events and misconduct.

4.6   Case Study Five

[367]   Mr C was employed as a registered nurse in an Intensive Care Unit (ICU). On a night shift he and another nurse were looking after an extremely ill patient who was receiving a continuous infusion of fentanyl. As fentanyl is

a Schedule 8 drug, two nurses were required by policy to access, sign for and administer the drug. During his shift Mr C requested 500mcg of fentanyl to prepare for his patient. The drug was removed from the cupboard in accordance with policy at 3:25 a.m., but the drawing up of the drug by Mr C was not witnessed.

[368] At 6:20 a.m. Mr C's colleague reported that Mr C had not been seen since he had gone for a break about an hour earlier. Mr C was found collapsed in the male toilets with a syringe on the floor near him and blood on his uniform.

[369] Mr C's colleagues covered for him. The syringe was disposed of in the sharps container (it was later retrieved) and Mr C was driven home by his colleagues.

[370] Two days later, the incident was reported to Human Resources and subsequently to Corporate Governance. Mr C was suspended with pay pending the outcome of an investigation. The Commission was notified eight days after the event. Mr C was charged by the Western Australia Police and pleaded guilty to stealing as a servant and using prohibited drugs, and the Nurses Board suspended his registration for two years.

[371] The significant issues to note about the case are as detailed below.

- Attempts to hide the misconduct were made. The syringe was discarded, Mr C was driven home, and two days elapsed before Human Resources and Corporate Governance were notified.

  > … [the incident] *was handled badly … we covered it up to "do the right thing" by the person, and not the hospital …*

- The nurse's condition was initially only dealt with as a health issue. The nurse was offered medical assistance, but the matter was not, at the time, viewed or treated as a misconduct issue (the theft and use of drugs).

- Staff providing statements were victimised and confronted by colleagues.

  > … [people involved said] *"I saw your statement and it's not right!" …*

- Some staff refused to make and/or sign written statements, which may have been due to fear of reprisal or not wanting to "dob in" a colleague.

- There was a risk to patient safety in this event.

[372] The manager interviewed stated that the result was that:

> … *the trust in the Unit was destroyed … I'm not sure if staff would report incidents in the future …*

[373]   The Commission is not critical of all aspects of the handling of Case Study Five, including the subsequent management of the patient involved (the syringe drawn up by Mr C was discarded and new medication drawn, to ensure patient safety). However, the Commission is concerned that unless the cultural issues of loyalty, protection and fear of retribution are addressed, success in implementing a misconduct management mechanism is unlikely, and future incidents such as this may not be reported by witnesses.

4.7   Case Study Six

[374]   A comment added to a Clinical Services Risk Register highlighted the magnitude of the problem of unaccounted for drug use. It is reproduced in Case Study Six below:

> *Data from an ICU audit pre and post introduction of recording Panadeine Ft* [Forte] *tablets found that there was a 99% reduction in usage, i.e., normal patient usage across* [two ICU areas] *is about 200 tablets per year and before the control was introduced it was about 16,000 tablets per year. A report is being sent to Corporate Governance.*

> [ICU Ward D] *recently discovered suspected theft of tablets and also found that patients own DDs* [Dangerous Drugs/Schedule 8 drugs] *recorded into the S8* [Schedule 8] *register had not been accounted for on discharge, i.e., they were not written out of the register and it is unclear whether they were returned to the patient or misappropriated.* [Ward D] *have decided to implement the S4R* [Schedule 4 restricted drugs "of interest"] *proposed procedures in advance of any Operational Directive. The Operational Directive* [OD] *is being drafted by the Chief Pharmacist, DoH* [the Department] *with assistance from members of the Chief Pharmacists Forum. Stakeholder feedback will be obtained before approval to release the OD.* [Another hospital's] *nursing* [staff] *object to the proposal and have fed back to the CNO* [Chief Nursing Officer].

> *The S4R aspect of the Treatment Plan is only one part of the plan and will not address theft of other drugs like antibiotics. A comprehensive approach has been drafted and submitted to* [the Director Clinical Services] *for review. Leadership and clear messages* [need to be] *given to all staff that stealing drugs is a job and career threatening offence,* [and are] *just as inappropriate* [as] *internet or other stealing charges. The Risk Likelihood is the same* [as before] *as limited changes have occurred although as a result of stakeholder input to the policy and visits to all wards by pharmacy and nursing an increased awareness has developed resulting in some wards being more proactive. The risk has not increased as far as I know but it could in the lead up to any policy change if a staff member has a drug habit and knows that their opportunity to steal drug*[s] *in*

the future is ending. The Risk does require Executive attention because [the Commission is] *involved and their report and Health's response will soon end up in Parliament and if there has been inadequate response by Health or Hospitals it will be very damaging to our credibility across the board.*

4.8 Anecdotes

[375] During the course of the review, people used anecdotes to describe their experiences with, and understanding of, misconduct. Some of these anecdotes have been reproduced below to illustrate the complex nature of misconduct in a clinical setting.

> *… a* [nurse] *was swapping the syringe a few years ago … he swapped* [the drug] *out for saline or water … he injected the Schedule 4 drug and collapsed and had to be "resussed"* [resuscitated] *… it could have gone on undetected for ages … he was doing it for some time … patients vary with how much they need but if you have to give more you don't suspect that it's just water, you might think "gee, that's strange" but carry on … you'd just give them another dose …*

> *… we had an unstable medic here, a doctor prescribing high level drugs, like to 22 out of 30 patients … I thought it was unnecessary … she was turning up to pharmacy and saying "I'll deliver them to the patient's house" … drug abuse isn't part of my training so I find it very hard to deal with … you think you can trust everybody but you can't … it was all intuitive and gut feeling … gathering the evidence took time …*

> *… I've had instances with staff* [stealing] *and it's very difficult to catch … in my case, she was pinching drugs and money off patients … we had surveillance and everything and still couldn't catch her out … eventually she took a ring off a dead patient's finger and got caught out … staff find it very difficult to believe that a colleague would do something like that, but they do …*

> *… we had a big problem in 07/08 where I believe there were significant numbers of drugs going missing but it was hard to reconcile … I think it was* [Schedule 4] *Panadeine Forte and temazepam …*

> *… there was a matter a few years ago when some Security officers were accused of theft, the outcome was that people were charged and dismissed …*

> *… there are problems with cronyism and nepotism in employment practices …*

> *… you hear of mogadon[32] slushies at parties …*

… a doctor was raiding the ED [emergency department] *cupboard and the nurses were letting them* [sic] *… no-one has tried to change the culture, it's pervasive, even the exec culture is there, they comment as if they can get a packet of this or that … it slips out now and then and you see the culture … the system is open, it's a lolly shop, people don't lock cupboards, it's systemic …*

… years ago I was relieving for someone, and this girl came to work, and patients complained about her being drowsy etc. … I warned them [management] *and we were told she was "unwell" … she got treatment for drugs and alcohol … she came back to work for us again, years later, again on nightshift … I investigated where she'd been borrowing drugs from, I was alert … she spent the first two hours of the shift borrowing benzos* [benzodiazepines] *from other wards …*

… there's a rumour going around that one of the [staff] *is the chief supplier of drugs for hospital staff …*

CHAPTER FIVE
INDEPENDENT SURVEY: MISCONDUCT MANAGEMENT AND REPORTING

5.1 Survey

[376] The Commission engaged an independent market research company to undertake a survey of the attitudes of WA Health staff to, and awareness about, a range of issues connected to misconduct management and reporting. The survey focused on:

    (1) employees' knowledge and understanding of misconduct; and

    (2) how their work place deals with it.

[377] The survey was anonymous and voluntary. Surveys were sent to 2,956 WA Health employees across the major occupational categories. The response rate was 31.12% (920 responses).[33]

[378] The occupational categories covered were as detailed below.

- **Administration and clerical:** includes all clerical-based occupations such as ward and clerical support staff, finance managers and officers.

- **Hotel services:** includes catering, cleaning, stores/supply, laundry and transport occupations.

- **Medical salaried:** includes all salary-based medical occupations (interns, registrars, specialist medical practitioners etc.).

- **Medical sessional:** includes specialist medical practitioners that are engaged on a sessional basis.

- **Medical support:** includes all Allied Health and scientific/technical-related occupations.

- **Nursing:** includes all nursing occupations (does not include agency nurses).

- **Site services:** includes engineering, garden and security based occupations.

- **Specialist categories:** includes indigenous and ethnic health worker-related occupations.

5.2 Demographics

[379] The basic demographic snapshot gathered from the survey is as detailed below.

- 78.4% of respondents were from the Perth metropolitan area, with the remaining 21.6% from regional Western Australia.

- 14.3% of respondents indicated that they were in a management role, and of those, 45.6% were in a supervisor role, 39.2% middle management, 4.0% management/corporate policy and 11.2% in an executive/senior role.

- 41.1% of respondents indicated that they have worked within WA Health for more than 10 years, 18.3% for less than two years and also 18.3% for six to ten years, and 22.2% for two to five years.

- As depicted in Figure 1, the bulk of metropolitan respondents came from the North Metropolitan (38.8%) and South Metropolitan (38.0%) Area Health Services. Almost equal numbers came from the Department (9.9%) and Other Metropolitan Health Services (9.6%) (including Peel Health Services, CAHS, Pathwest Laboratory Medicine WA, Dental Health Services and the Drug and Alcohol Office). The balance of respondents was from Other (3.7%).
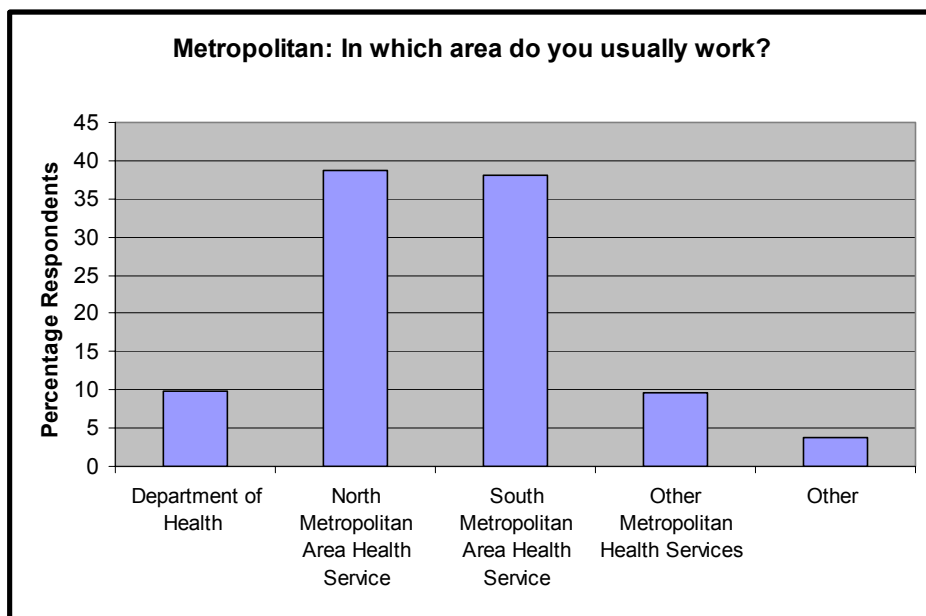

Figure 1

[380] As depicted in Figure 2, the majority of regional respondents were based in the South West (29.1%) and Wheatbelt (22.9%) regions, followed by the Great Southern (15.1%) and Midwest (14.0%). The balance of respondents was from the Goldfields (7.8%), Kimberley (5.6%) and Pilbara (5.6%).
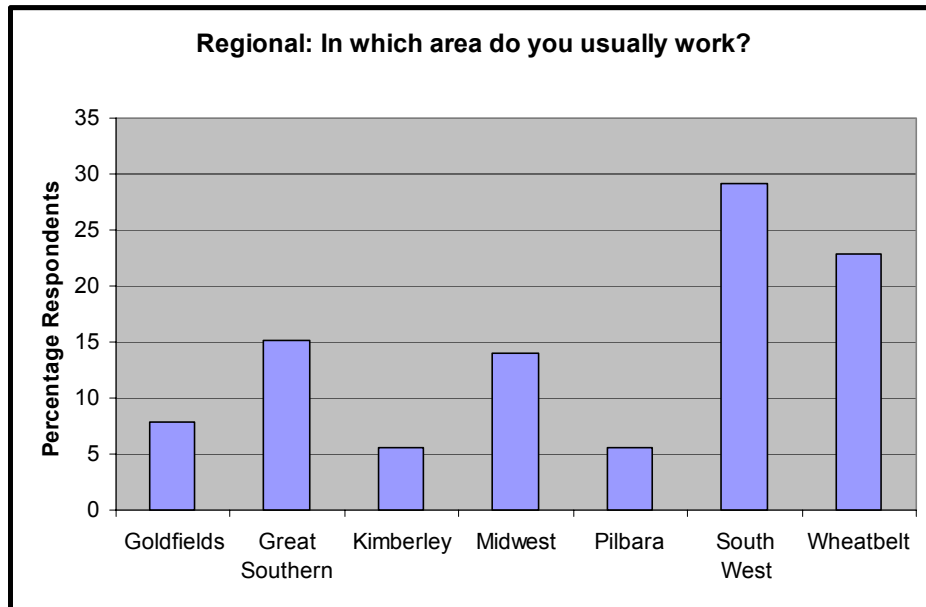
Figure 2

[381] As depicted in Figure 3, the three biggest occupational categories were nursing at 33.9% of respondents, medical support 21.5% and administration and clerical 17.2%.

Figure 3

5.3 Survey Results

[382] Fifteen questions/statements covering misconduct-related issues were included in the survey,[34] and responses were as detailed below.

[383] **Question 1:** *The Director General of the Department of Health has a legal obligation to report all suspected misconduct to the Commission* [True/False]*.*

- 92.1% of respondents answered correctly that this is true.

[384]   **Question 2:** *As an employee within WA Health, you have an obligation to report all suspected misconduct to the Department of Health* [True/False].

- 89.2% of respondents answered correctly that this is true.

[385]   **Question 3:** *Any public officer can report suspected misconduct to the Commission* [True/False].
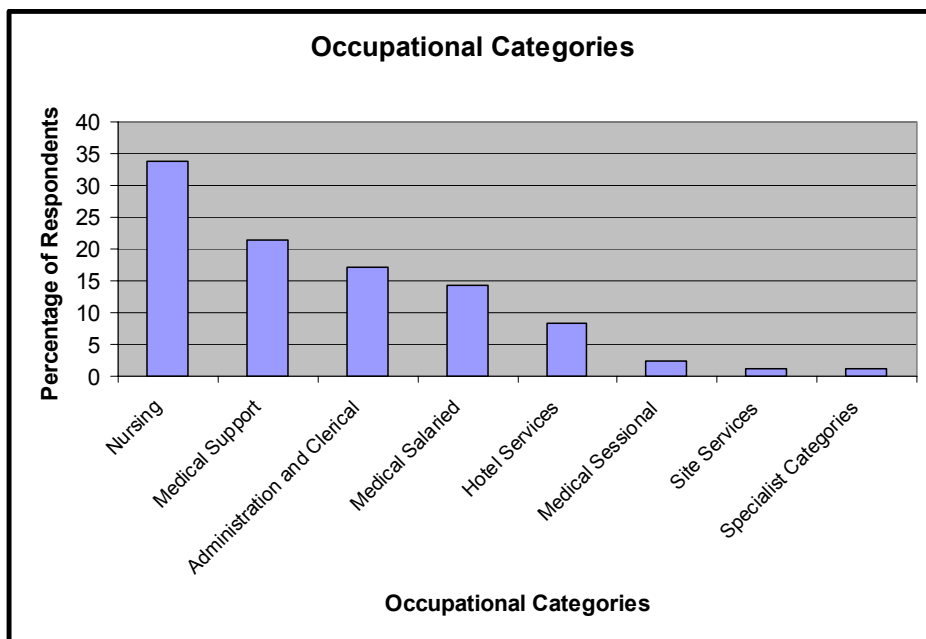
- 92.0% of respondents answered correctly that this is true.

[386]   **Question 4:** *You must report any personal conflict of interest to the Department of Health* [True/False].

- 71.1% of respondents correctly answered that this is true.

- The specialist categories of occupations recorded the lowest correct rating with 50.0%.

[387]   **Question 5:** *How informed do you consider yourself to be about misconduct risks in your workplace?* As depicted in Figure 4, 7.7% said they were well informed, 40.0% adequately informed, 40.5% poorly informed and 12% were not sure.

How informed do you consider yourself to be about misconduct risks in your workplace?

- Well informed
- Adequately informed
- Poorly informed
- Not sure
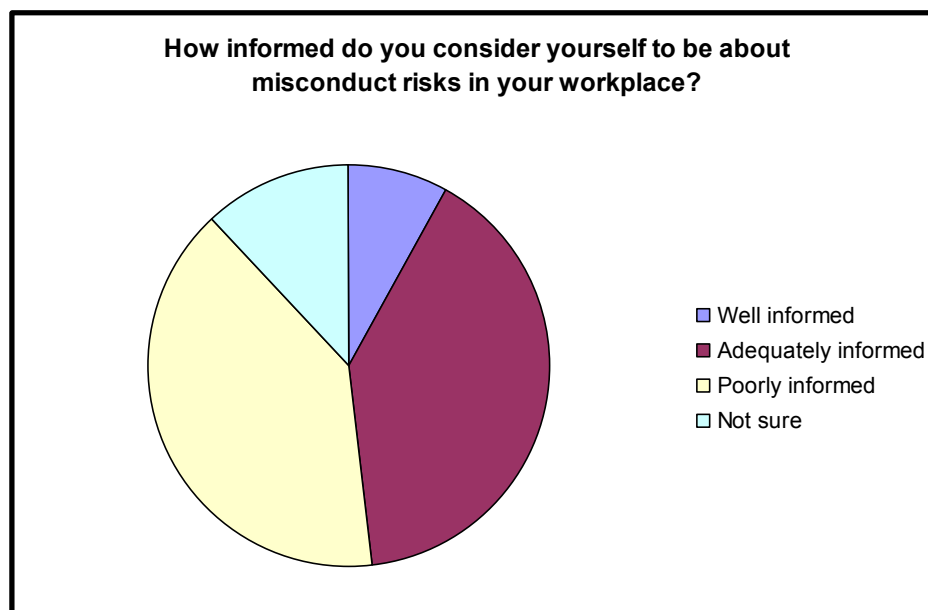
Figure 4

[388]   This means 47.7% of respondents considered themselves to be either well or adequately informed about misconduct risks, while 52.5% considered themselves poorly informed or not sure.

[389]   **Question 6(a):** *Are you aware of any policies that address issues such as the management and prevention of misconduct and how these relate to your workplace?* As depicted in Figure 5, 43.2% of respondents were not aware of any such policies, 17.9% did not know but knew where to look, and 12.2% were unsure. The balance of respondents (26.7%) knew of such policies. Medical sessional staff accounted for the highest proportion of staff unaware of misconduct-related policy, at 76.2%.

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Are you aware of any policies that address issues such as the management and prevention of misconduct and how these related to your workplace?

- Yes
- No
- No, but know where to look
- Don't know

Figure 5

[390] **Question 6(b):** *Please list any policies of which you are aware.* The most common policies listed were (in decreasing order):
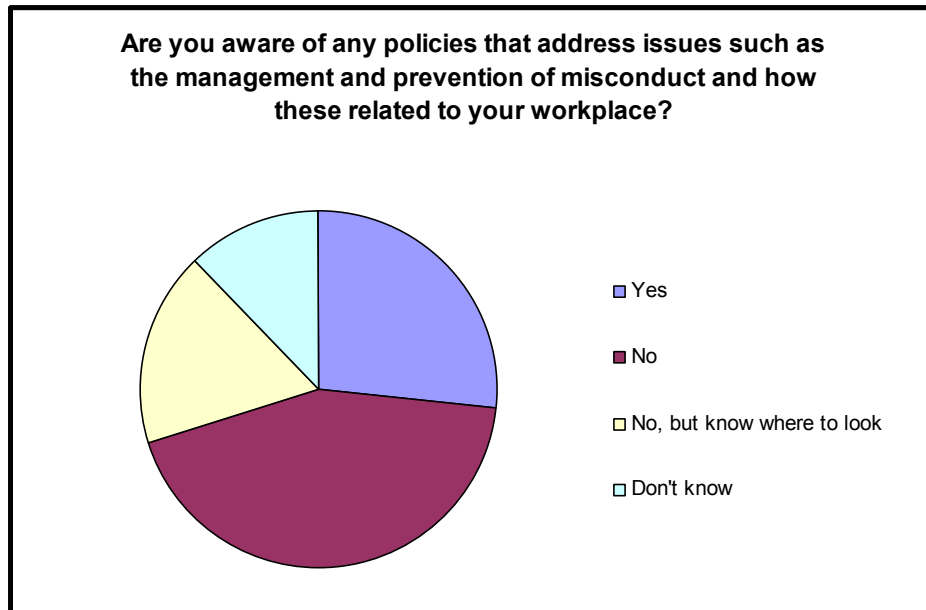
- Code of Conduct;

- Workplace Bullying and Harassment;

- Code of Ethics; and

- Misconduct Policy.

[391] **Question 6(c):** *How can you access these policies?* The most frequent examples of how to access the policies listed were:

- workplace intranet;

- Department Website; and

- hard copy documents issued from section/division/Area Health Service.

[392] **Question 7(a):** *Have you ever received training on misconduct?*

- 28.3% of staff said that they had received some training on misconduct.

  - The majority (51.5%) indicated that this was on-the-job or informal training (question 7(b)).

- None of the medical sessional staff said they had received any training.

[393] **Question 8(a):** *I am aware of the types of behaviour that could constitute misconduct* [Agree/Disagree etc.]. As depicted in Figure 6:

- 81% of respondents indicated they agreed with the statement;

- 7.5% disagreed;

- 6.4% neither agreed nor disagreed; and

- 5.2% of respondents answered "don't know/unsure".
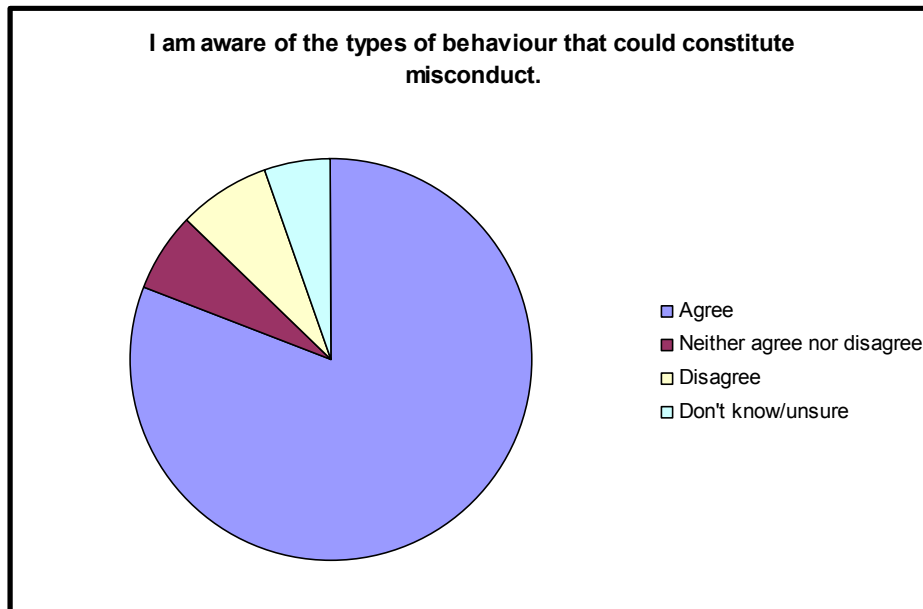
Figure 6

[394] **Question 8(b):** The most common examples of behaviour which might constitute misconduct provided by the respondents were, in decreasing frequency:

- stealing;

- bullying;

- sexual harassment;

- breach of confidentiality; and

- fraud.

[395] **Question 8(c):** Respondents who said they were aware of the types of behaviours that could constitute misconduct were asked to describe where they obtained their knowledge (and could list more than one source). 80.4% said that they gained their awareness from general knowledge and 36.3% indicated they found out from departmental notices/pamphlets/posters.

[396] **Question 9(a):** *I have personally witnessed misconduct in the workplace* [Yes/No]. Approximately 24.7% of respondents reported that they had personally witnessed misconduct in the workplace. The highest ratio of those witnessing misconduct by occupational group was hotel services

(catering, cleaning, stores/supply, laundry, transport services etc.), at 41.7%.

[397] **Question 9(b):** Of those respondents who had witnessed misconduct in the workplace, 62.8% had not reported it.

[398] **Question 9(c):** As depicted in Figure 7, the two main reasons for not reporting were (where respondents could provide more than one response):

- it's a waste of time, nothing would happen (27.4%); and

- my report would not remain confidential (26.1%).

[399] Where the response was "Other", the main reason given was that they were unsure whether it was serious enough to report to the Department (18.1%).

Figure 7

KEY: 1. It's a waste of time, nothing would happen.
2. My report would not remain confidential.
3 Other
4. I would be victimised by my manager.
5. I would be victimised by my colleagues.
6. I don't want to get involved – not my business.
7. I would be bullied.

[400] **Question 10(a):** *Management has demonstrated to me a commitment to preventing and managing misconduct.* As depicted in Figure 8:

- 47.5% of respondents indicated that they agree with the statement;

- 22.9% disagreed;

- 23.0% neither agreed nor disagreed; and

- 6.5% of respondents did not know or were unsure.

Management has demonstrated to me a commitment to preventing and managing misconduct.

- Agree
- Neither agree nor disagree
- Disagree
- Don't know/unsure
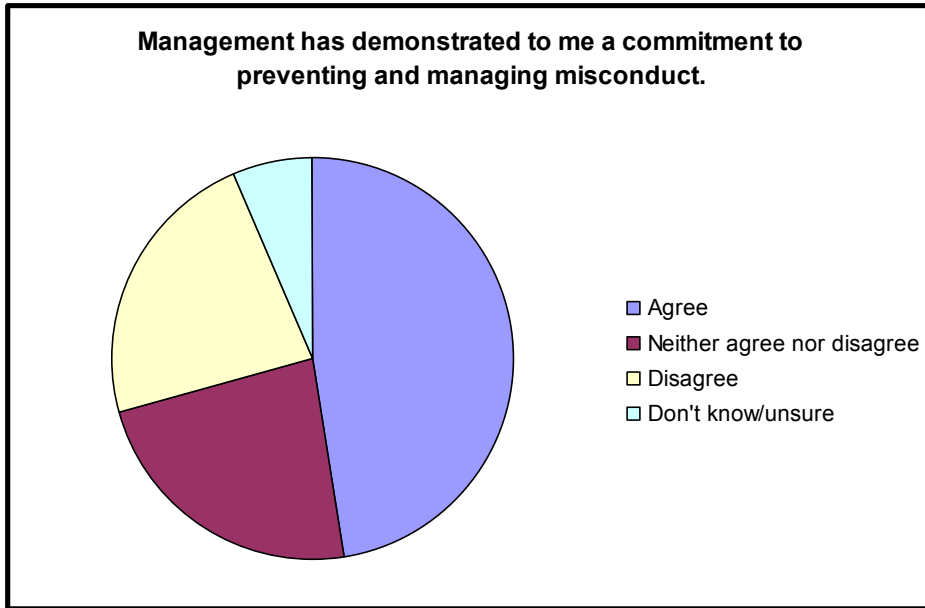
Figure 8

[401]   As depicted in Figure 9, of the respondents who agreed that management had demonstrated a commitment to preventing and managing misconduct, the top three examples given were:

- relevant policy and procedures (51.3% (or 24.4% of all respondents));

- electronic notifications/reminders (37.1% (or 17.6% or all respondents)); and

- taking action on reported matters (36.2% (or 17.2% of all respondents)).

Respondents were able to provide more than one example.

How has management demonstrated their commitment?

Percentage of Respondents

Relevant policies and procedures. / Electronic notifications/reminders. / Taking action on reported matters. / Posters/pamphlets. / Training/seminars. / Agency/section meetings. / Other
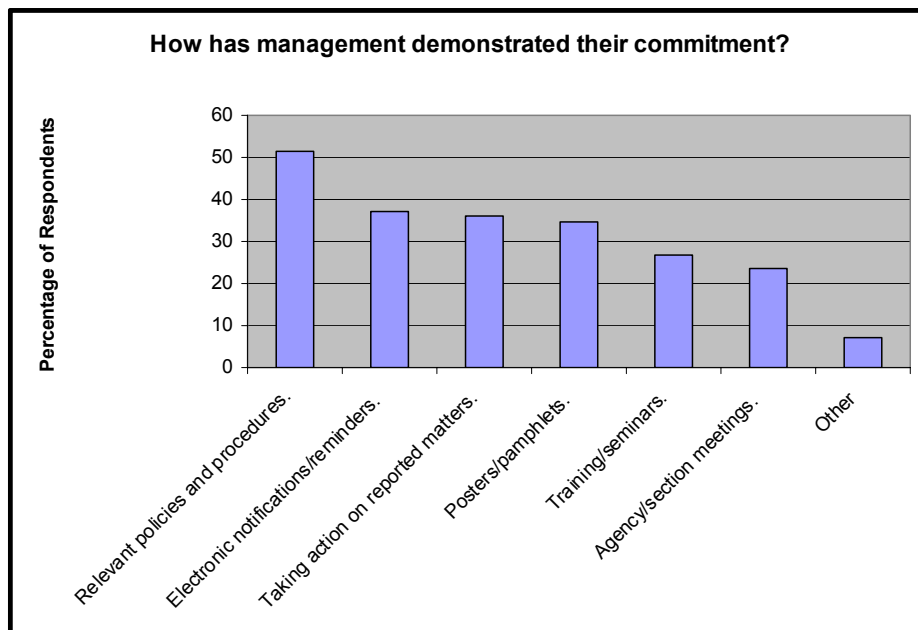
Figure 9

[402] **Question 11(a):** *To my knowledge, the Department of Health deals with misconduct by staff in a consistent and fair manner.* As per Figure 10:

- 32.8% of respondents agreed with this statement;

- 13.1% disagreed;

- 24.4% neither agreed nor disagreed; and

- 29.8% didn't know or were unsure.

Figure 10

[403] This means less than a third of respondents agreed with the proposition that management deals consistently and fairly with misconduct. Respondents were also asked why this was the case (Question 11(b)). Most respondents indicated that it was because they had not had any direct experience with or exposure to misconduct.

[404] **Question 12(a):** *The Department of Health is serious about protecting staff who report misconduct.* As depicted in Figure 11:

- 35.4% of respondents agreed with the statement;

- 11.3% disagreed;

- 24.0% neither agreed nor disagreed; and

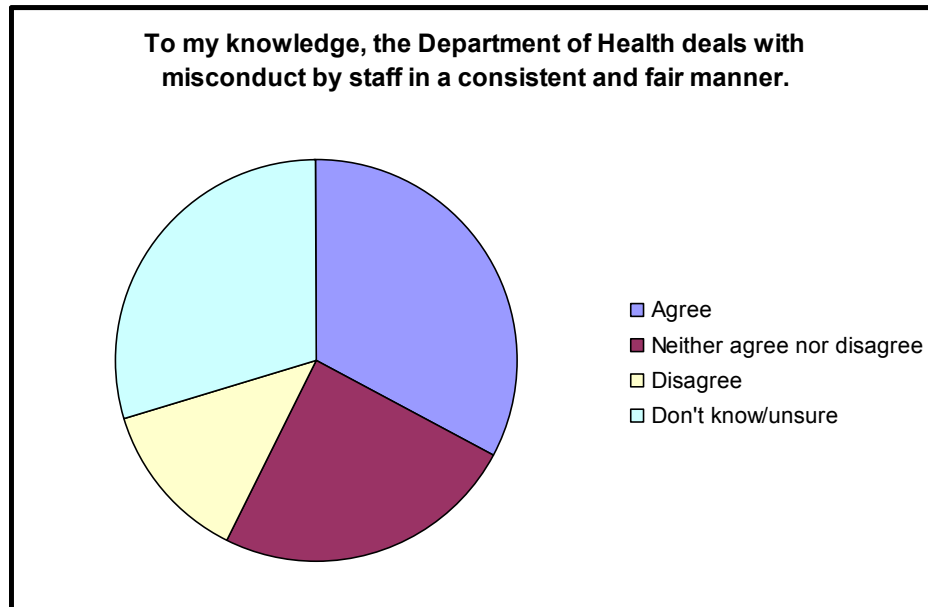- 29.3% indicated they didn't know or were unsure.

The Department of Health is serious about protecting staff who report misconduct.

- Agree
- Neither agree nor disagree
- Disagree
- Don't know/unsure
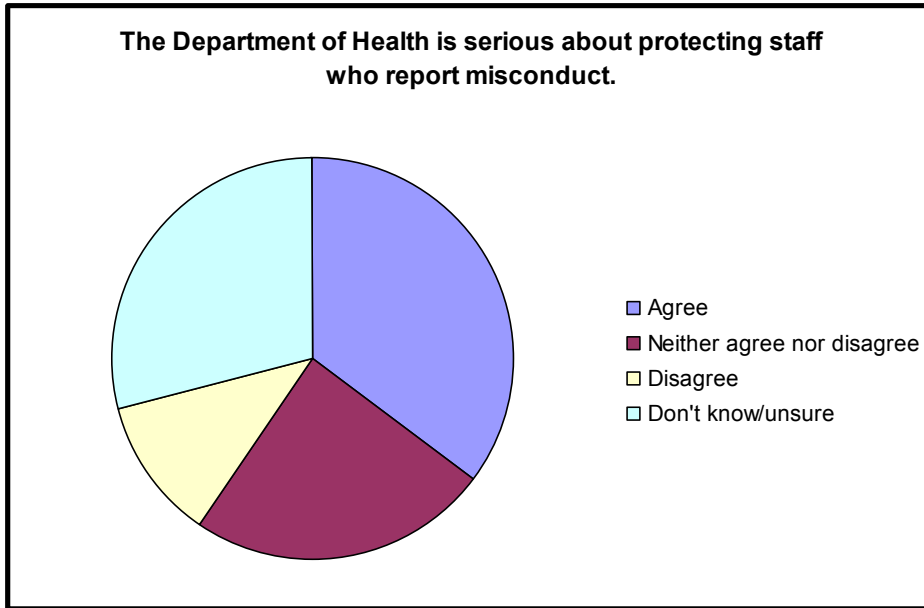
Figure 11

[405] **Question 13:** *If you observed misconduct within your workplace, is there a formal process for reporting it?* As per Figure 12:

- 53.8% of respondents said there was a formal process;

- 3.4% said there was not; and

- 42.7% were unsure.

If you observed misconduct within your workplace, is there a formal process for reporting it?

- No
- Yes
- Don't know/unsure
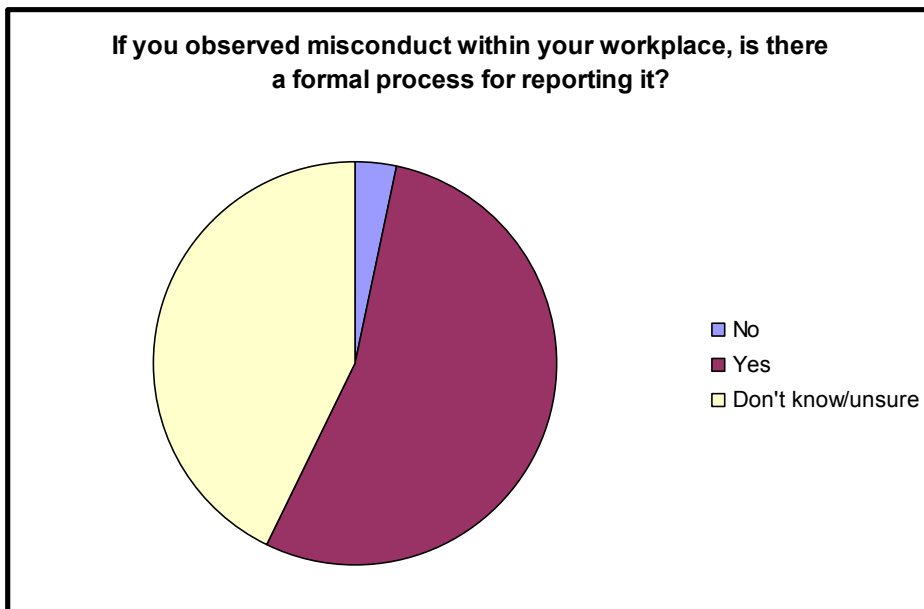
Figure 12

[406] **Question 14(a):** *If you observed misconduct within your workplace, would you report it?* As per Figure 13:

- 64.2% said that they would report misconduct if they saw it;

- 4.5% said they would not report; and

- 31.2% were unsure whether they would report.

100
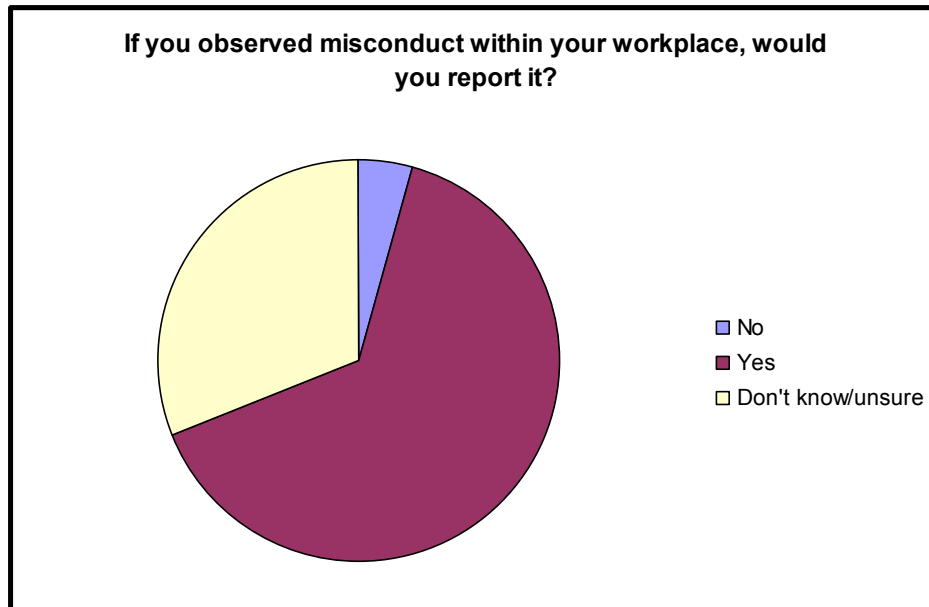
Figure 13

[407] **Question 14(b):** As per Figure 14, the top two reasons for not reporting were (where respondents could provide more than one response):

- the report would not remain confidential (42.5%); and

- that it would be a waste of time reporting, nothing would happen (29.5%).
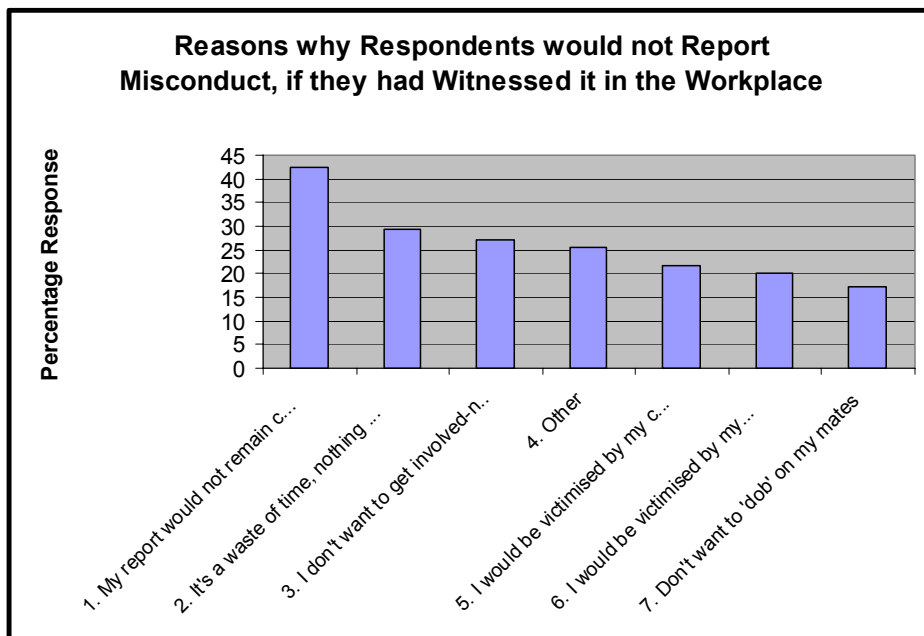
Figure 14

KEY: 1. My report would not remain confidential.
2. It's a waste of time, nothing would happen.
3. I don't want to get involved – not my business.
4. Other
5. I would be victimised by my colleagues.
6. I would be victimised by my manager.
7. Don't want to "dob" on my mates.

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[408] **Question 15:** *To whom within WA Health would you feel comfortable making a report about misconduct?* Respondents who indicated they would report misconduct said that they would do so to:

- their immediate manager/supervisor (66.5%);

- harassment/grievance officers (23.9%); and

- human resources (23.3%).

Respondents were able to provide more than one response.

5.4 Scenarios

[409] The survey also included ten scenarios. Respondents were asked to identify whether the circumstances outlined in the scenarios involved misconduct.

[410] **Scenario One:** *A supervisor is responsible for processing the leave applications of their team. He/she consistently knocks back applications for time off at Christmas, New Year etc. from staff, but approves their own applications instead.*

- 79.7% of respondents correctly identified that the behaviour of the supervisor was misconduct (that they used their position to benefit themselves).

- Of the respondents who said it was misconduct, 78.5% said they would report the supervisor's behaviour.

- Of the 20.3% of respondents who did not believe the supervisor's behaviour was misconduct, 38.4% of them still said that they would report the behaviour.

- The top three responses by respondents when asked to whom they would report were:

  - human resources (35.2%);

  - their supervisor (26.5%); and

  - a manager from another area (17.5%).

[411] **Scenario 2:** *A colleague takes some bandaids, tape and antiseptic from the hospital supply, to stock up their home First Aid Kit.*

- 93.6% of respondents correctly identified the colleague's behaviour as misconduct (that it was stealing and therefore in breach of *The Criminal Code*).

- Of the respondents who said it was misconduct, only 52.7% said that they would report it.

- The top three responses by respondents when asked to whom they would report were:

  - supervisor (26.5%);

  - work colleague (13.7%); and

  - human resources (3.7%).

[412] **Scenario 3:** *A cleaner is required to clean the public hospital toilets three times a day. Because of the cleaner's other duties, there is only enough time to clean the toilets twice a day. As a result the toilets remain smelly and dirty for long periods of time before they are cleaned again*.

- 83.4% of respondents correctly identified that this scenario did not constitute misconduct.

- 57.3% of these people said that they would report the behaviour even though it was not misconduct.

- Of the 16.6% who incorrectly thought the behaviour was misconduct, 83.3% said that they would report the behaviour.

- The top three responses by respondents when asked to whom they would report were:

  - supervisor (51.3%);

  - human resources (6.6%); and

  - a work colleague (6.3%).

[413] **Scenario 4:** *A nurse is working a night shift, which is a relatively quiet shift and after administering the evening medication to patients the nurse retires to a quiet room to take a nap. This is a common practice, the ward is generally quiet and staff often take short naps. The nurse wakes well before the next shift changeover and has ample time to check on patients*.

- 62.3% of respondents correctly identified that this scenario constituted misconduct (it is a breach of the trust placed in the nurse, and such conduct may provide grounds for dismissal).

- 75.5% of them said that they would report the behaviour.

- The top three responses by respondents when asked to whom they would report were:

  - supervisor (43.3%);

  - work colleague (6.0%); and

  - a manager from another area (4.0%).

[414]   **Scenario 5:** *A junior doctor is working in a regional hospital, under the supervision of a senior doctor. The junior doctor is found stealing and using hospital drugs by the nursing staff. The nurses report this behaviour to the senior doctor, who threatens them with legal action if they continue to make such allegations.* Respondents were asked whether the senior doctor's threatening behaviour was misconduct.

- 98.1% correctly identified that it was misconduct (the decision not to report, and the decision to threaten the nurses, were deliberate acts benefitting the junior doctor).

- Of these respondents 95.9% said that they would report it.

- The top three responses by respondents when asked to whom they would report were:

  - supervisor (59.5%);

  - human resources (22.8%); and

  - a manager from another area (21.5%).

[415]   **Scenario 6:** *A director of a health service downloads x-rated pornography at home. They use their own private computer to do so.*

- 75.3% of respondents correctly identified that this behaviour did not constitute misconduct, although 4.9% of these respondents would still report the behaviour.

- Of the 24.7% of respondents who incorrectly indicated that the behaviour was misconduct, 84.2% said that they would report it.

- The top three responses by respondents when asked to whom they would report were:

  - Western Australia Police (10.4%);

  - supervisor (9.8%); and

  - the Commission (4.1%).

[416]   **Scenario 7:** *There is some food left over after all of the patients have received their meals. Rather than throwing the food away, the senior cook distributes the leftover food to staff.*

- Only 31.1% of respondents correctly identified that this scenario did indeed constitute misconduct (that it was stealing and, therefore, in breach of *The Criminal Code*).

- Of these respondents, 43.5% said that they would report the behaviour.

- The top three responses by respondents when asked to whom they would report were:

- supervisor (13.0%);

- work colleague (1.3%); and

- human resources (1.0%).

[417] **Scenario 8:** *A consultant specialist instructs his/her departmental secretary to schedule patient consultations for their own private practice while the private practice secretary is on sick leave.*

- 75.9% of respondents correctly identified that the consultant's behaviour did constitute misconduct (it was a deliberate act on the part of the doctor to receive a benefit for him/herself).

- Of this group, 60.8% said that they would report it.

- The top three responses by respondents when asked to whom they would report were:

  - supervisor (28.9%);

  - human resources (10.0%); and

  - Corporate Governance (7.3%).

[418] **Scenario 9:** *A patient care assistant (PCA) is suffering from severe back pain caused by handling a patient. The PCA approaches nursing staff for some strong painkillers. Two tablets are supplied to the patient care assistant* [by a nurse].

- 60.2% of respondents correctly identified that the nurse's behaviour constituted misconduct (that it was stealing and therefore in breach of *The Criminal Code*).

- Of those respondents, 61.9% indicated that they would report it.

- 7.3% of respondents declared that they would report the behaviour even though they did not believe the nurse engaged in misconduct.

- The top three responses by respondents when asked to whom they would report were:

  - supervisor (33.9%);

  - work colleague (3.7%); and

  - a manager from another area (3.0%).

[419] **Scenario 10:** *A doctor has a psychiatric condition that requires regular medication. He/she steals anaesthetic-type drugs from work and takes them while on shift, to "self-medicate".*

- 97.4% of respondents correctly identified the doctor's behaviour as misconduct (that it was stealing and, therefore, in breach of *The*

Criminal Code; there is also a risk to patient safety and a breach of the trust).

- Of those who correctly identified the behaviour, 93.5% stated that they would report the doctor's behaviour.

- The top three responses by respondents when asked to whom they would report were:

  - supervisor (70.4%);

  - human resources (15.0%); and

  - a manager from another area (14.1%).

5.5 Discussion of Survey Results

[420] This section considers the results of the survey against the findings of the review. Overall, the survey revealed a variety of views and understanding about misconduct and misconduct risks. This is broadly consistent with the review where some managers interviewed thought they were reasonably informed about misconduct and misconduct risks, but others voiced having little or no knowledge.

[421] Almost half (48%) of respondents in the survey considered themselves "well informed" about misconduct and 80% indicated they were aware of the types of behaviour that could constitute misconduct. These statistics are worth exploring, since the results of the review would indicate staff are not so well informed. A possible explanation for this discrepancy is that WA Health staff *believe* they are well informed about misconduct and misconduct behaviour. If this is the case, this poses an inherent danger for WA Health since staff may not correctly recognise misconduct, and may mistakenly ignore misconduct behaviour, but still believe they are alert to "misconduct".

[422] Several examples from the review give credence to this explanation. Case Study Five, for example, examines the theft of Schedule 8 drugs by an on-duty nurse for self-use. Concerns were raised about the welfare of the nurse, but the misconduct actions were ignored (see Section 4.6). The "culture of entitlement" revealed through the review of RPH provides another example of the inherent danger in misinterpreting misconduct and misconduct behaviour. The review found that some staff considered a "perk" of the job was "free" consumables and drugs, and this was not considered misconduct (see Section 2.5.6.1). This action is misconduct, but not interpreted as such.

[423] This difference between actuality and belief is borne out in further analysis of the survey. The respondents who considered themselves well informed about misconduct were not required to indicate how they knew they were well informed. However, the responses to Questions 6 and 7 can be used to establish the level of knowledge of misconduct. Respondents were asked about their knowledge of policies and whether they had received

training in misconduct. Over two thirds of staff had not received any training in misconduct, and of those who had received training, half obtained that training on-the-job or informally. Further, only 26.7% of respondents knew of misconduct policies, while 17.9% knew where to look for them. This would indicate the majority of staff are not *actually* well informed of misconduct and misconduct risks, despite their belief to the contrary.

[424] Medical sessional staff were particularly uninformed in relation to policies and none of the medical sessional staff who responded to the survey had received training in misconduct. This indicates a challenge for WA Health in providing adequate training to all staff, including medical sessional staff.

[425] Further insight into WA Health employees' lack of understanding about what constitutes misconduct is that the workplace bullying and harassment policy was cited as a misconduct policy. Although bullying and harassment *might* constitute misconduct in some circumstances, they almost always do not. The fact that the workplace bullying and harassment policy was mentioned is not as significant as the rate at which it was mentioned. The policy was mentioned second only to the Code of Conduct, and more often than the Misconduct Policy or the Code of Ethics. This indicates confusion as to what constitutes misconduct by the majority of respondents.

[426] Respondents were asked to explain how they knew the types of behaviour that constituted misconduct. "General knowledge" was the basis of respondents' knowledge of misconduct and "bullying" was the second most identified behaviour when referring to misconduct. This illustrates lack of awareness despite the majority of respondents considering they would recognise misconduct behaviour. Whilst an important issue, bullying rarely amounts to misconduct.

[427] Although only 24.7% of people said they had witnessed misconduct in the workplace, this figure needs to be viewed with caution given the responses to questions about misconduct training and the apparently low level of *actual* understanding of misconduct. Nevertheless, this result, in conjunction with the response that 62.8% had not reported the misconduct they had witnessed, is revealing. These statistics, and the review evidence, are compelling indicators of the lack of traction in implementing a misconduct management mechanism in WA Health.

[428] The reasons given by respondents for not reporting witnessed misconduct are also revealing. Although there is no effective system into which misconduct could be reported, this was not a reason why respondents did not report misconduct. Taken as a whole, the responses indicate respondents were not confident about what would happen if they reported. In other words, WA Health not only has to build on a workable reporting system, it needs to convince staff it will properly deal with reported misconduct.

[429] Responses to the questions about reporting misconduct highlight the level of confusion within WA Health about the types of behaviours that

constitute misconduct and the system to deal with those behaviours. That 64.2% of respondents said they would report misconduct if they saw it is at odds with the 62.8% of respondents who said they had witnessed misconduct in the workplace but *not* reported it. In the context of an organisation that has low levels of understanding about misconduct, these conflicting statistics do not generate any confidence about the likelihood of staff reporting observed actual misconduct.

[430] In the review, managers and supervisors said they were ill-equipped to deal with misconduct reports. Uncertainty about the system was also highlighted by the significant proportion of survey respondents who would report to harassment/grievance officers – officers who do not usually have a role in dealing with misconduct.

[431] It is significant that almost half of the respondents either were not sure or believed there was no formal process to report misconduct. This supports the review findings that while there are parts of a system for managing misconduct, including reporting requirements, these are poorly articulated and are not linked to an overall, cohesive system. Although the review identified that some people were confident in the "system", others spoke of a fear of retribution for reporting. This was also revealed in the survey.

[432] The majority of respondents correctly identified most misconduct behaviour in the scenarios. This is consistent with the response where 80.4% of respondents indicated their knowledge of misconduct had been acquired through general knowledge. Responses to the scenarios, given the scenarios were artificial in context, may reflect such general knowledge. However the survey data and the review findings would predict that actual responses would differ when considering misconduct in a work setting which involved trusted colleagues and work pressures.

CHAPTER SIX
CONCLUSION

6.1   Summary

[433]   The review of WA Health began with PMH in June 2007. PMH did not have a mechanism for preventing and managing misconduct, albeit parts of a mechanism existed. This was reported in a working paper to PMH, the Director General and Corporate Governance, and recommendations were made. The Department accepted these findings and said that they needed to be addressed in a "whole-of-Health" strategy.

[434]   In December 2007, the Commission reviewed the WACHS-Kimberley, a regional and remote health service. There was little evidence of a mechanism for preventing and managing misconduct being in place. The working paper and recommendations reflected this. The Department accepted these findings (with some qualifications) and said they needed to be addressed in a "whole-of-Health" strategy.

[435]   In May 2008 a thematic review of misconduct risks associated with the management and handling of Schedule 4 and Schedule 8 drugs was undertaken. The working paper articulated a range of problems associated with WA Health's poor identification and control of misconduct risks associated with Schedule 4 and Schedule 8 drugs. The Department accepted these findings, and related recommendations, and reiterated the need for a "whole-of-Health" strategy.

[436]   The Commission started its final site-based review, at RPH, in January 2009. The review was based on more strategic issues and discussions with executive and senior staff. The Commission considered that any strategic message about misconduct management coming from the Department would be apparent at the most senior levels of RPH. Although some traction with respect to Schedule 4 and Schedule 8 drugs was evident, the review found no substantial evidence that such senior staff were aware of a strategic message from the Department about preventing and managing misconduct. There was no evidence of any intention at RPH to implement a misconduct management mechanism.

[437]   The final phase of the review commenced in August 2009. It aimed to determine what was preventing WA Health from establishing a misconduct management mechanism, notwithstanding the work undertaken to that date. This phase focused on high-level responsibility for misconduct management in WA Health – that of SHEF and Corporate Governance. Corporate Governance did not have the necessary authority or resources to translate WA Health's stated aim of implementing a "whole-of-Health" system to prevent and manage misconduct into a practical mechanism, and SHEF had not been charged with the responsibility. In the absence of one or the other being sufficiently empowered and resourced, WA Health's misconduct management capacity will remain limited to ad hoc responses to individual issues.

[438] The Commission also conducted a survey of WA Health staff as part of the overall review. The survey focused on employees' knowledge and understanding of misconduct, and how their workplace deals with it. The key responses to the survey are outlined below.

(1) Over half of the 920 respondents considered themselves to be poorly informed or not sure about misconduct risks in their workplace.

(2) Rather than formal training and education from WA Health, respondents who indicated they were aware of the behaviours that constitute misconduct obtained this awareness through "general knowledge".

(3) 62.8% of respondents who had witnessed misconduct in the workplace had not reported it.

(4) Less than one third of respondents agreed the Department dealt with misconduct in a "consistent and fair manner". A similarly small proportion agreed that the Department was "serious about protecting staff who report misconduct".

[439] The findings of the various phases of the review can be broadly summarised as detailed below.

(1) Serious, identifiable misconduct risks exist in WA Health. These pose a risk to patient safety and have financial impacts.

(2) There is limited practical capacity within WA Health to deal with misconduct, and no real improvement has occurred over the period of the review.

(3) Notwithstanding the work undertaken by WA Health during the period of review, there is no evidence the Department has established a misconduct management mechanism.

(4) There is no high level ownership or direction of misconduct management within WA Health.

6.2 Overall Opinion

[440] In light of these conclusions, the Commission has formed the opinion that WA Health is currently unable to adequately account to the wider community for the way it manages misconduct risk and related occurrences of misconduct in a demonstrably fair, reliable and transparent way.[35]

6.3 What Needs to be Done?

[441] WA Health needs to develop a strategy that builds its practical capacity to prevent and manage misconduct across the organisation – it needs an identifiable "whole-of-Health" misconduct management mechanism.

Central to this, at its most senior levels, it needs to identify and articulate this strategy, including a plan about how the strategy will be given practical effect.

[442] In applying this strategy, WA Health should work closely with the Commission in order to achieve progress.

6.4 Recommendations

[443] The Commission makes the following recommendations:

Recommendation 1

That the Department of Health articulate and promote its commitment to managing misconduct throughout WA Health.

Recommendation 2

That the Department of Health, through the Senior Health Executive Forum, identify and commit to a strategy for managing misconduct, including a plan to give practical effect to that strategy.

Recommendation 3

That the Department of Health, through the Senior Executive Health Forum, commit sufficient resources to that strategy to make it work.

Recommendation 4

That the Department of Health work with the Commission to achieve progress.

APPENDIX

Misconduct Management in WA Health

The table (refer following pages) entitled *Misconduct Management in WA Health: Timeline and Action Outline 2004-2010* outlines activities and initiatives undertaken by the Department to date (further actions may have been taken at the Area Health Service or hospital site level), and formed part of section 86 representations forwarded to the Commission by the Department of Health (see [9] and [11]-[14] of this report).

MISCONDUCT MANAGEMENT IN WA HEALTH: TIMELINE AND ACTION OUTLINE 2004-2010

1st Corporate Governance Compendium issued (June 09)

Misconduct and Discipline Policy issued (Oct 09)

Conflict of Interest Policy issued (Jan 2010)

Poster/pamphlet program: Integrity and Misconduct (Nov 08)

WAH Code of Conduct issued (Sep 08)

Directives on Scheduled Drugs issued (July 08)

Acceptance of Gifts Guidelines issued (Dec 07)

Mail-out re PID Act and PID Officers (Oct 07)

Complaints Management System starts (July 07)

Fraud & Corruption Control Plan issued (Mar 07)

WAH FTE Staff: 38,000

Attendees at misconduct education sessions in 2008/09: 942

WAH Integrity Framework presented to CCC (Oct 08)

Reports of suspected misconduct in 2008/09: 408

Attendees at misconduct education sessions in 2007/08: 750

Reports of suspected misconduct in 2007/08: 337

Misconduct and PID Education Sessions start (Apr 07)

Reports of suspected misconduct in 2006/07: 121

Revised Misconduct Reporting Policy issued (Nov 06)

Reports of suspected misconduct in 2005/06: 64

Circular re CCC and reporting misconduct issued (Sep 05)

CCC delivers its draft Overall Report, with final working papers

CCC delivers its 4th draft working paper: RPH

CCC delivers its 3rd draft working paper: S8 & S4 Drugs

CCC delivers its 2nd draft working paper: WACHS-Kimberley

CCC delivers its 1st draft working paper: PMH

Two of the case study incidents occurred

CCC commences its review of WAH

One of the case study incidents occurred

One of the case study incidents occurred

WAH FTE Staff: 32,000

CCC established

2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010

Period of CCC's review of misconduct handling in WAH.

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YEAR	MONTH	MISCONDUCT-RELATED ACTION	RELATED ACTIVITY; COMMENTS
2004			
		Areas with responsibility for misconduct management in the Department and the area health services were operating largely in isolation, with limited resources and coordination. The Corporate Governance Directorate (CGD) had been established in 2001, but was still focused on audit, with the accountability (investigation) and risk management functions yet to be integrated into CGD, and no formal education or research responsibilities. A review was undertaken of CGD, leading to the establishment of an Accountability area and the confirmation of two new positions: • Manager Level 7 – substantively filled • Senior Investigator Level 6 – substantively filled	The Corruption and Crime Commission (CCC) was established under the CCC Act. WA Health is an organisational concept, comprised of: • The Department of Health • The metropolitan area health services (North and South) • WA Country Health Service (WACHS) (seven regional networks) • Peel Health Service, and a variety of affiliated health service areas, including mental health, child and adolescent health, Aboriginal health, pharmacy and family health. In 2004, FTE staff of WA Health numbered approximately 32,000; in 2009: 38,000.
2005			
	September	Operational Circular 'New Corruption and Crime Commission' issued and distributed across WA Health (via OP 1996/05). The circular advised staff of the existence and role of the CCC, providing a definition of misconduct as per the CCC Act and the CCC's advice, and advising of the obligation on staff to report suspected misconduct.	Publicised by Health Circular and global email, and available via intranet.
2006			
	June	For the 12 months 2005/06 – 64 reports of potential misconduct in WA Health made to CGD – approximately 50 assessed as CCC-reportable.	
	July	Review of CGD undertaken, leading to confirmation of: • Senior Investigator Level 6 – established and substantively filled • Principal Policy & Research Officer Level 7 – temp (12-month) position established and filled	

Year	Month	Misconduct-related Action	Related Activity; Comments
	November	Misconduct Reporting Policy revised and distributed across WA Health (via Operational Circular OD 0010/06).	
		This policy confirmed the definition of misconduct, and advised staff that all reports of suspected misconduct should be made to CGD for assessment and recording prior to delivery to the CCC.	
2007			
	March	Regular liaison meetings between WA Health and CCC begin (and are ongoing).	These meetings have generally been conducted monthly as well as on an out-of-session needs basis.
		CGD request advice of CCC on the draft misconduct education material and the proposed approach to delivering the information.	The CCC provided commentary and particular advice which was incorporated into the sessions and documents.
		WA Health Fraud & Corruption Control Plan issued and distributed (via Operational Circular OD 0046/07).	Publicised by Health Circular and global email, and available via intranet.
			Information about the Fraud & Corruption Control Committee is set out below (September 2007).
			CCC advised of the existence and plans for the FCCC in May 2007
	April	CGD begins conducting information sessions on Misconduct and Public Interest Disclosures to all areas of WA Health – following extensive consultation across the public health and government sectors, including the CCC, as to formal requirements and how best to deliver the information.	The sessions continue to be organised in conjunction with the area health services (to ensure maximum attendance and minimal disruption to work, particularly in clinical divisions). Sessions have been conducted across all areas of WA Health, delivered to all levels of staff, and to those working in clinical, support and administrative areas.
		The sessions were available to all areas of WA Health, with the metropolitan hospitals and major centres being the initial focus.	The information sessions are continuing, and the subjects covered have now been extended to include the Public Sector Code of Ethics and WA Health Conduct and the Management of Conflicts of Interest.
	June	For the 12 months 2006/07 – 121 reports of potential misconduct in WA Health made to CGD – 63 assessed as CCC-reportable.	CCC commences review of misconduct handling in WA Health, with the first phase being a site-based review of Princess Margaret Hospital.
			CCC facilitate 2 'Conflict of Interest' sessions for WA Health.

Year	Month	Misconduct-related Action	Related Activity; Comments
	July	Principal Policy & Research Officer Level 7 position established in CGD and substantively filled.	
		WA Health Complaints Management System (CMS) established in CGD.	Improvements continue to be made to the CMS, the ultimate goal being a secure, integrated system that can be used across the public health sector. By late 2009, the CMS provided: • statistical recording • reliable (accurate) data retrieval and manipulation • searching capabilities • security - restricted and limited access.
	September	First Fraud & Corruption Control Committee (FCCC) meeting held. The FCCC was established to: 1. Liaise with senior management of WA Health. 2. Monitor and review fraud and corruption risk assessments undertaken by various operational units or internal and external consultants and working groups. 3. Establish the timetable for the implementation of fraud and corruption control measures together with the monitoring of progress. 4. Monitor the implementation of the Fraud & Corruption Control Plan and regular performance reviews at an operational level. 5. Oversight the review of relevant WA Health policies and procedures to ensure they appropriately reflect WA Health's fraud prevention plan, including the nature, content and timetable of a suitable awareness training regime. 6. Monitor the provision of fraud and corruption control information to all parties associated with WA Health (internally and externally). 7. Provide advice to the Director General, Director CGD, the Fraud & Corruption Control Coordinator, and other staff members.	FCCC membership is comprised of a member of the WA Health Audit Committee and representatives nominated by each Senior Health Executive Forum (SHEF) member and areas identified as being open to high or particular fraud risks. Committee meetings are ongoing, held quarterly.
	October	Hardcopy mail-out to all staff advising of the existence of the Public Interest Disclosure Act, summarising the rights and responsibilities under the Act and publicising the names and contact details of WA Health's PID Officers.	Publicised by global email and delivered to all staff via a pamphlet enclosed with payslips.

Year	Month	Misconduct-related Action	Related Activity; Comments
	December	WA Health Attendance at Functions and the Acceptance of Gifts, Prizes or Inducements Guidelines issued and distributed (via OD 0086/07).	Publicised by Health Circular and global email, and available via intranet.
			All subjects covered under these guidelines relate to the identification and management of conflicts of interest, and the prevention of misconduct.
		First PID Officer Network meeting held.	
		Senior Investigator Level 6 temporary position (1 year) established in CGD for 1 - filled.	
			CCC provided WA Health with the first draft working paper *Misconduct Handling Procedures in the Western Australian Public Sector: Princess Margaret Hospital for Children*
			WA Health provided a detailed response to the CCC's draft, but no feedback was received.
			WA Health's first sighting of the final working paper was in January 2010, as an appendix to the draft overall report on misconduct management handling in WA Health.
			This was the case with all four working papers.
2008			
	April		CCC provided WA Health with the second draft working paper *Misconduct Handling Procedures in the Western Australian Public Sector: WA Country Health Service – Kimberley (including Broome and Derby hospitals and regional services)*
			WA Health provided a detailed response to the CCC's draft, but no feedback was received.
	June	WA Health sought advice from the CCC in relation to the draft Misconduct & Discipline Policy and Guidelines.	CCC advice limited to observations on the need for WA Health to promote a strategic view, but without specific advice in relation to the draft policy and guidelines.

Year	Month	Misconduct-related Action	Related Activity; Comments
		For the 12 months 2007/08 – 337 reports of potential misconduct in WA Health made to CGD (127 assessed as reportable to the CCC).	
		For the 12 months 2007/08 – 750 staff attended misconduct-related information sessions across WA Health.	
	July	Strategic Risk Management Forum commences (and is ongoing).	
		Directive on the Administration of Schedule 8 Medicines to Patients Attending for Emergencies issued and distributed (via OD 0142/08).	
		Directive on the Code of Practice for the Handling of Schedule 8 Medicines (drugs of addiction) in hospitals and nursing posts issued and distributed (via OD 0141/08).	
		WA Health Employee Grievance Resolution Policy issued and distributed (via OD 0138/08).	
	August	CGD commenced providing quarterly reports to area health services and the FCCC in relation to types of misconduct, including information about trends in reporting and incidents.	
	September	WA Health Code of Conduct issued and distributed (via Operational Directive OD 0152/08).	
		WA Health PID Guidelines issued and distributed.	
		WA Health PID Support Officer Protocols issued and distributed.	
	October	Prevention of Bullying, Harassment and Discrimination in the Workplace Policy issued (via OD 0153/08).	
		WA Health SHEF Operations and Review Committee (ORC) establishes Chief Pharmacists Forum.	
		The Director General of WA Health and the Director CGD met with the CCC Commissioner to discuss misconduct management in WA Health generally, and specifically to present WA Health's 'Organisational Integrity Framework'. The CCC Commissioner subsequently advised the Director General that he was encouraged by the strategy outlined in the presentation.	In preparing for this presentation, advice was sought from the CCC's Prevention & Education area as to whether the proposed strategy was appropriate. The informal response was that each organisation was, as the area-expert, expected to develop their own strategy and, once it had been established, the CCC would be in a position to offer an opinion.
		Creation of the senior position Manager, Governance & Strategic Support in the WA Country Health Service (WACHS).	Similar positions were in existence in the North Metropolitan Area Health Service (NMAHS) and the South Metropolitan Area Health Service (SMAHS).

Year	Month	Misconduct-related Action	Related Activity; Comments
		WACHS develops and implements a centralised incident database.	
		Three-day Administrative Inquiry Training courses commence.	Developed by CGD in conjunction with an external facilitator, seven training courses have now been conducted, with a further four courses scheduled for 2010.
		Staff from a variety of areas have attended, including: the Department; CAHS – PMH; Graylands Mental Health; Heart and Lungs Area; HCN ; NMAHS; SMAHS; WACHS; WA Cancer and Palliative Care Network and Nurse West.	
	November	Review of CGD undertaken, resulting in confirmation of establishment: Accountability:	These areas were subsequently amalgamated into one unit: Ethical Standards, reporting to a Level 8 Assistant Director, with administrative assistance provided by a Level 3 Project Officer.
		2 Principal Investigators Level 7	
		3 Senior Investigators Level 6	A range of pool positions for Level 6 and 5 investigators was also established.
		2 Investigator Level 5	
		Education & Research:	
		Principal Policy & Research Officer Level 7	
		Ethics Education Coordinator Level 6	
		FOI Coordinator Level 6	
		Criminal Records Screening Officer Level 5	
		Senior Analyst Level 5	
		Specific functional coordination commences between the Internal Audit and Ethical Standards areas of CGD, with joint audits and reviews, information gathering and monitoring (this is ongoing).	
		Whole-of-Health pamphlet mail-out and poster distribution: Promoting Integrity – Reporting Misconduct, which included the following statement:	The posters were (and continue to be) located in all major health institutions; the pamphlets included the definition of misconduct and contact details for the CCC, the OPSSC and CGD.
		Recognition:	
		WA Health acknowledges that deciding to report misconduct is not always an easy decision to make and deserves to be recognised as ethical and courageous.	
		Encouragement:	
		WA Health appreciates that reports can be valuable contributions to the organisation and the public health system, and encourages people to report misconduct and wrongdoing in the public sector.	

Year	Month	Misconduct-related Action	Related Activity; Comments
		WA Health Audit Committee Charter and Operating Procedures reviewed and amended.	
	December	WA Health Criminal Records Screening Policy & Guidelines issued (via Operational Directive OD 0163/08, which also provided access to the policy and guidelines.	Publicised by Health Circular and global email, and available via intranet.
		SMAHS Policy & Legislative Compliance Unit introduce 'Policy of the Month' quiz program to update staff about key policies.	
2009			
	January	WA Health participates in the DTF process of evaluating a CUA in relation to Accountable & Ethical Decision Making.	CCC provided WA Health with the third draft working paper *Misconduct Handling Procedures in the Western Australian Public Sector: The Management and Handling of Schedule 8 and Schedule 4 drugs within WA Health – Various Hospital Sites* WA Health provided a detailed response to the CCC's draft, but no feedback was received.
	February	Whole-of-Health Staff mail-out advising of updating of Code of Conduct in line with the revised Public Sector Code of Ethics (via Operational Directive OD 0152/08).	
	March	Second meeting of all WA Health PID Officers; PID Officer Training and Refresher course, facilitated by the OPSSC.	
	May	Freedom of Information Procedures Manual completed.	Available via CGD intranet site, included in the Compendium
		WA Health commences work on eLearning package for Accountable and Ethical Decision Making.	A Beta version of the eLearning package has been tested, and the approved version will be rolled out in March 2010.
		WA Health Staff Climate Survey conducted, including six questions relating to integrity.	36,530 staff invited to participate; 15,244 respondents (42%).
	June	Ethics Education Coordinator Level 6 position created in CGD and substantively filled.	
		For the 12 months 2008/09 – 408 reports of potential misconduct made to CGD (260 assessed as reportable to the CCC).	

Year	Month	Misconduct-related Action	Related Activity; Comments
		For the 12 months 2008/09 – 942 staff attended misconduct-related information sessions across WA Health.	
	July	First part of the WA Health Corporate Governance Compendium drafted and published. Consisting of regular chapters, Compendium topics covered so far include: Misconduct, PID, FOI, Conflicts of Interest, Bullying, Criminal Records Screening, Acceptance of Gifts & Hospitality and Use of Public Resources.	In addition to being available via the WA Health and CGD intranet sites, FCCC members advised who should receive hard copies of the Compendium. Since the first advertisement, hard and soft copies of the Compendium have been in demand.
			CCC provided WA Health with the fourth draft working paper *Misconduct Handling Procedures in the Western Australian Public Sector: Royal Perth Hospital* WA Health provided a detailed response to the CCC's draft, but no feedback was received.
			Australian Public Sector Anti-Corruption Conference held in Brisbane, attended by representatives from CCC and WA Health; CCC presented paper, focusing on its review of WA Health, particularly the review of the handling of scheduled drugs.
	August	CCC and CGD conduct joint misconduct presentation to WACHS-Great Southern region staff.	CCC requested permission to use a scenario developed by CGD in their information sessions.
	September	PID Officer Network meeting (third meeting of all WA Health PID Officers).	
		Whole-of-Health advice relating to the Storage and Recording of Restricted Schedule 4 Medicines issued and distributed (via OD 0215/09).	Publicised by Health Circular and global email, and available via intranet.
	October	WA Health Misconduct & Discipline Policy and Guidelines issued and distributed (via OD 0222/09).	
	December	Confidential 24/7 Ethical Advisory Line launched by CGD.	Awareness of the Ethical Advisory Line (which is available to all staff of WA Health) was by way of global email (Jan 2010) and ongoing distribution of updated Reporting Misconduct pamphlets.
		CGD intranet site updated and relaunched.	The intranet site now provides information and ethics-related hyperlinks, including: regular updates to the CGD compendium; the 2010 schedule for education awareness sessions; links to the OPSSC, PSC and FOI Commissioner.

Year	Month	Misconduct-related Action	Related Activity; Comments
2010			
	January	Induction packages for NMAHS and SMAHS amended to incorporate specific advice on the identification and reporting of suspected misconduct.	The Department's induction process already covered this information.
		WA Health Managing Conflict of Interest Policy and Guidelines issued and distributed (via OD 0264/10).	
		Global email to staff advising of the instigation of the Confidential 24/7 Ethical Advisory Line and the availability of the Corporate Governance Compendium.	
			CCC provides WA Health with the draft overall report *Misconduct Handling Procedures in the Western Australian Public Sector: WA Health.* The report included, as appendices, the final versions of the working papers on PMH, WACHS-Kimberley, Scheduled Drugs and RPH. The final versions of the working papers had not previously been seen by WA Health.
	February	First 7 months of the 2009/10 period – 353 reports of potential misconduct were made to CGD (170 assessed as reportable to the CCC).	
		First 7 months of the 2009/10 period – 1841 staff attended misconduct-related information sessions across WA Health.	
		First month of the Confidential Ethical Advisory Line (Jan 2010) – 10 calls received.	
		Work continuing on WA Health's Exit Survey Policy & Guidelines.	
		Work continuing on revision of the WA Health Acceptance of Gifts Policy & Guidelines.	
		Work continuing on the Pre-employment Integrity Check Procedures.	
		Work continuing on establishing a Governance Liaison Officer Network.	
		The Public Sector Commission facilitates the first Accountable & Ethical Decision Making session for executives (for WACHS).	Further sessions have been scheduled for the executives of NMAHS, SMAHS and CAHS.
		CCC has advised they will be conducting an outreach program in the Pilbara (not limited to WA Health).	
		CGD has suggested a joint presentation to the Pilbara Health Executive. Plans for a combined, or at least coordinated, effort are being considered.	

WA Health Organisational Integrity Framework
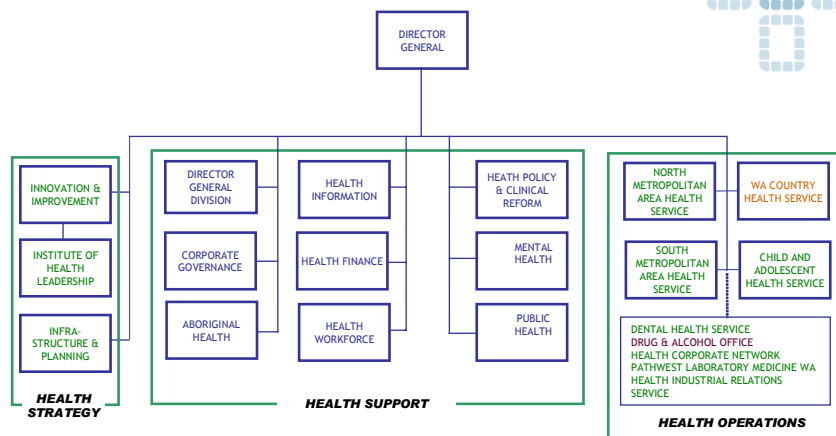The document (refer following pages) entitled *WA Health Organisational Integrity Framework: Presentation for the Director General of WA Health and the Commissioner of the CCC 21 October 20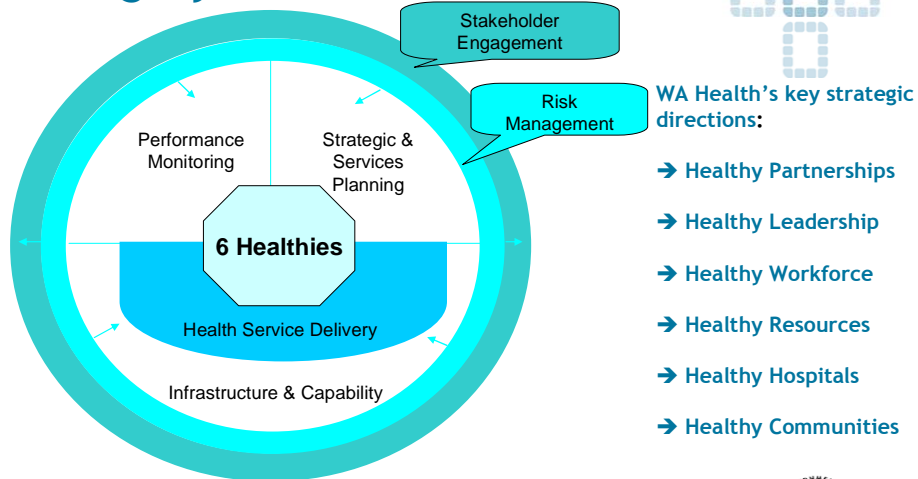08* provided the basis for a presentation delivered by the Department's Corporate Governance Directorate, and formed part of section 86 representations forwarded to the Commission by the Department of Health (see [9] and [11]-[14] of this report).

WA Health: Organisational Structure

Corporate Governance and Public Health: Integrity in Context

Stakeholder Engagement

Risk Management

Performance Monitoring

Strategic & Services Planning

6 Healthies

Health Service Delivery

Infrastructure & Capability

WA Health's key strategic directions:

➔ Healthy Partnerships

➔ Healthy Leadership

➔ Healthy Workforce

➔ Healthy Resources

➔ Healthy Hospitals

➔ Healthy Communities

References: NSW Health, *Corporate Governance and Accountability Compendium* (2005); *WA Health Promotion Strategic Framework 2007-2011; WA Health Operation Plan 2008-2009*

Department of Health

Organisational Integrity: Promoting Values to Reinforce Culture

Culture

Communication

Leadership
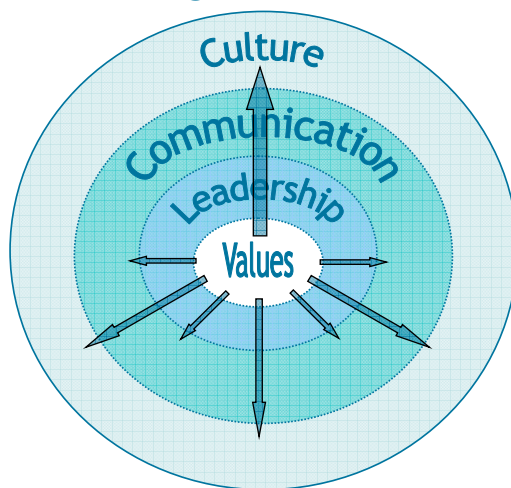
Values

Strategic elements:

➔ Public duty values

➔ Codes of ethics and conduct

➔Professional standards

➔Corporate strategies

➔ Policies and procedures

➔ Administrative structures

➔ Systems

➔ Resources

➔ Training, education & awareness

➔Interaction between patients, staff, stakeholders and the environment

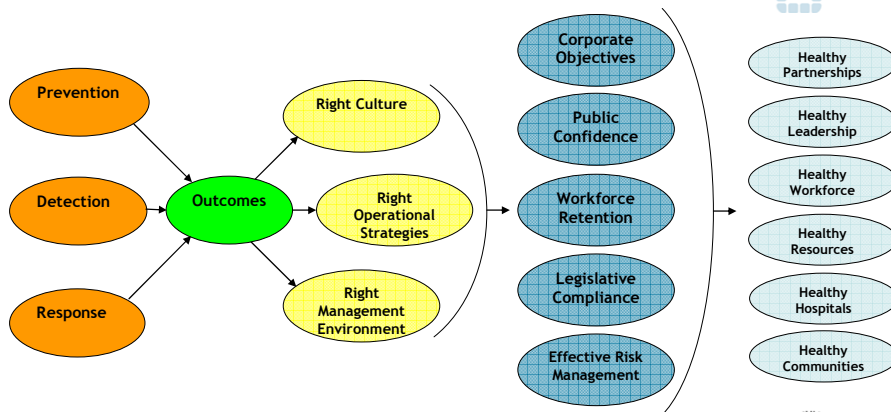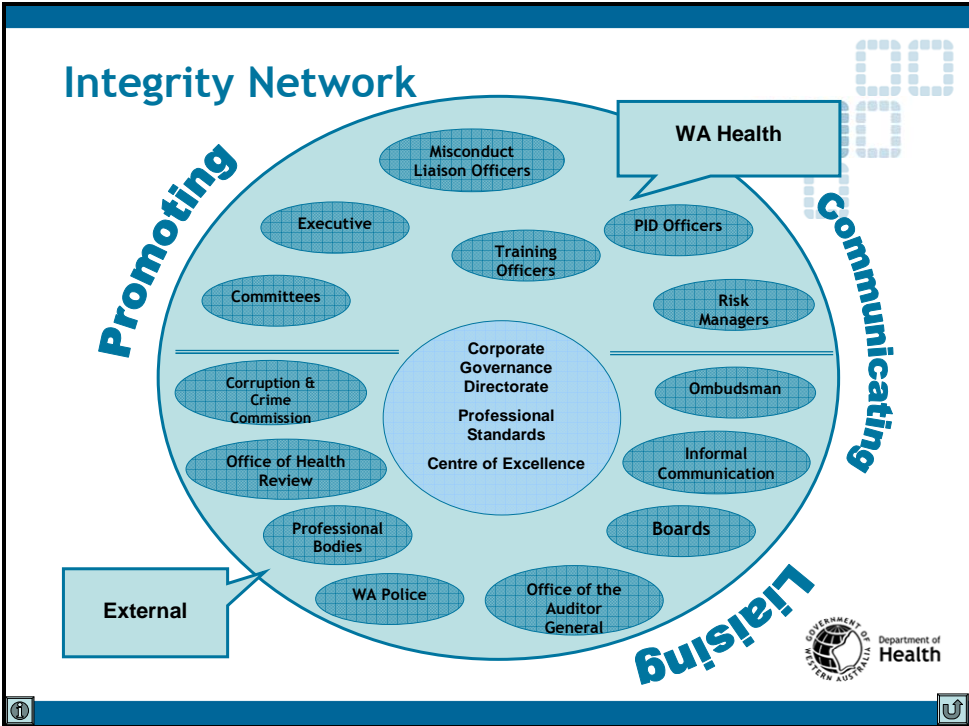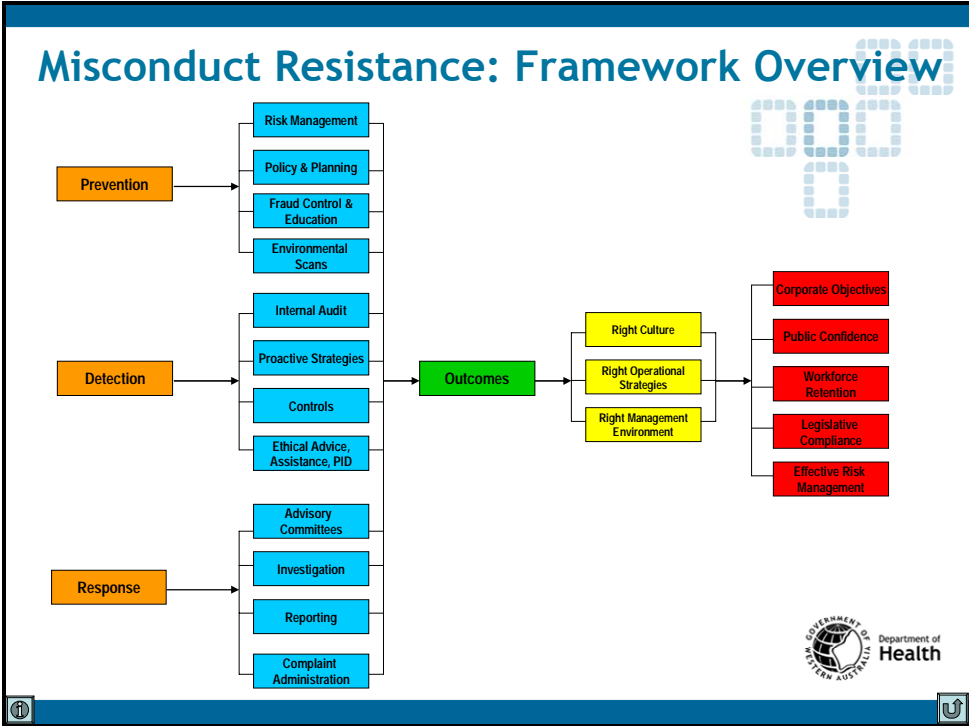**Reference :** ICAC (NSW), *The Do-It-Yourself Corruption Resistance Guide* (2002)
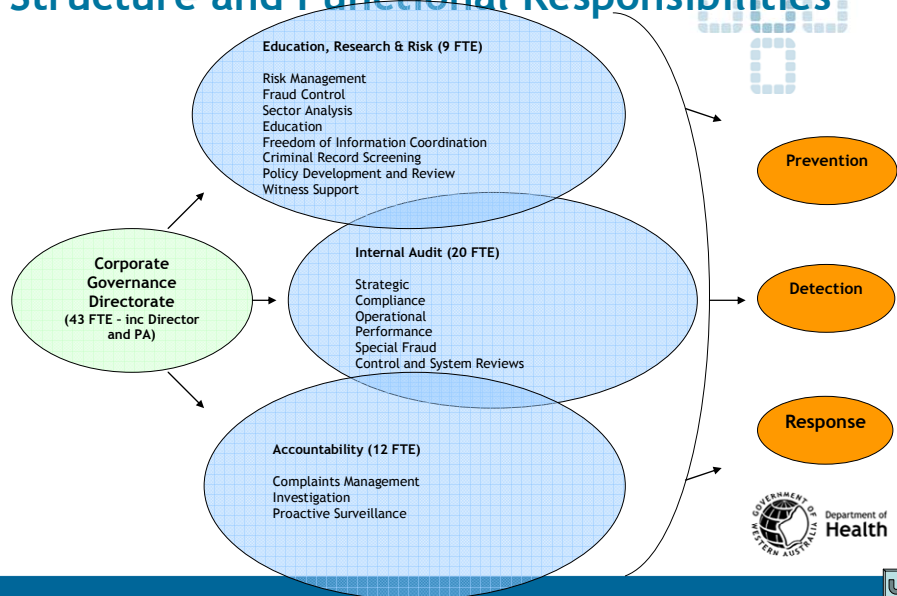
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Frameworks and Strategies
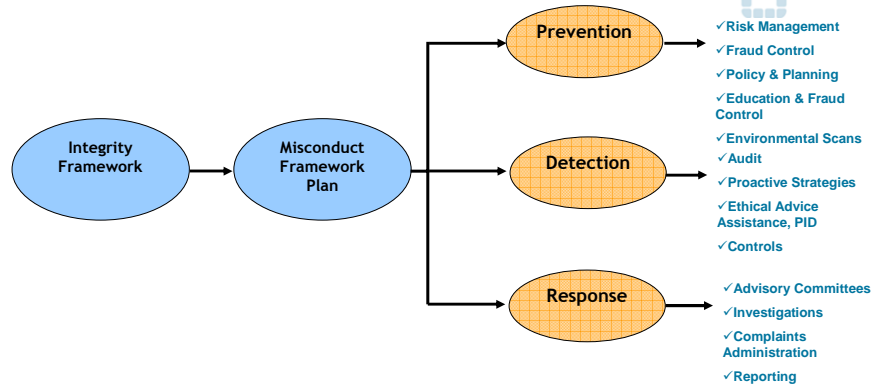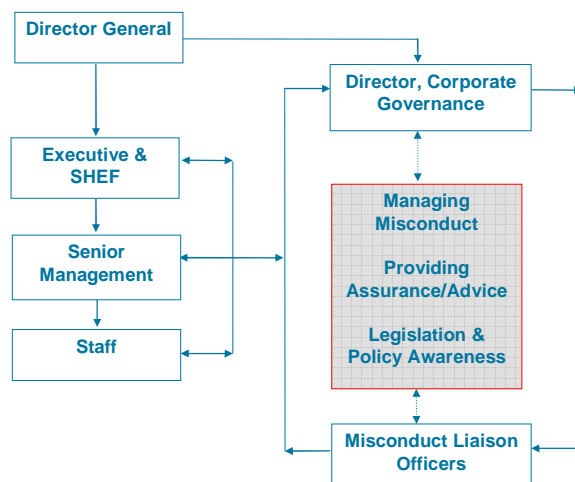
Misconduct Resistance: Objectives and Outcomes

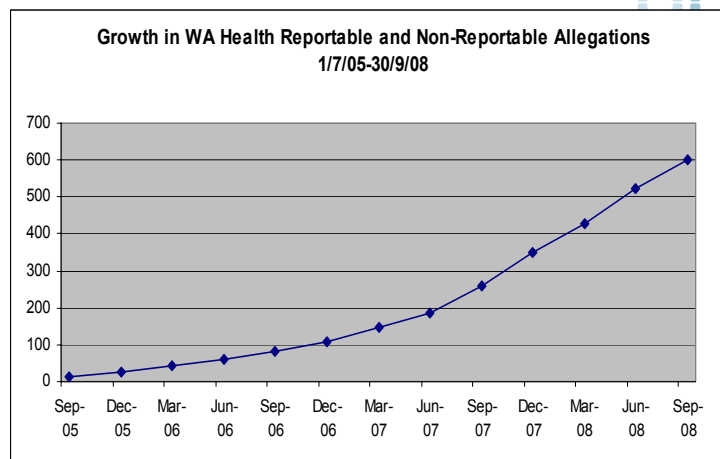**Corporate Governance Directorate: Structure and Functional Responsibilities**

Education, Research & Risk (9 FTE)

Risk Management
Fraud Control
Sector Analysis
Education
Freedom of Information Coordination
Criminal Record Screening
Policy Development and Review
Witness Support

Corporate Governance Directorate (43 FTE - inc Director and PA)

Internal Audit (20 FTE)

Strategic
Compliance
Operational
Performance
Special Fraud
Control and System Reviews

Accountability (12 FTE)

Complaints Management
Investigation
Proactive Surveillance

Prevention

Detection

Response

Department of Health

Accountability & Responsibility

Director General

Director, Corporate Governance

Executive & SHEF

Senior Management

Staff

Managing Misconduct

Providing Assurance/Advice

Legislation & Policy Awareness

Misconduct Liaison Officers

Department of Health

Progress: Completed Initiatives

➔ Misconduct Framework and Plan

➔ Whole of Health Misconduct & Discipline Policy

➔ Education Awareness sessions relating to Accountability and Public Interest Disclosure

➔ Review of Misconduct Complaints Administration

➔ Code of Conduct

➔ Consolidating Corporate Governance Directorate role and increasing establishment

➔ Implementation of Administrative Inquiries workshops across the sector

Department of Health

Statistical Analysis: General

Growth in WA Health Reportable and Non-Reportable Allegations 1/7/05-30/9/08

Department of Health

ENDNOTES

[1] In its response the Department states across WA Health, clinical risks will always be rated as more serious than those relating to misconduct. The Commission disagrees. Misconduct may lead to the same adverse clinical outcomes as breaches in clinical standards.

[2] In its response to the draft report the Department accepted this finding, with clarification, stating not all misconduct risks have patient safety or financial implications, and that the draft report "does not seem to present any evidence suggesting that any incident of misconduct has resulted in adverse clinical outcomes, significant financial loss or the undermining of public confidence". The Commission disagrees. The case studies clearly illustrate the possible clinical impacts of misconduct occurring (misdiagnosis of a patient in the case of Dr A). Financial impacts can clearly result from theft of hospital property (be it drugs or other items) or fraud (falsifying salary sacrificing documentation, falsifying time attribution, misuse of contracts/tenders etc.). One nurse manager was quoted as saying $5,000 a month could be lost on nurses in one area taking a can of deodorant each per week.

[3] In its response to the draft report the Department agreed WA Health has limited practical capacity for dealing with misconduct. However, it disputed that there has been no real improvement over the period of the review. The Commission maintains the fundamental finding is that, overall, there was a lack of progress (notwithstanding all the work being done) and that little has changed over the course of the review in terms of evidence of an identifiable strategic, planned and clearly articulated mechanism for managing misconduct across WA Health. The Commission has not changed the wording of this finding.

[4] The draft finding provided to the Department was "WA Health has not moved beyond rhetoric about establishing a misconduct management mechanism to some demonstrable commitment to do so". The Department disagreed on the basis the finding did not reflect the work undertaken by the Department to date. The wording of this finding was modified in order to clarify the Commission's position.

[5] This finding was not included in the draft report provided to the Department.

[6] The Department's response to the draft report stated: "[t]here is an unpleasant implication presented both in this itemised paragraph and throughout the draft report that staff of WA Health are potentially predatory, corrupt or liable to be seduced into behaving unethically". The Commission disagrees that the draft report conveyed a negative message and maintains that risk exists, as reflected in this report.

[7] The term Schedule 4 drugs "of interest" was used colloquially by the managers interviewed to refer to drugs including the benzodiazepine group, analgesics and anaesthetics. These drugs are more likely to be abused than other Schedule 4 drugs because of their effects (for example, inducing "highs" or "lows", inducing sleep and controlling pain).

[8] *An Evolution: Corporate Governance Directorate*, Corporate Governance Directorate, Department of Health, v2009/01, p.6.

[9] *Fraud and Corruption Control Plan*, 2007, Corporate Governance Directorate, Department of Health, Western Australia.

[10] The Commission understands the appropriateness of a clinical risk focus in the health setting, but notes that there was no recognition of misconduct risk.

[11] *Fraud and Corruption Control Plan*, 2007, *op cit*.

[12] Section 28 of the *Corruption and Crime Commission Act 2003* requires that the principal officer of a notifying authority – in this case, the Director General – must notify the Commission of any matter which that person suspects on reasonable grounds concerns or may concern misconduct.

[13] It is commonly understood within WA Health that regulation 36A (*Poisons Regulations 1965*) requires Schedule 4 drugs in hospitals to be stored in locked facilities. Reference is often made to the Poisons Regulations as the basis for the practice, but this appears to be a misinterpretation of the regulation. Regulation 36A does not make any reference to storing Schedule 4 drugs in public hospitals either generally or specifically. The regulation refers specifically to "pharmaceutical chemists", who, if supplied with Schedule 4 drugs, are to ensure restricted access to these drugs in a "pharmacy", and medical practitioners, veterinary surgeons and dentists, who, if supplied with Schedule 4 drugs, are to store these drugs in a locked

facility at their "usual place of practice". The Poisons Regulations aside, as Schedule 4 drugs are prescription issue only, and are potentially harmful, it seems logical and good management practice to store them in a locked facility.

[14] The response from the Department to the draft report claims this statement implies that WA Health, and its area health services, have an open approach to the management of scheduled drugs. The Department claims this is not true and uses South Metro Area Health Service (SMAHS) as an example. The Department states "all SMAHS sites have strictly enforced policies in relation to the management of Schedule 8 drugs", and "risk assessment of procedures around the storage of Schedule 4 drugs were identified by staff in its health services". The Commission agrees that there are many policies and procedures relating to drugs in hospitals. However, the issue is whether they are appropriate (from a misconduct management perspective), and whether these are followed by staff and management. The Commission stands by the draft report's assertion in this paragraph.

[15] The term Schedule 4 drugs "of interest" was used colloquially by the managers interviewed to refer to drugs including the benzodiazepine group, analgesics and anaesthetics. These drugs are more likely to be abused than other Schedule 4 drugs because of the nature of their properties.

[16] The head of the Office of the Chief Pharmacist in the Department's organisational structure is referred to as the "Chief Pharmacist" across WA Health and in this report. However, this position should not be confused with hospital-based pharmacy heads – a role also colloquially referred to as "Chief Pharmacist".

[17] http://www.health.wa.gov.au/services/detail.cfm?Unit_ID=2301, viewed 18 March 2010.

[18] "Unusual usage patterns" may include large increases in frequently-used drugs, small increases in rarely-used drugs, and the use of drugs not matching patient needs, for example, the use of oral painkillers in a ward where patients are intubated (fitted with breathing tubes).

[19] In making this recommendation, the Commission was mindful of the longstanding review of the Poisons Act and Poisons Regulations.

[20] The terms "executives", "senior managers" and "managers" in the RPH section refer to Executive Directors, Directors, Nursing Directors, Business Managers and Managers of various corporate and clinical divisions and departments, and are used interchangeably so as not to identify individuals.

[21] As at 24 April 2009.

[22] The details in this section concerning the identified risks contained within the Information Services, Clinical Services and Executive Significant Risk Registers have been taken directly from the registers.

[23] Dated 1 October 2008.

[24] 2 November 2008.

[25] "Benzos" are the benzodiazepine group of drugs. These are Schedule 4 drugs including temazepam and midazolam and are drugs "of interest".

[26] Servio Online is RPH's intranet site.

[27] During the course of the interviews, an analysis of the role and function of SHEF was undertaken by the members. However, this does not materially affect the views they expressed related to the Commission's review.

[28] All but one (due to absence) of these positions was interviewed as part of the Commission's review.

[29] "Area Health Services" includes NMAHS, SMAHS, CAHS and WACHS.

[30] Some members were unavailable due to annual leave.

[31] *Fraud and Corruption Control Plan*, 2007, *op cit*.

[32] Nitrazepam, a benzodiazepine drug.

[33] The sample required to meet the statistical standard at 95% confidence interval and +/- 5% sampling error interval of 37,993 population was 388. The minimum strata samples for Occupational Type were also met.

[34] Note in this section some totals add up to more than 100%. This occurs where respondents were able to select more than one listed response.

[35] In its response to the draft report, the Department stated the Commission's opinion was unable to be justified on the evidence, and was unhelpful to WA Health as motivation: "[t]he use of the word 'unable' suggests that, despite all the effort that has been put into improving accountability, the organisation is either incompetent or incapable of achieving its objectives. If anything, such statements undermine confidence in the public sector and frustrate the efforts of all public officers involved in promoting better misconduct management". The Commission disagrees based on the overall review. However, as a part-concession, the word "currently" was added.