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Queensland Government
Queensland Health

Clinical Audit of General Surgical Services
Bundaberg Base Hospital

Confidential Audit Report

Prepared by:
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Office of the Chief Health Officer

March 2005

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Controlled Document Number:

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Acknowledgements

The Chief Health Officer, Dr Gerry FitzGerald, wishes to thank all the staff members of Bundaberg Base Hospital involved in this clinical audit for their assistance, participation, advice and support. Thanks are also extended to the staff of Client Services, Data Services Unit for their assistance in the provision of data for this audit.

Introduction

Bundaberg is a progressive modern city with a population of 44,670, where residents are catered for with excellent shopping, medical services, education facilities and a diversity of recreational pursuits and experiences including the coral isles, coast and country. The city of Bundaberg is located 386kms north of Brisbane and 321km south of Rockhampton on the Central Queensland coast.

The Bundaberg Health Service District comprises a 136-bed hospital in Bundaberg, an 18-bed hospital in Gin Gin, an 18-bed hospital in Childers and a Health Centre in Mt Perry. The district extends from Miriam Vale in the north (including Town of 1770 and Agnes Waters), to Woodgate in the south, and services a population of 84,049.

Bundaberg Hospital is a modern 136-bed hospital and is the district's major referral centre, providing a broad range of secondary level services, including:

Hospital services including: emergency medicine, general medicine, renal dialysis, general, orthopaedic and vascular surgery, obstetrics, gynaecology, intensive care, coronary care, paediatrics and psychiatry. Surgical procedures are undertaken by visiting specialists and staff surgeons with the support of a staff anaesthetist. A staff physician is supported by a range of visiting specialists.

Diagnostic and laboratory services at a secondary level are provided.

Allied Health services include: physiotherapy, occupational therapy, dietetics, speech therapy, psychology, social work, pharmacy, medical imaging and pathology.

Background data source: *Queensland Government, February 2005, 'District and Hospital profiles' in the Queensland Health Electronic Publishing System (QHEPS) [Online]. Available at: http://qheps.health.qld.gov.au/*

Background

This clinical audit of general surgical services at Bundaberg Base Hospital was undertaken in February 2005 by the Chief Health Officer, Dr Gerry FitzGerald and Mrs Susan Jenkins, Manager of the Clinical Quality Unit in the Office of the Chief Health Officer, both of whom are appointed by the Director-General as Investigators pursuant to Part 6 of the *Health Services Act, 1991*, enabling access to relevant clinical data.

Definition of clinical audit

Clinical audit is a systematic review and critical analysis of recognised measures of the quality of clinical care, which enables benchmarking and identifies areas for improvement. Clinical audits are designed to complement accreditation surveys and focus on the outcomes of care rather than structures and processes.

Purpose of the clinical audit

This clinical audit was undertaken to measure the quality and safety of general surgical services at Bundaberg Base Hospital and identify areas for improvement. The Chief Health Officer had been approached by the District Manager (Bundaberg Health Service District) to conduct a clinical audit of general surgical services at Bundaberg Hospital. The catalyst for this request was a level of concern raised by a number of staff at the hospital in regard to some patient outcomes. In addition, some staff members expressed a level of distress about a number of staff interactions.

Scope of the clinical audit

The Chief Health Officer and Manager of the Clinical Quality Unit conducted an on-site visit at Bundaberg Base Hospital on February 14th and 15th 2005, to collect data and interview staff. In addition, data from the following facilities across Queensland were reviewed:

Northern zone:	Mt Isa, Mackay
Central zone:	Rockhampton, Gladstone, Hervey Bay, Maryborough, Redcliffe, Caboolture,
Southern zone:	Ipswich, QEII, Logan, Redland,

These facilities were chosen to enable benchmarking between hospitals of similar size and scope across the three zones. This peer group of hospitals had previously been identified and used by the Measured Quality Programme for benchmarking purposes.

Data sources

Data were sourced from the following:

- Queensland Hospitals Admitted Patient Data Collection (QHAPDC – routinely collected hospital in-patient data)
- Interviews with staff members
- Other data collection systems at Bundaberg Hospital (for example, ACHS clinical indicator data, infection rates)

Service Capability Levels

The Queensland Health Service Capability Framework (2004) was used to compare the stated service levels at Bundaberg Hospital with the recommendations in the framework. The framework outlines the minimum support services, staffing, safety standards and other requirements for public and licensed private health facilities to ensure safe and appropriately supported clinical services. The Service Capability Framework serves two major purposes:

- To provide a standard set of capability requirements for most acute health facility services provided in Queensland by public and private health facilities
- To provide a consistent language for health care providers and planners to use when describing health services and planning service developments

When applied across an organisation, the same set of underlying standards and requirements for similar services will safeguard patient safety and facilitate clinical risk management across the state's health facilities.

Data source: *Clinical Services Capability Framework – public and licensed private health facilities. Version 1.0 - July 2004. Queensland Health.*

Routinely collected data

The Client Services Unit (CSU) of the Queensland Health Information Centre (HIC) provided data for this review. The CSU was asked to provide data for the calendar year 2004, by doctor, ICD-10* and ICD-10-AM** codes and by specified hospital (as described above), including the following:

- Number and percentage of surgical episodes
- Number and percentage of episodes where the patient died in hospital
- Number and percentage of episodes where the patient was transferred to another hospital
- Number of episodes with a T81 ICD-10 code (complication of procedure not elsewhere classified)
- Number of episodes with a Y40-Y50 ICD010 code (drugs/medicaments/biologicals causing adverse effects in therapeutic use)
- Number of episodes with a Y60-Y69 ICD-10 code (misadventures to patients during surgical/medical care)
- Number of episodes with a Y70-Y82 ICD-10 code (medical devices associated with misadventures in diagnostic and therapeutic use)
- Number of episodes with a Y83-Y84 ICD-10 code (surgical/medical procedures as a cause of abnormal reaction of a patient without mention of misadventure)
- T81.0 - Haemorrhage/haematoma complicating a procedure not elsewhere classified
- T81.1 - Shock during or resulting from a procedure
- T81.2 - Accidental puncture and laceration during a procedure not elsewhere classified
- T81.3 - Disruption of operation wound not elsewhere classified
- T81.41 - Wound infection following a procedure
- T81.42 - Sepsis following a procedure
- T81.5 - Foreign body left in a body cavity or operation wound
- T81.6 - Acute reaction to foreign substance left during a procedure
- T81.7 - Vascular complications following a procedure not elsewhere classified
- T81.8 - Other complication of procedure not elsewhere classified
- T81.9 - Unspecified complication of procedure

Interpretation of these data

On review of the data supplied by the CSU, there appear to be a number of areas worthy of a further, in-depth statistical analysis and, if indicated, a review of the clinical records in these cases. The areas are:

- Number of episodes with a T81 ICD-10 code (complication of procedure not elsewhere classified)
- Number of episodes with a Y60-Y69 ICD-10 code (misadventures to patients during surgical/medical care)
- Number of episodes with a Y83-Y84 ICD-10 code (surgical/medical procedures as a cause of abnormal reaction of a patient without mention of misadventure)
- Haemorrhage/haematoma complicating a procedure not elsewhere classified
- Accidental puncture and laceration during a procedure not elsewhere classified
- Other complication of procedure not elsewhere classified

(At Appendix 1 is a table summarising the key findings of ICD-10 codes T81 (all), T81.0, T81.2, T81.3, T81.41, Y60-69 and Y83-84, and a comparison of Bundaberg Hospital data with data from Queensland peer group hospitals.)

** ICD-10 – the latest version of the International Statistical Classification of Diseases and Related Health Problems, approved by the International Conference for the tenth revision of the International Classification of Diseases in 1989 and adopted by the 43rd World Health Assembly.*
***ICD-10-AM – the Australian modification to the ICD-10, endorsed by the Australian Health Minister's Advisory Council.*

Identification of staff opinion

Discussions were held with staff at Bundaberg Hospital and included the district manager, director of medical services and director of nursing. The discussions were designed to provide a non-threatening situation where participants could discuss their views so that these could be recorded and inform future practices. Several staff members were supported by representatives of their industrial organisation. Comments have been 'themed' below with the nine quality dimensions of the National Health Performance Framework.

Quality dimension	Summation of comments	Opportunities for improvement
Accessible	In medical services, there has been a lack of continuity, significant unrest and staff movements.	Review staff recruitment and selection processes.
	There is a high percentage of overseas trained doctors at Bundaberg Hospital.	Review staff retention strategies.
	The director of this division is accessible to GPs and easy to contact	
	The divisional director has a good work ethic and a heavy workload.	
	The divisional director undertakes most procedures	
Appropriate	The divisional director carried out excellent work triaging in ED following the tilt train disaster.	
	Some procedures and selection of patients are outside the scope of Bundaberg Hospital.	Implement the Service Capability Framework.
	There is not always good teamwork between OT and ICU and clinical issues are sometimes complicated by 'personality issues'.	Institute team building between and within disciplines.
	There is a lack of understanding of the Australian healthcare system.	Develop an orientation programme on this topic.
	Lack of protocols for the management of medical and surgical patients in ICU means there is no 'multi-disciplinary team management' of patients – this is detrimental to patients and staff.	Develop and implement policies and procedures for the multi-disciplinary management of patients in ICU with a view to improving patient outcomes and work practices for staff.
	No protocols to manage the transfer of patients from ICU to a higher level facility.	Develop and implement appropriate policies and procedures for patient transfers.
	Documentation in clinical records is sometimes less than optimal.	Develop, implement and monitor a policy and education programme for clinical documentation.
	Clinical decision-making is sometimes left to junior doctors.	Review leave arrangements to ensure appropriate ongoing patient care.
	No systems in place for involvement of relevant clinical specialists in patient care.	Review processes for multi-speciality involvement in patient care.
	Appropriateness of and/or capability to carry out some treatments.	Review all clinical policies and procedures to ensure they are current, update as necessary and monitor staff compliance.
Contemporary	No systems for review of data to support the evaluation of patient care.	Develop a process of clinical audit (using routinely collected data) for evaluation of patient care.
	The divisional director is keen to be involved in activities such as ACHS accreditation.	

Identification of staff opinion (continued)

Quality dimension	Summation of comments	Opportunities for improvement
Capable	There is a mix of skills in the clinical workforce.	Review processes to ensure equitable access to professional development and training programmes.
	The credentialling and clinical privileges process has not yet been fully implemented.	Complete this process for all medical staff.
	Hospital doctors and doctors working in the private sector do not always work well together.	Facilitate the development of good working relationships between the public and private healthcare sectors.
	Teams do not always work well together.	Institute team building between and within disciplines.
	No clear protocols for handover of patients to appropriate staff when surgeons go on annual/other leave.	Develop and implement appropriate protocols to ensure ongoing patient care when clinical staff are on leave.
	The divisional director is committed to teaching.	
	Discussions between staff members regarding patient care do not always take place in a relevant setting.	Ensure all staff are aware of their obligations in regard to patient confidentiality.
	There are no protocols for multi-disciplinary team meetings and ward rounds to plan, implement and review patient care.	Develop and implement a system for multi-disciplinary ward rounds and meetings to ensure the continuum of care.
Responsive	Staff do not always comply with policies and procedures for patient confidentiality.	Ensure all staff are aware of their obligations in regard to patient confidentiality
	Patient satisfaction rates have increased.	
Effective	Throughput of elective surgery cases is good, but there are some unplanned re-admissions.	Implement an audit process to monitor, assess, take appropriate action and review this indicator.
Efficient	Lengths of stay for some procedures have increased.	Implement an audit process to monitor, assess, take appropriate action and review this indicator.
	The divisional director has created efficiencies on OT by changing some outmoded work practices.	
Safe	Complication rates have increased.	Implement an audit process to monitor, assess, take appropriate action and review this indicator.
	Staff do not always comply with infection control policies and procedures, including wearing of OT attire outside OT, hand washing between patients and appropriate use of instruments.	Review, update according to best practice and implement infection control policies and procedures and ensure staff compliance. Continue to monitor infection rates.
Sustainable	Interactions between some staff members could be improved.	Institute team building between and within disciplines. During significant organisational change, ensure Queensland Health's change management guidelines are used.
	Sometimes staff need more support from senior management.	Implement appropriate processes for staff to access senior management.
	Hospital doctors and doctors working in the private sector do not always work well together.	Facilitate the development of good working relationships between the public and private healthcare sectors.

Discussion of staff feedback

In general, staff have enjoyed their work at Bundaberg Hospital and only relatively recently have issues arisen which have caused concern. Staff clearly demonstrated their keenness to provide health services of a high standard.

However, as well as raising concerns, some staff made complimentary comments about the divisional director's commitment to teaching and mentoring of junior medical staff.

In addition, there has been a significant improvement in efficiency, especially in the operating theatre, and in meeting elective surgery targets with significant reductions in waiting times for surgery.

Opportunities for improvement identified from staff discussions

While it is recognised that many regional district health services (including Bundaberg Hospital) are faced with problems of lack of continuity, significant unrest and staff movements in medical services and that many hospitals have a high percentage of overseas trained doctors, this may be an opportune time to review recruitment, selection and retention policies and strategies in an effort to identify innovative solutions.

For staff in regional areas, access to professional development opportunities can be limited, and it may be useful therefore, to explore alternative strategies for the provision of ongoing training and development for all staff, including relevant topics for orientation and in-service education programmes.

In order to ensure optimal outcomes for patients and enhanced work experiences for staff, ongoing attempts to improve and maintain good communication between professional groups in the public and private sectors are essential.

Hospital policies and procedures, particularly for transfer of patients, management of surgical patients, multi-disciplinary involvement in patient care, case-conferencing, management of patients in ICU, clinical documentation, leave arrangements, patient confidentiality and infection control should be reviewed to ensure they are consistent with current best practice.

Multi-disciplinary involvement in a process of clinical audit needs to be developed and encouraged to maintain high quality services.

The process for credentialling of medical staff to ensure appropriate granting of clinical privileges, should be progressed.

The Queensland Health Service Capability Framework should be implemented to ensure all service levels are consistent with the framework.

1. Unplanned re-admissions within 28 days as a percentage of total discharges (ACHS Hospital-wide Clinical Indicator – 2.1)

Bundaberg Hospital

Time period	Specialty	Discharges - 1 period	Unplanned re-admissions	
		Number	Number	%
Jan-June 2003	All surgery	2648	50	1.9
	Surgery/Vascular/Urology/Endoscopy	1307	32	2.4
July-Dec 2003	All surgery	2392	36	1.5
	Surgery/Vascular/Urology/Endoscopy	1092	27	2.5
Jan-June 2004	All surgery	2695	56	2.1
	Surgery/Vascular/Urology/Endoscopy	1218	36	3.0
July-Dec 2004	All surgery	2561	45	1.8
	Surgery/Vascular/Urology/Endoscopy	1208	30	2.5

The latest ACHS results to be published (Determining the Potential to Improve Quality of Care, 5th Edition, ACHS Clinical Indicator results for Australia and New Zealand, 1998-2003) for this indicator are as follows:

Stratum	Year	No Hosps	Numerator	Denominator	Stratum rate %
NSW	2002	110	14,158	779,834	1.8
	2003	119	18,605	829,599	2.2
Queensland	2002	50	6,916	404,226	1.7
	2003	45	8,348	429,914	1.9
SA	2002	28	2,658	179,055	1.5
	2003	25	3,050	150,315	2.0
TAS	2002	8	1,569	120,261	1.3
	2003	7	1,239	131,810	0.94
VIC	2002	90	10,355	576,034	1.8
	2003	84	10,402	560,182	1.9
WA	2002	19	1,903	120,747	1.6
	2003	28	4,018	286,880	1.4

2. The rate of patients having bile duct injury requiring operative intervention (ACHS Surgical Clinical Indicator – 7.1)

Bundaberg Hospital

Time period	Specialty	Number of procedures	Number of injuries	Rate
January-June 2003	General Surgery	52	0	0.00
July-December 2003	General Surgery	53	2	3.77
January-June 2004	General Surgery	56	3	5.36
July-December 2004	General Surgery	62	5	8.06

(Note: Small numbers should be interpreted with some caution)

The latest ACHS results to be published (Determining the Potential to Improve Quality of Care, 5th Edition, ACHS Clinical Indicator results for Australia and New Zealand, 1998-2003) for this indicator are as follows:

Year	No HCOs	Numerator	Denominator	Rate %
1998	110	46	8,976	0.51
1999	118	42	9,527	0.44
2000	143	73	16,294	0.45
2001	167	70	15,676	0.45
2002	176	55	15,898	0.35
2003	155	45	15,436	0.29

3. Patient opinion

Surveys of patient opinion were conducted at Bundaberg Hospital by the company 'Press Ganey' in 2001 (pilot survey), 2003 and 2004.

In 2003, the results indicated that patients had rated the surgical services as 'significantly higher' than the mean Bundaberg Hospital score for 'doctor care'. Most aspects of surgical 'doctor care' were rated higher than the mean for all facilities participating in the survey, public hospitals participating in the survey and hospitals surveyed in the 101-150 bed range.

In 2004, the results indicated that patients rated 'doctor care' for surgical services as higher than the Bundaberg mean, although the difference was not statistically significant.

No statistically significant differences were found between the results for 'doctor care' between the 2003 and 2004 surveys. The Bundaberg Hospital scores were not significantly different from the mean scores of other hospitals participating in the survey. There was, however, a general decline in the score when compared to 2003.

Service Capability Framework

As stated previously, the Queensland Health Service Capability Framework (2004) outlines the minimum support services, staffing, safety standards and other requirements for public and licensed private health facilities to ensure safe and appropriately supported clinical services.

The capability levels applied to services at Bundaberg Hospital relevant to this audit are as follows:

Clinical service	Level
Anaesthetic services	2
Colorectal surgery	3
Diagnostic Imaging	2
Endoscopy services	2
Gastroenterology	2
Gastrointestinal surgery	3
General Surgery	3
Intensive Care Units	2
Internal medicine	3
Nuclear medicine	1
Interventional radiology	2
Operating Suite services	3
Pathology	2
Pharmacy	2
Urology	3
Vascular surgery	2

The service definition for a surgical service level 3 is as follows: ***'surgical service level 3 provides a combination of intermediate surgery with high anaesthetic risk and complex surgery with medium or high anaesthetic risk'.*** (Service Capability Framework, Section C3, page 106).

For a Level 3 general surgical service, the support services should be at the following levels:

Required clinical services	Level	Level applied at Bundaberg Hospital
Anaesthetics	3	2
Critical care	ICU 1	2
Diagnostic imaging	2	2
Emergency	-	-
Endoscopy	2	2
Interventional radiology	2	2
Medical	2	3
Nuclear medicine	1	1
Operating suite	3	3
Pathology	1	2
Pharmacy	3	2

Comment: Service levels applied at Bundaberg Hospital for anaesthetic and pharmacy services (shaded areas) should be reviewed according to the Service Capability Framework.

Summary

During this audit, a number of issues and concerns were raised with the reviewers. In addition, positive comments were made about the general surgical service, including the commitment of the Director of Surgery to his teaching responsibilities, throughput of elective surgical cases and the increased level of efficiency in the operating theatres.

The concerns raised by staff can be categorised into two main groups – these are:

1. ***General surgical procedures being undertaken which are outside the scope of Bundaberg Hospital.*** Comments made in regard to this included: there is sometimes a tendency to treat patients at Bundaberg when they should be transferred to a higher level facility with appropriate resources: a preparedness to demonstrate accountability (i.e. hand over patient care when indicated) is not always evident: there is a demonstrated lack of understanding of the capability of Queensland regional health services: infection rates and wound dehiscence rates have increased: unplanned returns to operating theatre have increased: the care of two patients in particular have highlighted the concerns of staff and caused them to voice their distress.
2. ***Lack of good working relationships between all staff in the general surgical service.*** Comments made in regard to this included: the director of surgery has high standards and this has led to some degree of conflict with staff: there has been some 'cultural' conflict: there are not always good working relationships between hospital doctors and doctors in the private sector: the increase in work levels may be causing concern to some staff members: the director has a confronting personality which causes conflict with some staff members.

Discussion

The two issues that appear to have been of significant concern to staff in the general surgical service and intensive care unit, have been the performance of complex procedures without the appropriate level of support services and the poor working relationships between some staff members. In addition, concerns were also raised about increasing unplanned readmission, complication and wound dehiscence rates.

With regard to the conduct of inappropriate complex procedures, the surgeon involved has agreed to undertake only those procedures which are within the scope of the surgical service and relevant support services. The surgeon has also agreed to transfer patients more readily to higher level facilities.

As can be seen from the data presented earlier in this report (page 8), the rates of unplanned readmissions (general surgery/vascular/urology/endoscopy) at Bundaberg Hospital were higher in all time periods (2003 and 2004) than for the 'all surgery' category. The Queensland rate for 2003 was 1.9 (ACHS data - Determining the Potential to Improve Quality of Care, 5th Edition, ACHS Clinical Indicator results for Australia and New Zealand, 1998-2003). The rates of bile duct injury during laparoscopic cholecystectomy (page 9) at Bundaberg Hospital in 2003 were 0.00 (January-June), 3.77 (July-December) and in 2004, 5.36 (January-June) and 8.06 (July-December). The ACHS rate for 2003 (the most recent data) was 0.29 (Determining the Potential to Improve Quality of Care, 5th Edition, ACHS Clinical Indicator results for Australia and New Zealand, 1998-2003).

Following the discussions with staff held during the on-site visit, the issues raised about poor working relationships, both in the general surgical unit and between this unit and support services (e.g. ICU and infection control), still appear to be of concern to a significant number of staff members.

As has been stated above, although some staff members had reported examples of poor teamwork in the general surgical unit, other staff were keen to highlight positive aspects of general surgical service delivery, for example, a significant commitment to teaching of junior medical staff and efficiencies achieved in operating theatre processes.

Recommendations

Recommendations are provided, having been separated into 'strategic' and 'operational' areas.

Strategic

1. Complete the implementation, and ensure the ongoing process of credentialling and granting of clinical privileges to medical staff which delineates the scope of practice.
2. Review staff recruitment, selection and retention strategies in an effort to attract and retain clinical staff and improve continuity of service.
3. Review the Queensland Health Service Capability Framework to ensure appropriate levels are applied to each service.
4. Ensure all staff are supplied with (or are able to access through QHEPS) the Queensland Health Code of Conduct, and that all staff are aware of their obligations and responsibilities in regard to the Code, for example, confidentiality of patient information, having respect for people, treating people with dignity.
5. Institute team building within and between disciplines.
6. Encourage all clinical units/divisions to be involved in an ongoing process of multi-disciplinary clinical audit, which is used to evaluate and improve patient care. This process should embrace performance indicators relevant to the clinical service, for example the ACHS clinical indicators, including unplanned re-admissions, unplanned returns to operating theatre, average lengths of stay, complication and infection rates.
7. When significant organisational changes are planned, ensure Queensland Health's change management guidelines are used.
8. Include education/information on the Queensland healthcare system in the hospital orientation programme to ensure all staff understand how the public and private sectors operate and the linkages between the two systems.
9. Facilitate improved working relationships between clinicians in the public and private sectors.
10. Review processes to enable equitable access to ongoing professional development and training programmes.
11. Implement appropriate processes to enable staff to access senior management.
12. Ensure the development and implementation of a policy (which is based on best evidence) and education programme for clinical documentation.

Operational

1. Review all clinical policies and procedures to ensure they are based on best evidence and implement a process to make certain that staff know about and comply with all policies and procedures.
2. Implement the Queensland Health Code of Conduct at department/ward/unit level.
3. Develop and implement policies and procedures, which are based on best practice for the following:
    - Multi-disciplinary management of patients in ICU
    - Transfer of patients to higher level facilities
    - Clinicians' leave arrangements to ensure appropriate ongoing patient care
    - Multi-specialty and multi-disciplinary involvement in patient care
    - Multi-disciplinary ward rounds, case conferences and meetings to ensure continuity of appropriate care for all patients
    - Infection control
    - Patient confidentiality, using the Queensland Health Code of Conduct as a guide

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Appendix

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Summary table – ICD-10 codes T81 (all), T81.0, T81.2, t81.3, T81.41, Y60-69, Y83084. Comparison of Bundaberg data with data from Queensland peer group hospitals.

These data are for the calendar year 2004

ICD-10 code	Bundaberg		Peer group	
	Number of surgical episodes = 408		Number of surgical episodes = 10,055	
	Number of complications	% of surgical episodes	Number of complications	% of surgical episodes
T 81 (all)	52	12.8	738	7.3
T 81.0 Haemorrhage or haematoma complicating a procedure	11	2.7	239	2.4
T 81.2 Accidental puncture and laceration during a procedure	17	4.2	66	0.66
T 81.3 Disruption of operation wound	4	0.98	73	0.73
T 81.41 Wound infection following a procedure	11	2.7	292	2.9
Y60-69 Misadventures to patients during surgical/medical care	9	2.2	60	0.6
Y 83-84 Surgical/medical procedures as cause of abnormal reaction of patient without mention of misadventure	118	28.9	1278	12.7

Queensland Government Queensland Health	MINISTERIAL BRIEFING	Number For Noting **DEADLINE** April 15 2005	BR April 15 2005

BRIEFING NOTE to be limited to two pages only. Where additional information is required, supporting schedules / attachments should be used

SUBJECT:

Bundaberg Health Service District and Dr Patel

PURPOSE:

To provide a brief on the issues surrounding Dr Patel, former Director of Surgery at Bundaberg Base Hospital.

DEPARTMENTAL OFFICER ATTENDING THE MEETING / EVENT: (Optional)

N/A

BACKGROUND:

Dr Patel commenced work at Bundaberg Base Hospital March 2003 after being recruited from overseas (USA). Dr Patel resigned from Bundaberg Base Hospital on 25 March 2005.

Four patient complaints were received by the District between April and November 2003. The District responded to each of the complaints within appropriate timeframes. In two cases further surgery was required and provided.

In July 2004 a sentinel event occurred which resulted in considerable concern being expressed by staff with regards to Dr Patel's competence to practice. A further adverse event occurred in August 2004 which resulted in a meeting between concerned staff and the District Manager followed by formal correspondence being submitted to the District Manager in October 2004.

In October 04 the District Manager contacted Operational Audit regarding the need for a Review to be undertaken into Dr Patel's performance.

The CHO commenced the Clinical Audit on 14 February 05.

The issue was escalated on 22 March 05 when Mr Messenger tabled in Parliament a letter from

Bundaberg Staff regarding staff concerns about Dr Patel.

KEY ISSUES:

The CHO's Clinical Audit findings were as follows:

- The complexity of procedures being undertaken by Dr Patel at Bundaberg Hospital were outside the service capability of the facility,
- Dr Patel's complication rates were found to be higher than complication rates in other hospitals of similar size and service capability,
- Dr Patel's reluctance to refer patients with complex conditions to tertiary level facilities.
- Lack of clinical governance framework in the District.
- Lack of team work and poor interpersonal relations both within the District and with key external stakeholders

The Minister announced on the 9 April that there would be a departmental Review of Bundaberg Base Hospital.

The team to undertake the Review includes four senior clinicians including 3 Senior Medical Officers and a Senior Nurse. The Team commenced preparation for the Review on 11 April 05. The Team will commence in Bundaberg on 18 April 05 (Terms of Reference for the Review are being drafted and will be provided as soon as they have been endorsed)

The CHO went to Bundaberg Base Hospital on 13 April to provide a summary of the outcome of the Clinical Audit and to also advise staff of the review that is now to be undertaken.

The District Manager notified the Director General on the 14 April 05 that he would stand aside pending the outcome of the Review He stated his intent to be available for the Review Team. The Zonal Manager is currently managing the District until Monday 18 April at which time Dr Michael Daly will act as District Manager for the duration of the Review.

A Ministerial Press Conference was held 14 April 05

A Public meeting was held on Thursday 14 April in Bundaberg where patients of Dr Patel and their families expressed severe displeasure and discussed coordinated legal action.

The Medical Superintendent notified the Senior Executive Director Health Services of his intent to take leave from the 15 April 05. He stated that he would be available to provide information to the Review Team as required.

A staff Forum was held at Bundaberg Base Hospital at 3pm 15 April 05 by the Zonal Manager to brief staff on the interim management arrangements and the Review process.

A further Ministerial Press conference was held on 15 April 05.

MEDIA IMPLICATIONS:

The issues surrounding Dr Patel at Bundaberg Hospital have already been widely reported by the media. Several patients have spoken to the media and voiced personal concerns regarding treatment provided to them by Dr Patel. At least two law firms are involved with patients and their families in discussions regarding class actions

Key Messages:

1. The processes of registration for medical officers in Queensland need to be reviewed.
2. The processes of selection and recruitment for medical officers needs to be reviewed
3. Queensland Health will continue to pursue its agenda in improving the quality of systems and process and patient safety in Queensland hospitals and health care facilities.

CONSULTATION:

Dr Gerry Fitzgerald, Chief Health Officer

IS THIS IN ACCORDANCE WITH ANY COMMITMENTS / INITIATIVES:

N/A

RECOMMENDATION:

That the Minister note the contents of this brief.

ATTACHMENTS:

Nil

MEDIA RELEASE: (Optional)

☐ YES ☐ NO

COMMUNICATION STRATEGY / SPEECH: (Optional)

☐ ATTACHED ☐ NOT ATTACHED

Cleared by:
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Date 15/4/05

Cleared by:
Dr John Scott
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Date: 15/4/05

(Use both sections if this brief requires clearance from District Manager & Zonal Manager.

BUNDAB~1 Bundaberg Base Hospital & Dr Patel

otherwise please delete one section)

(Please include Contact Officer details below)

Prepared by: Sue Jenkins & Leanne Patton
Unit: Chief Health Officer Office & Central Zone Management Unit
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RECOMMENDATION:

BRIEFING

Noted . ...

COMMENTS:

GORDON NUTTALL MP
Minister for Health
Member for Sandgate

/ /

BUNDAB~1 Bundaberg Base Hospital & Dr Patel

Queensland Government
Queensland Health

A BRIEFING TO THE SENIOR EXECUTIVE DIRECTOR HEALTH SERVICES DIRECTORATE

BRIEFING NOTE NO:	
REQUESTED BY:	Dr John Scott, Senior Executive Director, Health Services
DATE:	18th May 2005
PREPARED BY:	Jane Hedger, Public Affairs, Bundaberg Health Service District, Contact 07 4150 2021
CONSULTATION WITH:	Dr Michael Cleary, Acting District Manager, Bundaberg Health Service District, Contact 07 4150 2021 Mr Peter Heath, Director of Corporate Services, Bundaberg Health Service District, Contact 07 4150 2050
CLEARED BY:	Dr Michael Cleary, Acting District Manager, Bundaberg Health Service District, Contact 07 4150 2120
DEADLINE:	
SUBMITTED THROUGH:	Graeme Kerridge, Acting Zonal Manager, Central Zone
SUBJECT:	**Travel Expenses – Dr J Patel**

COMMENTS SED HEALTH SERVICES:

DR JOHN SCOTT
Senior Executive Director
Health Services Directorate

/ /

PURPOSE:

To inform the Senior Executive Director, Health Services of the circumstances relating to the return travel of Dr Patel to the United States in April 2005.

BACKGROUND:

The Acting District Manager, Dr Michael Cleary in reviewing concerns raised about alleged "cash payments" to Dr Patel following a media inquire became aware that an expense reimbursement of $3,547.00 (includes Airfare from Bundaberg to Brisbane, Overnight Accommodation, Airfare from Brisbane to Los Angeles, and Airfare from Los Angeles to Portland) was made to Dr J Patel.

An extensive review of Dr Patel's personnel file reveals that his annual employment contracts did not include an agreement to pay for return airfares to the United States. The contracts however did make provision for relocation expenses to be paid. His last contract of employment concluded on 31st March 2005.

A file note contained in his Personal File indicates that for the term of his first contract there was an agreement to meet the costs of a return flight to the USA and that this was agreed between the District and Wavelength Consulting (recruitment agency). Apart from a file note there is no formal advice from Wavelength Consulting outlining this requirement. The terms of the contract with Wavelength Consulting this is silent in relation to the terms and conditions of employment which are deemed to be a matter for the employer.

It is noted that on the 7th February 2005 Dr Patel signed a contract which would come under the broad definition of a "contract medical officer" covering the period 1st April – 30th June 2005. In this contract he was to be paid $1,150 per day, be provided with accommodation and a maintained motor vehicle.

It is also of note Dr Patel withdrew from the contract prior to the 1st April 2005 that the Acting Director of Medical Services, Dr K Nydam completed a termination of employment form which was signed by Dr Patel on the 29/3/05.

District Manger signed a staff claim for expenses form on the 1st April 2005 for reimbursement of return travel expenses. There are no additional notes on file relating to this approval however staff advise that Dr Patel and the District Manager had a conversation on the 1st April 2005 where his travel request was discussed.

KEY ISSUES:

Payment of return travel to the United States was approved by the District Manager, however there are no contractual requirements for this payment to be made nor are there file notes to explain why this payment was made.

Travel arrangements were made through a private provider (Jetset Sunstate Bundaberg) and not through Queensland Health corporate travel which is not in accordance with Queensland Health policy.

RELATED ISSUES:

A number of investigations are underway which are reviewing the treatment provided by Dr Patel to patients and his registration with the Medical Board of Queensland.

There will be ongoing media interest in aspects of Dr Patel's employment arrangements.

An Operational Audit is to be undertaken in the District beginning 6th June 2005.

BENEFITS AND COSTS:

N/A

ACTIONS TAKEN/ REQUIRED:

The Senior Executive Director, Health Services note the contents of the brief and that the District will be referring the matter to Audit and Operational Review Branch for review.

ATTACHMENTS:

Claim For Payment (Staff Expenses) form and attached receipt.

JGS - 16.

Queensland Health Budget Process

Overview:

Departmental:

Queensland Health's budget for the new financial year is handed down through the **State Budget process** as detailed in the Ministerial Portfolio Statements (MPS).

Queensland Health is funded under the **Queensland Treasury Managing for Outcomes (MFO) framework (net appropriation)** where the Department receives output revenue from Treasury and 'own source' revenue directly from user charges, grants and other contributions to deliver Departmental outputs that directly contribute towards Government outcomes/priorities.

The budget is aligned to the Whole-of-Government priorities with the **five departmental outputs**: Treatment and Management – Acute Inpatient Services, Treatment and Management – Non Inpatient Services, Integrated Mental Health Services, Health Maintenance Services and Public Health Services set out separately each with an Output Statement of Financial Performance for the new financial year.

A **consolidated set of statements** for Queensland Health set outs the Financial Performance (operating result), Financial Position (balance sheet) and Cash Flow for the new financial year.

The **Capital Acquisition** Statement sets out the Capital Works Program based on the detail planning done within the Departments capital planning process.

These statements are an annual estimate for the new financial year and the actual result is reported each month throughout the year. The **Annual Report** and **Annual Financial Statements** report the final position after the close of financial year which is audited by the Queensland Audit Office.

Directorates:

Queensland Health's approach to budget management is to devolve annual and forward year current approved budget allocations for operating expense and minor capital to the five Directorates and executive units to deliver on the *Smart State: Health 2020 Directions*. These budgets are then distributed in further detail by each of the following Directorates on an organisational basis to the greatest possible extent without compromising effective corporate governance:

- Strategic Policy & Government Liaison
- Health Services
- Innovation & Workforce Reform
- Information
- Resource Management
- and Executive Units (Audit & Operational Review, Chief Nursing Advisor, Child Safety, Legal & Administrative Law, Chief Health Officer, Public Affairs and Director-General)

Broad business rules with budget performance principles and funding arrangements underpin the budget process to facilitate equity and appropriate accountability as set out in the Business Rules and appendix to annual service agreements with health service districts. Budgets are in rolling forward year format by fund (State base and specials, Commonwealth Programs, General Trust, State Research) to promote funding certainty for planning purposes at the local level.

Budget Definitions

Budget Funds / Groups:

For budget management purposes the line item budgets allocated to Directorates are separately identified for tracking and monitoring purposes by **fund and group** or broad banding, and made up from the various revenues from ordinary activities (ie. output revenue, user charges, grants and other contributions and other) in the Statement of Financial Performance as detailed in the Ministerial Portfolio Statements (MPS) and the Annual Financial Statements (AFS).

1. **Funds** are State, Commonwealth Programs and General Trust.

   State funds are mainly output revenue received from Treasury and user charges from own source revenues under the net appropriation funding arrangements.

   Commonwealth Programs are grant revenue received directly from the Commonwealth and subject to acquittal and specific terms and conditions of various Commonwealth agreements. Some programs require State matched funding as per of the terms and conditions.

   The base grant funding through the Australian Health Care Agreement (AHCA) is not subject to acquittal and therefore not separately identified or tracked as a commonwealth program and forms part of the overall State funds for Health Services Directorate.

   General Trust funds comprise all moneys received and held in trust by Queensland Health but excludes Patient Trust funds and as specifically defined in the Queensland Health General Trust Policy. These funds are mainly from other revenue contributions.

2. **Budget Groups** broad band line item budgets for various purposes.

   Base Operating Budget is the opening and closing balance of annual and forward year operating budget allocations.

   Awards Added to Operating Budget is the recurrent allocations for approved employee award / agreements outcomes and variations.

   Variations to Operating Budget are all other recurrent allocations excluding employee award/agreement funding decisions that occur throughout the year and are separately identified to reconcile the increments / decrements that comprise the opening / closing balance for the Base Operating Budget.

   State Carryover is unspent revenue from the prior year (ie. cash funds) re-provided to Directorates as approved for continuing commitments in the new financial year due to timing differences in delivering health services and projects.

   State Specials are quarantined funds allocated for specific purposes, and non discretionary.

   New Funding is for new initiatives, service enhancements and election commitments, all separately identified and of special interest to Queensland Health direction and or Government. Allocations are quarantined, tracked and monitored in the initial year of allocation, and recurrent allocations are added to Base Operating Budget of Directorates in forward years.

Retained revenue is mainly user charges and other revenue devolved to Zones/Health Service Districts under the Queensland Health Revenue Retention Arrangements. Zonal targets are distributed to Health Service Districts in the service agreement process and gain / loss are retained by the respective Zone / Health Service District for local priorities.

Awards Current Year is the non-recurrent or part-year allocations for approved employee award / agreements outcomes and variations.

Commonwealth Programs are the allocation of the program funds across Health Service Districts subject to acquittal and specific terms and conditions of various Commonwealth agreements.

Trust Funds are the allocation of all moneys received and held in trust across Health Service Districts subject to Queensland Health General Trust Policy.

State Research Funds are all payments to projects falling within the scope of the Queensland Health Research Management Policy and therefore required to be listed on the QH Research Register and are kept separate to General Trust Funds as per the Queensland Health General Trust Policy.

Minor Capital allocations are separate and quarantined from the above operating budget funds / groups. These allocations are sourced from equity and not revenue.

HANSARD EXCERPTS 2003-2005

25 March 2003 – Questions without Notice

Ms LEE LONG (Tablelands—ONP) (10.27 a.m.): I speak once again on the state of Queensland's hospitals. According to media reports, while the Health Minister was busy last sittings trying desperately to convince Queensland that everything was fine in her department she already had a secret report under way. That report by a Queensland Health task force apparently identifies serious flaws in operating theatre management, a lack of accountability when surgery is cancelled or postponed, and calls for a major shake-up of the public hospital system. But just two weeks ago, the Minister moved a motion congratulating herself on her department's performance. It appears that would be the same performance that the department's 'squirrel' report now says needs a major shake-up so far as hospitals go. What else did the minister say two weeks ago? She said that Queensland Health was a world-class system that was the envy of the rest of the world. But how can this be when it needs a world-class shake-up?

The media report indicates that many operating theatres cannot keep up with the number of new patients referred from outpatient clinics. Can this be true? The minister's world-class system is not coping? It just gets worse. This government is apparently going to align outpatient sessions with operating theatres, because some hospitals have too many outpatient sessions. Instead of increasing its ability to provide that surgery, it talks about identifying alternatives. The fact that surgery was the proper course of action as identified by a doctor does not seem to matter to this government. Last sittings, the minister claimed that this government was committed to a public health system built on the principles of universality and equity of access according to need. Now it appears that a need for surgery as identified by a referral from one of Queensland Health's own outpatient clinics is not need enough. So much for equity of access.

26 March 2003 – Health and other Legislation Amendment Bill

Mrs LIZ CUNNINGHAM: I would challenge that and so would the community. The perception and the reality is that outpatient services have changed. They have been through a cycle of new programs. Years ago a person just sat and waited in the outpatients area. They could tell by the length of the line ahead of them how long they would wait. They might have waited three or four hours, but they saw a GP because, depending on the hospital size, there was a bank of four, five or six GPs who were seeing people for colds, flus and ordinary medical issues—the ones that the minister now says should go to their GP. Then hospitals went through the stage where patients would make an appointment. That was in place for a little while until it was found that people made the appointments too far ahead and forgot to turn up for their appointment and then hospitals would only take appointments for the ensuing three days, and that created frustration as well.

Hospitals have now turned to the triage system where a person turns up and they are triaged as 1, 2, 3, 4 or 5 and they wait their turn. There have been instances where people have not been seen and I have sent letters to the minister about this. One man in particular went to the hospital with flu-like symptoms. He waited for six hours and left. Rightly—and I thank the minister for it—the minister wrote and apologised for the wait. There had been some system breakdown and this gentleman actually went home. He was too sick to sit and wait to be seen by a doctor. So outpatient services are seen to be deteriorating.

Specialist services in rural Queensland are seen to be deteriorating. I again say to the minister that for her to say that our patient numbers are dropping is a red rag to a bull, because one reason for that which has just been remediated is the oncology situation. They were not seen in that hospital because the oncologist stopped coming and they had to be sent to Rocky and Brisbane. That is why patient numbers dropped. That is why the minister saying that patient numbers are dropping is inciting anger. I commend the Mater Hospital for its co-location and want to finish on a positive note, and that is to thank the minister for the allocation or the awarding of the contract for the construction of the Boyne Valley clinic to enable construction to proceed. Boyne Valley is an isolated community in terms of accessing emergency medical services. Mary Faint has worked there, as her mother did before her, for many years and has provided not only a physical service but also a comfort to the residents to know that they have quick access to somebody with clinical first-aid qualifications who can provide immediate help while waiting for an ambulance or the medivac helicopter to attend. There are a couple of sawmills up there. God forbid that it should happen, but accidents are usually quite horrific. Therefore, the presence of some medical person to give initial treatment until more extensive services arrive is more than welcome. The staff who work at the hospital do an excellent job, but they are working under very trying circumstances in a community that is growing. The growth area is in heavy industry.

The community's perception—the minister says that services have not been reduced but certainly the public's and my perception is that they have—is that these services are reducing and that access locally to specialists is reducing when the community is growing exponentially and those industries that are being attracted to the area are process industries with quite dangerous procedures in terms of the mechanical work that occurs and also potentially quite damaging results in terms of emission of toxic gases if there were an incident. Health is a basic service for quality of life. We need to build our health services, not diminish them. I commend those concerns to the minister.

29 April 2003 – Matters of Public Interest

Surgical Waiting Lists, Queensland Health

Miss SIMPSON (Maroochydore—NPA) (12.11 p.m.): According to Queensland Health's own figures, less surgery per year took place under the Beattie government than during the reign of the Borbidge government. In the 1997-98 year, more than 600,000 surgical procedures took place, yet in 2002 this fell to 586,000. It is well documented that one of the major issues concerning the Queensland populace is lengthy surgical waiting lists. Latest Queensland Health figures indicate that 11,000 Queensland patients are overdue for elective surgery. 9,000 of those waited more than a year. This is clearly unacceptable. But Health Minister Wendy Edmond will not even admit there is a problem, despite having the gall to criticise the federal government which is actually trying to fix the problems within its realm of influence. Health is a problem in Queensland and the figures show that Queensland is going backwards. The state Health Minister's solution to bringing down waiting lists is to stop more people from going on the list. Many of Queensland's sick and elderly are waiting years for appointments with specialists. That is Queensland's hidden waiting list, which is much more extensive than what the Health Minister would have us believe. In the Health Smart State 2020 document it was suggested that there should be fewer specialist clinics because they encourage unrealistic expectations that patients would not receive treatment. This is where it is outrageous, because there are people who are waiting to get on a waiting list. The hidden problem with people being unable to get a timely appointment with a specialist means that they are being gate kept; in other words, they are being kept out of the official figures for surgery. If the media did not report on the numerous people who have had difficulty getting medical attention in the public system regardless of their condition the Beattie government would not bother doing anything to help them. The minister repeatedly criticises the opposition for making the issues public. In many of these cases these people—these patients—cannot wait a month for the Health Minister to return our letters. Like the Sunshine Coast lady who had a deadly aneurism on her brain, or the Rockhampton gentleman who had been told he could not be seen within the estimated time he had left to live, or the Mackay lady whose husband died while on a waiting list for angiogram. These people cannot wait. There are many other people who fall through the cracks. This is the human face of the Queensland Health crisis and yet the state Health Minister pretends that there is not a problem. The Queensland coalition recognises the problem and is developing a multifaceted policy to reduce elective surgery waiting lists. We are also looking at how we reduce the outpatient specialist wait times, because this is a critical factor to people receiving timely and appropriate treatment. Earlier, I tabled documents revealing the proposal by Queensland Health to close the Princess Alexandra Hospital Gynaecology Unit. More than 700 gynaecology patients in Queensland are already overdue for surgery. So what does the Health Minister do? She decides to shut down another facility despite protests from the PA Hospital's senior specialist staff association. Mrs Edmond admits to a plan to actually exacerbate wait times rather than improve them. Right now the wait times must be improved. The state Health Minister must get serious about bringing down hospital wait times. If she is not prepared to do that, she should not be in the job. Not only does this state government seem unprepared to do anything, it is actually working to increase wait times. No longer will the coalition accuse the Beattie government of sitting on its hands; the Beattie government is actually working to make the public health system worse for Queenslanders. I know the role of Health Minister is a difficult one. It is an extremely important one which must be tackled head on. But this state Health Minister hides behind the director-general or district managers of hospitals every time something goes wrong. Today I issue a challenge to the state Health Minister to be the Health spokesperson for the Beattie government. If she is not willing to stop plans which increase the waiting times for elective surgery, she could at least be made to explain to the public why she is allowing wait times to spiral out of control even further. I implore her to perform her role and actually answer people's questions about elective surgery waiting times or emergency department waiting times. I issue that challenge to Mrs Edmond. It is really the very least she can do.

27 May 2003 - Papers

Response from the Minister for Health and Minister Assisting the Premier on Women's Policy (Mrs Edmond) to a paper petition presented by Mrs Sheldon from 160 petitioners regarding the Caloundra Health Service—

Mr N Laurie
The Clerk of the Parliament
TableOffice@parliament.qld.gov.au

Dear Mr Laurie

Thank you for your letter dated 27 March 2003, enclosing a petition from the residents of Caloundra received by the House on 25 March 2003, regarding the Caloundra Health Service. I apologise for the delay in responding. I am advised by the District Manager, Sunshine Coast Health Service District, that service provision and staffing levels at Caloundra have increased considerably since that time aided by an additional $1 million funding in the 2001/2002 financial year and a further $650,000 in 2002/2003.

One of the major enhancements at Caloundra has been the expansion of the Department of Emergency Medicine, which included the provision of a 24 hour service. The Department of Emergency Medicine at Caloundra is currently treating an average of 1200 patients each month and the number is increasing.

I am further advised that both theatres are available for use and the second theatre is used on a needs basis. There has also been an increase in the number of specialists visiting the Hospital providing clinic services, ward rounds, and operating theatre sessions. Increased Specialist Outpatient clinics have been provided in a range of specialties. The

provision of outpatient physiotherapy services by acute care facilities is determined by clinical priority. Therefore, outpatient physiotherapy services are provided to patients in acute/sub-acute priority groups at Caloundra.
The rehabilitation unit for the Sunshine Coast Health Service District has been relocated to the purpose built 17 bed unit at Caloundra and has been fully operational since 9 September 2002.

I am further advised that the waiting time for general dental treatment at Caloundra has increased due to an increased demand and the difficulties the District has had in recruiting Dentists. Some emergency dental services were outsourced to the private sector until full staff complements were recruited. All patients presenting for emergency dental treatment are treated according to clinical priority.

It is recognised that the Sunshine Coast, including Caloundra, is a rapid growth area. The Sunshine Coast Health Service District has been developing a Master Plan to ensure a planned approach is taken to providing health care services in line with population growth, changes in demographics, and advances in medical technology.

Therefore, the Caloundra Health Service will continue to be expanded and enhanced in line with service needs and District priorities.

Thank you for bringing this matter to my attention and I trust this information is of assistance.

Yours sincerely

Signed

Wendy Edmond MP
Minister for Health and Minister Assisting the Premier on Women's Policy

25 November 2003 – Questions without Notice

Hospital Waiting Lists

Mrs PRATT: My question is directed to the Minister for Health. Constituents in my electorate, and no doubt in the electorates of many other members, would have been approached with concerns that, although being booked to undergo major surgery, they would not be placed on the actual surgery waiting list immediately but instead their names would be put on a pre-waiting list. Were these people who are waiting on the pre-waiting list included in the figures published in the report that the Premier is so proudly pushing in his advertising campaign? If not, just how long is the list of people waiting on the pre-waiting list?

Mrs EDMOND: I am not quite sure what the member is referring to. There are two issues. The first is that people are put on the waiting list when they are seen and they are determined to need surgery. They are not always given an appointment for that surgery until closer to the time. One of the ways we have improved throughput is by removing a lot of people who have either forgotten or did not show. They may be on the list and counted from that point in time, but their appointment may not be given to them until closer to the time. There was a letter in the paper today from someone making the claim that his wife had not gone on the waiting list. Clearly she had gone on the waiting list because she has received notification of her surgery. They wait until five or six weeks out from the date of the surgery before they tell people of the date. There has been a lot of talk from the member for Maroochydore and others about the waiting list to get on the waiting list, which was something I exposed when I was in opposition. This relates to outpatient waiting times. Members will remember that I made several speeches on that issue. Mr Horan has his head down because he knows that I highlighted that at the time. We have done a lot to reform that process. I was actually quite intrigued to hear people say that we should be doing what they do in New South Wales. There has been a lot of hot air about this. Let us have a look at the facts. Queensland offers the most comprehensive public specialist outpatient services in Australia. These services are for medical services as well as surgery. They include pre-assessment, ongoing care and follow-up care. Not everybody on those lists is going to be needing surgery. Not everybody on those lists is appropriate to have surgery. What happens is that if they are seen and they need surgery they are placed on the elective surgery waiting list immediately. Until they are seen we do not know whether they need elective surgery. We cannot put people on a waiting list for surgery in case they need it. That is nonsensical. The members opposite have said that we should do what they do in New South Wales. In New South Wales and Victoria the majority of patients have to go to the private consulting rooms of individual specialists. In other words, they have to save up and have enough money to afford to go to a private specialist before they can be seen, assessed and go on the waiting list.

Mrs PRATT: Mr Speaker, I raise a point of order. This woman was actually told she required surgery and it would be arranged.

Mrs EDMOND: And, as I have said, if that is the case and she has been seen and told she needs surgery she would have gone on the waiting list and been counted. We have to explain things several times for these people to understand. Part of the reason is that they have no comprehension of what happens in other states. When they are calling for us to do as they do in New South Wales and count them the same, do they mean we close down the $300 million of specialist outpatient services we provide now and make people wait until they can afford to go to a specialist?

20 October 2004 – Questions without Notice

Health Services; Waiting Lists

Mr COPELAND: My question is addressed to the Minister for Health. During the Health estimates committee hearings this year, when questioned about waiting lists the minister stated—

There is a misnomer about waiting to get on the waiting list ... I get quite surprised at that theory that there is a wait to get on the waiting list.

Today's *Gold Coast Bulletin* again confirmed that the Gold Coast Hospital is refusing to allocate specialist appointments so that surgeons cannot add more patients to the waiting lists, which results in a waiting list to get on the waiting list. The report also again revealed the widespread downgrading of the clinical category of patients, which results in surgery being put on to the never-never list. Just how dodgy are the published elective surgery figures? Will the minister now give a cast-iron guarantee that the practices of the Gold Coast Hospital and every other Queensland public hospital have not been adopted to address the lack of funding and resources to the detriment of patients' wellbeing?

Mr NUTTALL: Members do not need to take my word for the issue around waiting lists. The Productivity Commission actually produces a report on waiting lists for all states.

Mr Copeland: Where is your independent auditor?

Mr NUTTALL: The Productivity Commission report clearly shows that our benchmark is the best in the country in terms of our waiting lists. In response to the first part of the honourable member's question, there is no doctoring whatsoever of the waiting lists in this state. The Productivity Commission's report clearly indicates that. On the second part about the independent audit, we gave a commitment during the election campaign that an independent audit of waiting lists would be conducted. That election commitment, as I have said in this House previously, will be honoured and will be honoured at some stage during the term of this government. That was the commitment we made and that is what we will deliver on. In relation to the third part, let me talk a little bit about waiting to get on the waiting list. As I have said on many occasions in this House, we are the only state that has a specialist outpatient service. We are the only state in the country that has that. We rely very heavily on visiting doctors to assist us in terms of providing specialist outpatient services. To visit one of those specialists people require an appointment, as they would if they went to their own doctor. If their doctor said, 'You need to see an ear, nose and throat specialist,' the person would ring up and make an appointment. That person may have to wait three months to see that specialist.

Mr Copeland interjected.

Mr SPEAKER: Order! Member for Cunningham. You are on a warning.

Mr Schwarten: My son just waited four months for one of those appointments.

Mr NUTTALL: I take that interjection from the honourable member for Rockhampton. There is no difference in the public system. We simply say to the patient, 'You will have to arrange to make an appointment to see the specialist when he is available.' And I would be the first person to admit that it is difficult. We have a shortage of specialists. It is very difficult for me as the Minister for Health in the public health system to obtain the number of specialists to work the number of hours required in order for people to see a specialist in the outpatients area on very short notice. It is simply not achievable while we have a substantial shortage of specialists in the health system throughout this country.

21 July 2004 – Estimates Hearing

Mr COPELAND: Thank you, Minister. I look forward to receiving information regarding those issues. Minister, I would like to move on to specialist services. You referred to this in your opening statement. Page 1-2 of the MPS, under Strategic Issues, states that Queensland Health has commenced the Integrating Strategy and Performance Project. This will provide ways to measure success or, if necessary, change practices or implement new initiatives to better meet the department's strategic directions. As you are aware, in many health districts throughout the state there is a hidden waiting list to get on the elective surgery waiting list which means that patients seeking specialist services can wait up to six years in some districts. What steps have you taken to diminish the specialist waiting lists? How much funding this financial year have you allocated to a specialist service waiting list reduction strategy?

Mr NUTTALL: We need to get a couple of things very clear here. There is a misnomer about waiting to get on the waiting list. I have to say, I get quite surprised at that theory that there is a wait to get on the waiting list. If, for example, you were to go to your doctor and your doctor wanted to refer you to an ear specialist because you had something wrong with your ear, if you were in the private sector you would have to make an appointment to see that specialist and you would have to wait some time to see that specialist. There is no difference. The same thing applies in the public system. If a doctor who sees you says that you need to see a specialist in our outpatients area, you need to wait. The waiting times for specialist outpatient services do vary quite considerably throughout the state depending on patient numbers, the referral demand, the location and of course the speciality the doctor is

referring you to. This has, of course, a great bearing on what time it takes to actually get to see the specialist in the outpatient area. To try to improve the consistency of practice and promote good data collection, we have recently approved a policy framework for specialist outpatient services which provides instruction, information and guidance to all Queensland Health employees involved in the provision of outpatient services.

The management practices continue to be supplemented by system enhancements to the outpatient scheduling system. Further administrative and clinical improvements will be gained following the establishment and implementation of the specialist outpatient service policy framework over this 12 months. The framework will reinforce standardised principles and practices across the state. All specialist outpatient referrals received by hospitals will be entered on to a waiting list register to enable hospitals to manage their workloads in a more effective manner. We will have a standardised urgency categorisation system similar to that used in elective surgery which will be established for use by hospitals across the state, ensuring that patients are allocated appointments according to the urgency of their clinical needs.

The department is also currently establishing work practices to audit outpatient waiting lists to ensure that lists provide an accurate reflection of the number of patients waiting for specialist outpatient appointments. One of the continuing problems we have is the shortage of specialists in the country. At its last meeting the ministerial council agreed that we again meet at the end of July and that some data be brought forward to that meeting so that we can start addressing the shortage of specialists on a nationwide basis.

Mr COPELAND: Any member of parliament will know, because we see it through our offices every day, that people are waiting significant amounts of time to see a specialist. Regarding specialist wait times, you stated in answer to question on notice No. 215, previous to the estimates, that Queensland Health does not currently collect waiting times for specialist outpatient appointments in a consistent manner. I take it from your comments that that will now be happening. If that is going to happen, will you be releasing that information so that we can all have a look at it and so that you can actually address the problem that we all know is out there?

Mr NUTTALL: We are the only state in the country that has a specialist outpatient service. No other public hospital system in the country has that. We are the only one. You heard my response to your first question in terms of the new systems we are putting in place. We release on a quarterly basis all of the elective surgery waiting lists. In terms of people waiting to see specialists, we will have to get the system up and running. We are not about hiding anything that we do in Queensland Health. It is an open book. We are more than happy to say to the people of Queensland, 'Yes, it is difficult when you have got to see a specialist and it does take time.' We do not hide that issue under a bushel. It is a major problem for all Australians in terms of the shortage of doctors and the shortage of specialists that we have had.

In my opening statement I said that 3,500 young people want to study medicine and we say no to them around this country. You cannot be a specialist until you have done your study to be a doctor and you have studied another six or seven years to be a specialist. So that is 14 or 15 years before we bring specialists online. We are trying to do our part. It is also the responsibility of the federal government. I have spoken to Tony Abbott about that. Actually, today there will be a meeting, which I could not attend, with Tony Abbott and Brendan Nelson, the Education Minister, to talk about this issue. I was invited to attend that meeting today. I cannot be there because I am here, but I will be following that through with them. The only way we are going to reduce the waiting lists for people to see specialists is to have more specialists. It is as simple as that. But the problem we have in this country is that at the moment we cannot say how many specialists are necessarily practising at any one time in the field in what part of the country or how many we are going to need into the future. None of that work has been done and it needs to be done. I cannot sit here today and give a commitment to the people of Queensland that they will not have to wait to see a specialist until we have enough specialists in this country. The only way we are going to do that is by providing the education places in our universities and then subsequently in our hospitals to train them.

Mr COPELAND: Thanks, Minister. Minister, I refer to the fourth last dot point on page 1-19 of the MPS concerning the construction of a clinics building at Hervey Bay which will include specialist clinics. How many private specialist clinics are operating within the state's public hospitals and where are those clinics located?

Mr NUTTALL: I do not have those exact details of every hospital. I will pass over to my director general to answer some of that.

Dr Buckland: As you are probably aware, every full-time specialist who works for Queensland Health has the right of private practice, whether that is under option A, which means that we pay them an allowance and then bill for private patients they see, or under option B, where they can keep up to 100 per cent of a salary base. As part of their condition of service, every full-time specialist in Queensland has the right of private practice. So right across the state where we employ full-time specialists there will be, in most of those instances, private practice clinics, depending on the specialty. We do not sit down and monitor on a statewide basis which particular clinics run in which particular hospitals. That is a local business decision for the local hospitals and for the local districts who run those hospitals. I would expect that in the major hospitals we would have a significant number of clinics because we have a significant number of specialists who have right of private practice, and in the smaller places where we do not then there will not be any. So it varies across the whole state, but we do not centrally control or intend to control the number of clinics that we conduct. We have put the federal government on notice through the Department of Health and Ageing to say that, while Queensland is the only state that provides significant public access to specialist clinics, we intend to move that quite deliberately back in line with other states so Queensland is not disadvantaged under the federal payments. In the other states, clearly, if you are referred, you go straight to a practitioner, even if he is in the hospital, to a private clinic. We are the only state that provides significant and substantial public

outpatients. Everything after 1998 under the Medicare Agreement allows us to move those patients into a Medicare billing arrangement. That is not cost shifting. We had to maintain our effort as at 1998. Any new services that we bring on within the state we are entitled to move into a private practice arrangement, and that is a revenue issue for Queensland Health and it is an agreement with the Commonwealth government.

The CHAIR: That concludes the time for the first block of opposition questions. Minister, in what way will the investment of an additional $40 million for 2004-05 for elective surgery affect waiting lists?

Mr NUTTALL: Following the success of the government's $20 million program to reduce the waiting lists in Queensland public hospitals over the last five months, as I said in my opening statement, there will be an additional $40 million that we will spend this financial year to reduce waiting lists even further. That is part of our $110 million commitment in the election campaign and that program will be over three and a half years to reduce waiting lists.

$25 million will be allocated to public hospitals to enhance the number of patients that are treated, specifically targeting areas with the longest waiting lists and highest demand. In situations where public hospitals are unable to further increase their capacity to perform additional surgery, we will continue to enter into partnership arrangements with private hospitals to ensure that the public patients are assured access to surgery. $5 million will be spent specifically on providing joint replacement procedures for approximately 300 additional patients that are waiting statewide, $2.5 million will be allocated to funding an additional 1,000 cataract operations and an additional two eye specialist training positions will be made available.

Other initiatives to be funded this year out of the $40 million also include $2 million for new operating theatres and 10 additional beds at the Caloundra Hospital, $1.5 million for full specialist vascular services to be established at the Nambour Hospital, $1 million for additional orthopaedic surgery at the Noosa Hospital, $1.5 million will help address those Cairns patients waiting longer than usual for ear, nose and throat surgery, and we will employ a specialist ENT surgeon at the Cairns Base Hospital. $500,000 will be allocated to employ six new nurses at the Cairns Base Hospital to expand the hospital's capacity to treat critically ill patients. On top of all that there will be a further $1 million that will be invested in a Fit for Surgery initiative to avoid postponements that become quite costly and help patients prepare for surgery through programs aimed at weight loss, cardiovascular fitness and, of course, giving up smoking.

07 October 2004 - Questions without Notice

Redcliffe Hospital, Orthopaedic Clinic

Dr FLEGG: My question without notice is to the Minister for Health. I refer the minister to the pro forma letter issued to referring doctors by the orthopaedic clinic at Redcliffe Hospital which states—

The demand for this service is significant. We only book appointments three months in advance. Your patient has been placed on the waiting list for an appointment with the orthopaedic clinic.

I ask: why is the minister deliberating manipulating the waiting list data by placing patients on a waiting list before they are included in the official waiting list figures and does this not make a mockery of his claim that 95 per cent of patients receive treatment within the specified time frame? I table the pro forma letter.

Mr NUTTALL: I would like to have a look at the letter first. In relation to the pro forma letter, I presume this is an appointment to see a specialist at the outpatient service. Would the member agree with that?

Dr Flegg: Yes.

Mr NUTTALL: Right. We are the only state in the country that has an outpatient service. In order to obtain funding from the current coalition federal government under the health agreement we have to continue to provide an outpatient service for the people of Queensland. Most of the specialists who attend the outpatient services, as the honourable member would know, are visiting medical officers, visiting specialists. The state system relies very heavily on visiting medical officers to assist us in the delivery of public health services.

The reality is that the majority of specialists in Queensland are in private practice. They allocate part of their time per week to the public health system. From the public health point of view we obviously appreciate and value that very much. The fact that we have only a limited amount of their time per week necessitates that when people want to see a specialist it takes time. If someone goes to their own doctor and the doctor refers them to a specialist up on the terrace, they would have to make an appointment and wait to see that specialist. In some areas they may have to wait months. It is no different in the private system than it is in the public system. People have to make an appointment to see their specialist, wait until they are able to see that specialist and, once they have seen the specialist and the specialist agrees that they need surgery, they then they go on the waiting list. It is very simple.

Notes

09 August 2005 – Parliament

Page 2186 - **Redcliffe Hospital**

Dr FLEGG: My question without notice is to the Minister for Health. I table for the minister a standard letter from the Redcliffe Hospital telling an orthopaedic patient that she has been put on a waiting list to await an appointment. She must then wait to be seen at an outpatient clinic in order to finally then be placed on the official waiting list for her operation. That is two secret waiting lists before this lady can even get on to an official waiting list. I ask the minister: will he overturn his predecessor's policy of unpublished secret waiting lists, and what advice does he as minister give this lady and other patients about how long they will actually wait?

Mr ROBERTSON: The one thing that I have learnt in the time that the honourable member for Moggill has been in this House is that any document that he presents needs to be thoroughly checked, and that is something which I will undertake to do before responding to him personally.

11 August 2005 – Parliament

Page 2448 - **Queensland Health; Hunter, Mrs A**

Mrs LIZ CUNNINGHAM (Gladstone—Ind) (10.01 pm): A doctor in my electorate contacted me this week. He wrote—

The old waiting list farce is continuing. Please note the following:

1 Gladstone Hospital do only general surgery.
2 All Orthopaedics, ENT, Ophthalmology and the rest are being referred to Rockhampton.
3 The actual surgical waiting lists once characterised is in some cases much too long but:
4 What is worse is the waiting time to get to see a specialist in the public systems i.e. even before a person is given a category for a specific waiting list they can in some cases expect to wait a year or longer TO BE SEEN BY THE
SPECIALIST in the 1st place. The waiting times for the outpatient appointments has been completely ignored in the
debate on waiting lists. We would like to see these initial waiting times to be published for all to see. Only then will the public be getting a better picture of how bad things really are in QLD Health.

12 August 2005 – Parliament

Pages 2460 – 2469 – numerous mentions of outpatient – referring mainly to the waiting list issue which broke in the papers around this time.

08 July 2005 – Estimates Hearing

Page 13 – makes reference to outpatient re Medicare and billing for services

Received Time 7 Jul 17:29

Queensland Government
Queensland Health

FAX MESSAGE

Rockhampton Health Service District
District Manager's Office
C/- Administration Building
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Canning Street, Rockhampton Q 4700

TO:		FROM:	
Fax:	07 3234 1865	Fax:	07 49206335
Name:	Peter Brocke	Phone:	07 49206282
Organisation:		Name:	Lillian Hart
Date:	7 July 2005	Position:	Executive Support, District Manager's Office

CONFIDENTIAL COMMUNICATION

SUBJECT: Information Re: Dr William Kelley

Pages 8 (Inclusive)

See copies of Memo to Staff

- Review of Emergency Department, Rockhampton Hospital (August 2004)

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Queensland Government
Queensland Health

MEMORANDUM

To: All staff, Emergency Department, Rockhampton Hospital, Rockhampton Health Service District

Copies to: District Director of Nursing, Rockhampton Health Service District
Nursing Director, Division of Surgery, Rockhampton Hospital
Nursing Director, Clinical Improvement Unit, Rockhampton Health Service District
Registrar, Medical Administration, Rockhampton Hospital
Director of Emergency, Rockhampton Hospital
Nurse Unit Manager, Emergency Department, Rockhampton Hospital
Human Resource Services Manager, SSP District

From: District Manager, Rockhampton Health Service District
Contact No: (07) 4920 6282
Fax No: (07) 4920 6335

Subject: **Review Emergency Department, Rockhampton Hospital**

File Ref: 314sids doc

The following is to provide an update on the Review that was conducted of the Rockhampton Hospital Emergency Department by Dr Peter Miller, Ms Michelle McKay and Mr Tim Williams.

A report has been finalised with a number of recommendations on how the service may be enhanced. The Review Team highlighted a number of issues that need to be addressed (an Executive Summary is attached). In summary, the issues identified relate to the following matters:

- Supervision and staffing levels;
- The process for collection, management and use of data;
- The development of a quality and patient-focussed service;
- Education and performance management processes for staff;
- Triage practices;
- Facilities.

As a hospital it is now necessary using the information provided in the report, to consider what recommendations and actions will be implemented, and how this process will be managed. A consultative process will be established that involves staff and other key stakeholders, in the development and implementation of an action plan for the service. A communication strategy will also be developed to ensure that staff within the department, and other stakeholders, are kept informed.

To progress the development and to oversee the implementation of the Action Plan, a Steering Committee has been formed. The members of this committee are as follows:

- Andrew Montague, Registrar, Medical Administration
- Lex Oliver, District Director of Nursing
- Nick Milns, Director of Emergency
- Jan Randall, Nurse Unit Manager, Emergency Department
- Jean Devine, Human Resource Services Manager, SSP District
- Deanne Walls, Nursing Director, Division of Surgery
- Debbie Carroll, Nursing Director, Clinical Improvement Unit

Should you have any specific queries in relation to the review, please discuss these with Andrew Montague or Lex Oliver.

I'd like to take this opportunity to thank all staff who participated in the review and encourage you to be actively involved in the change process that we are about to undertake.

Sandra Thomson
District Manager
Rockhampton health Service District
05/08/2004

Emergency Department Review
Rockhampton Hospital

FINAL REPORT

June 2004

Updated 6 July 2005 to include RHSD's progress regarding implementation of review recommendations.

Executive Summary

The Emergency Department at Rockhampton Hospital was reviewed on the 15th and 16th June, 2004. The Review Team have made a range of recommendations for consideration by the District Manager, District Executive and the Emergency Department Management Team. The major issues that need to be addressed include the medical staffing of the ED, education and performance management processes for ED staff, the development of a quality and patient-focussed service, improvement in data quality and use, and the issue of professional isolation for ED staff at Rockhampton Hospital.

Summary of Recommendations

Data Collection

The Review Team recommends that:

- Processes be implemented and enforced within the ED that ensures all data is entered for the relevant patients in real time directly into the HBCIS field
- The HBCIS emergency department module be utilised as a real time department management tool and for real time data entry. This will facilitate the implementation of EDIS in the future as there will already be a cultural acceptance of data entry by all staff by the time EDIS is implemented.

Action

- Feb 05 all medical staff trained in EMG module as part of orientation to the Emergency Department. Medical staff were supported by the ED Project Officer and encouraged to use the EMG module.
- March and April 2005 – Problems encountered with the number of computers and constraints of the physical environment leading to limited PC access by staff. Definitive number of PC's needed again dependant on architectural changes however an additional printer has been ordered for shift coordinator station, currently waiting on ISU response.
- There is a lack of buy in from medical staff and no medical champion to drive the real time data entry process as HBCIS is not a user friendly system. For example it takes considerable time to obtain diagnosis codes. These factors collectively create numerous barriers to the implementation of Medical staff entering real time data.
- It is unclear when EDIS will be implemented.

- As part of triage education outlined elsewhere in this report, the triage nurses should only enter the final 'correct' triage category into the HBCIS field.

Refer to triage response

- The data collected by the staff in ED be collated and displayed for all the staff in a way that they are able to comprehend, participate and initiate service improvement activities. It is expected that this would have the effect of improving data quality.

education provided
- Outreach clinics to Marlborough and St Lawrence. These clinics have ceased
- Orthopaedic clinic remains within ED due to proximity to medical imaging and plaster technician however discreet waiting room has been established. This issue is currently being addressed through the current master planning process
- Ward Call to inpatient wards overnight (continues)
- Medical Retrievals via Capricornia Helicopter Rescue Service (very rare)
- Provision of regional medical relief services to other hospitals in the district from the ED (continues)

- The emergency department develop, and the Executive endorse, a policy whereby patients who are medically stable and have a clear requirement for admission, are able to be directly admitted to the ward if there is to be a delay in inpatient medical review. This policy should outline that interim management orders, including appropriate fluid and medication orders, are fully documented and that the patient has been discussed with the ED SMO.

patient f admissi

Action:
- Hospital Admission policy reviewed and implemented 2005
- March 2005 Data collected relating to Bed Blockages and presented to key stakeholders. Medical director was reluctant to progress the SMO admitting medical patients to the ward without Medical Registrar examining patients due to the skill mix of current Medical staff skill mix
- Fast tracking of transfer patients was considered as a viable option and if the patient is stable then the transfer admission policy is in place and should be followed
- Surgically there has been significant improvement with trauma patients and patients of concern are notified to the Surgical Registrar sooner rather than later. HEAPS analysis on cases to continue to improve processes
- An audit has been conducted June 05 to determine all levels of interruption to patient flow through the ED with outcome yet to be correlated

Medical Staffing

The Review Team recommends the following in respect of medical staffing:

- The department and the district make the accreditation of the Rockhampton emergency department as a training department for advanced training with the ACEM a priority issue.
- As part of the move to accreditation, there is a need to create a specialist workforce in the ED. A minimum number of 4 FTE Fellows of the Australasian College of Emergency Medicine, or equivalent, will be required to provide a stable sustainable quality service.
- As an interim measure until the department can attract and recruit registered emergency specialist staff, the review team recommends that the department seek to establish formal links with either individual emergency specialists on

Performance Management

The Review Team recommends the implementation of a mandatory performance management framework that is multi-disciplinary and multi-level.

Action

- Workshop/education sessions provided
- Nursing staff defining portfolios with second workshop to be scheduled to finalise PAD requirements
- Dr Greg Prescott to undertake medical PAD process

Triage practices

The Review Team would recommend the following in respect of triage practice:

- The practice of "rapid" triage cease and a more appropriate model be introduced
- Analysis of triage practice should occur to ensure consistency with accepted benchmarks
- The roll out of the Triage Education Work Book continue and include all staff who are performing the triage role
- A mental health triage scale be introduced
- Consideration be given to a single point triage process

Action

- In May 05 NUM and Project Officer visited Ipswich, Redcliffe, Toowoomba and Caboolture ED's to benchmark triage practices. Only one ED utilized a single point of triage and the process was time consuming and created line up issues for patients.
- ED's current physical layout does not enable implementation of a single point of triage and this will be considered in the Master planning forums.
- Triage area will be revised once new relative's room is completed and habitable. At present relatives room at triage is still in use. Multi function room is awaiting work requested to be conducted and then selection of appropriate furnishings.
- It is hoped that the shift coordinator trial will alleviate some of the current triaging issues in the acute care area. E.G. The Shift Coordinator will triage all presentations to the acute care area and allocate patients and staff accordingly. This will enable the Triage process to continue in the non acute care area uninterrupted. The triage nurse and the shift coordinator will communicate re the department situation. Anecdotal feedback indicates implementation of shift coordinator trial has initially pushed patients through the acute care area and reduced the number of patients in the non acute care area. As consulting rooms have no longer been occupied with patients lying on beds, non acute patients have been able to be seen in a more timely manner. Patient flow has been affected positively from the trial in both areas.
- Primary triage assessment is undertaken on presentation and recorded on EMC module followed by a secondary triage assessment when required. Primary triage score is changed as indicated by the secondary assessment.
- Triage working group has been formed to address triage practices addressing both administrative and nursing processes.
- Environmental factors affecting the main triage area will be reviewed when the

Chapter 1 Workload and Performance

It is difficult to ascertain the workload of the Rockhampton Emergency Department (ED) due to the fact that data was not collected for the June/July 2002 period as a result of industrial action at that time. This meant that neither the 2001/2002 or 2002/2003 data are accurate. According to data provided to the Review Team, see attachment C, 35,735 patients have been recorded as attending the ED during the first 11 months of 2003/2004, of which 2336 or 6.5% were for dressing clinic. In addition the department has a number of patients who return for reviews or procedures who are counted within the attendance numbers.

The Australasian Triage Scale breakdown of the 2003/2004 attendances, is as follows:

ATS Category	Percent
1	0.4
2	3.7
3	41.7
4	45.8
5	8.3

As part of the Surgical Access Service benchmarking process, Rockhampton ED is in the major regional group, which includes Cairns, Nambour, Redcliffe and Toowoomba Emergency Departments. The admission rates per triage category, as reported in the Emergency Department Benchmarking Report December Quarter 2003/2004, Attachment D, are as follows:

ATS Category	Rockhampton	Major Regional average	Queensland average	ACHS and ACEM range
1	71.2	84.3	83.1	75 - 90
2	65.7	67.4	63	60 - 70
3	27.2	38.7	36.3	40 - 60
4	5.6	14.5	12.4	20 - 30
5	1.7	4.4	3.7	5 - 10

The Rockhampton admission rates for categories 1, 3, 4 and 5 are below the major regional and Queensland averages and below the reference range identified by the Australian Council for Healthcare Standards (ACHS) and the Australasian College for Emergency Medicine (ACEM). There are two potential explanations for this variance. The first is that the Rockhampton ED has access to high level community support structures which allow patients to be managed in the community as an alternative to hospitalisation. The second, and in the opinion of the Review Team a far more likely explanation, is that triage is not being applied in a manner that is consistent with state and national practice. Triage will be discussed in more detail in other sections of this report.

A measure of ED performance is the percentage of patients seen within the recommended timeframes per triage category. The following table outlines the Rockhampton performance as reported in the ED benchmarking report for the December Quarter 2003/2004:

- and 8 other). The data indicates a reduction in reported APO's. HEAPS analysis are performed on APO's of concern and through the QTR Committee.
- Nursing Portfolio to address consumer focused services is in the process of being developed.
- Complaint rates remain high in 04-05 due to waiting times and medical staffing issues. Currently 04/05 reports indicate 24 % of complaints are due to communication issues, 38 % due to treatment and 33 % due to access issues.
- DNW is a measurable criteria on the recently endorsed Standards of Care plan

appears to have adequate computer workstations to allow HBCIS to be used for these purposes. Given the physical layout of the department where clinical care for ED patients currently occurs in two physically separate areas, a real time department management system would be an ideal way to keep track of patients under the care of the ED. This does not occur and neither does the direct entry of data.

Again this practice is part of a cultural apathy that is a remnant from the philosophy of the previous director. The NUM is keenly awaiting the implementation of EDIS as a new department management tool in the Rockhampton department. The review team acknowledges that the HBCIS emergency department module is not intuitively easy to use for people with limited IT skills. Despite this there needs to be an acceptance in the ED that data collection is part of core business.

Aberrant triage practices

The Rockhampton ED employs an unusual practice of 'rapid triage' which is later followed by a more thorough triage assessment following the patient being registered by the triage clerks. The initial triage category is placed on HBCIS, but is often later amended following the more thorough and detailed triage assessment. It was widely reported amongst all staff that if the triage category is clinically amended on the triage sheet it is not always amended on the HBCIS screen. This is an obvious source of inaccurate data.

Data collected is not utilised by the ED for quality or service planning activities

The data that is collected could be a source of quality initiatives in the department to improve performance in measured areas and directly feedback any improvements to the staff. Furthermore, it could also be utilised by ED management for roster planning and statistical evidence in workforce planning. It appeared to the review team that any data collected was not being directly utilised within the department. This has the effect of devaluing the whole process in the eyes of the staff and reinforces the view that data collection is not core business.

The Review Team recommends the following in relation to data collection:

- **processes be implemented and enforced within the ED that ensures all data is entered for the relevant patients in real time directly into the HBCIS field**
- **the HBCIS emergency department module be utilised as a real time department management tool and for real time data entry. This will facilitate the implementation of EDIS in the future as there will already be a cultural acceptance of data entry by all staff by the time EDIS is implemented.**
- **as part of triage education outlined elsewhere in this report, the triage nurses should only enter the final 'correct' triage category into the HBCIS field.**
- **the data collected by the staff in ED be collated and displayed for all the staff in a way that they are able to comprehend, participate and initiate service improvement activities. It is expected that this would have the effect of improving data quality.**

Core business

Emergency departments in regional areas evolve to meet the service needs of the community. This tendency often creates situations where the ED extends its care to areas outside of the scope of standard emergency care practice in an attempt fill a gap in medical service provision in the community. While the desire to 'fix' the situation is admirable, non-core business in an ED can be a significant drain on resources and can blur the focus of the emergency department. Emergency departments providing services outside their scope can be likened to the department of medicine providing surgery.

The Rockhampton Hospital ED is currently providing a number of services that fall outside the scope of core ED business. They are provided at the level that can be a significant staffing and financial drain on the department. If the ED were to 'trim' its services to meet the objective of 'providing high quality timely emergency care to the community of Rockhampton and surrounding areas', this would provide clear direction and focus and limit the creep of services to areas outside of this objective.

Current practices that the review team identified as non core ED business include:

- Dressing clinic and dressing reviews
- Needle exchange service
- Sedation and fracture manipulation in children
- Management of chest pain in the observation unit
- Unregulated scheduled review of patients (ie more than a limited defined number of conditions)
- Outreach clinics to Marlborough and St Lawrence
- Scheduled general outpatients services
- 'Ward Call' to inpatient wards overnight
- Medical Retrievals via Capricornia Helicopter Rescue Service
- Provision of regional medical relief services to other hospitals in the district from the ED

While it is recognised that some of these services will, out of necessity, still need to be provided by the District, they should not fall under the responsibility of the emergency department management and resources.

The co-location of the needle exchange service in the ED is an area that warrants particular mention. This is a necessary service for the community in terms of public health risk management, but causes particular issues to the ED. It has been the source of several complaints about perceived positive discrimination towards IV drug users being given apparent preferential service before unwell people in the waiting room. While this is clearly an issue of public perception it is quite simply managed by not co-locating the two services. The clientele of the needle exchange service are also prone to aggression and violence and this escalates an already tense environment in an ED waiting area.

The Review Team recommend that core business for the ED be identified and articulated and alternatives for other services be explored.

It is certainly preferred practice that patients presenting to an ED see a clinician first, and it was encouraging to see that this is the practice at Rockhampton. This practice reduces the risk that an acutely unwell patient will be required to spend unnecessary time in the waiting room prior to medical attention. The concept of the triage nurse "quickly eyeballing" waiting patients to ensure that the acutely unwell ambulatory patients are identified and treated as rapidly as possible is a standard triage practice. However the description given to the Review Team of the Rockhampton practice seems to be a very labour intensive hybrid version. As discussed in the nursing staffing section of this report, it would be preferable to have the triage nurse complete the triage process on patients at first contact and the nurse in the sub-acute area be responsible for managing ongoing interventions for the group of waiting ambulatory patients.

As discussed in Chapter 1, the Review Team believe that the application of the Australasian Triage Scale (ATS) at Rockhampton is not consistent with the broader Queensland practice. It was encouraging to see the roll out of the Triage Education Work Book that has been occurring over the last year. This process needs to be made mandatory for all staff who are performing the triage role and, once all staff have moved through the education process, analysis of triage practice should be occurring as a strategy to move triaging to being within the accepted standards. Unfortunately there is no tool in existence at this point that can be utilised to ensure consistency of triage application. However, analysis of admission rates per triage category and retrospective triage audits are two means that can, and should, be utilised.

It is also unfortunate that the Rockhampton ED does not use a mental health triage scale, specific to that vulnerable group of patients. The Emergency Mental Health Project 2002 – Report of the Consultative Committee recommends the use of the South East Sydney Area Health Service triage scale which is widely used within Queensland, and the Review Team would endorse this recommendation.

Finally, as discussed in Chapter 5 of this report, consideration should be given to having a single triage point where all patients, both ambulatory and ambulance, are triaged by the triage nurse.

The Review Team would recommend the following in respect of triage practice:

- **The practice of double triage cease and a more appropriate model be introduced**
- **Analysis of triage practice should occur to ensure consistency with accepted benchmarks**
- **The roll out of the Triage Education Work Book continue and include all staff who are performing the triage role**
- **A mental health triage scale be introduced**
- **Consideration be given to a single point triage process**

however is unsustainable at current staffing levels and is impacting in a number of other areas both within and outside the ED.

The obligation of the ED to provide junior staff for weekend and holiday relief to the rural hospitals places a disproportionate and unacceptable load on the remaining junior staff to provide cover to the department. The current rostering pattern has RMOs working 7 out of 10 weekends during a rotation, and PHOs working a 1 in 2 weekend roster. The current accepted industry standard for weekend work in EDs is a maximum of 1 in 2 weekends.

While the hospital obviously has a duty to provide support for remote practitioners in rural hospitals, the requirement that these staff are rostered through the ED places an inequitable burden of weekend and antisocial shifts on this group of doctors. This contributes heavily to poor morale and ongoing recruitment difficulties.

Supervision

Many of the junior medical staff felt that supervision by more senior staff in the department was inadequate. This sentiment is juxtaposed against what is clearly good extended hours senior medical staff coverage.
This situation may arise due to:

- Inadequate staffing numbers,
- The heavy personal caseload of the SMOs,
- The senior staff concentrating their supervision on the underperformers at the expense of the good performers
- A cultural issue within the department that does not foster close clinical supervision of junior doctors as a high priority goal.
- Lack of confidence of the SMO staff in their own clinical abilities

The exact root of this issue could not be determined at the time of review, but it is clearly an issue for the quality of care being provided in the ED as well as an issue affecting morale and retention of junior medical staff.

Skill mix

The emergency department medical staffing skill mix is highly variable. Many people on the roster are not performing at an acceptable level according to their level of employment. This has many trickle-down effects. It causes competent medical staff to carry a higher case load to make up the deficit. It forces the senior medical and nursing staff to more closely supervise them at the expense of supervision and education of other more competent staff. It forces the Director to roster according to skill mix and not according to level of employment and therefore places an inequitable burden on staff performing acceptably. In fact the situation often arises where staff on lower pay scales are rostered to 'supervise' staff on higher pay scales. This obvious inequity needs to be addressed through recruitment, education and performance management strategies.

There is the perception amongst the ED senior medical staff, which is supported by other department senior staff, that the hospital 'manages' its underperforming doctors by placing them in ED. While this perception is rife, there appear to be structural issues in the term allocation process that reinforce this perception and indeed this occurrence.

outlined above. It also has the potential to compromise clinical care. Emergency medicine specialist presence in the ED should be made a priority.

Hospital perceptions

There is a widely held perception in the hospital that the emergency department provides substandard care. There is a perception that the department is a 'dumping ground for underperforming doctors' and that the senior medical staff are not regarded as specialist or senior colleagues. As part of the process of rebuilding the emergency department, the hospital management will need to take conscious steps to address each of these perceptions about the medical staff in ED. This can be approached initially through a variety of measures:

- ED presence at relevant hospital committees
- Participation in grand rounds by ED on areas of ED expertise
- Multidisciplinary case reviews involving ED Senior staff

Solution

The main solution to the chronic medical staffing issues in the emergency department is to create a specialist workforce in the ED. It is the view of the review team that the *minimum* quantum of emergency specialists required to provide a stable sustainable quality service is 4 FTEs.

This injection of staff should initially be over and above existing staff levels as they exist at present. This will have the flow on effect of raising the standard of clinical care and supervision, improving the status of the emergency department in the hospital and community, aiding the department in obtaining training accreditation, providing positive role models and career options for junior staff and hopefully aid recruitment and retention of local graduates.

The culture of apathy that is prevalent throughout the department seems to be largely a "hangover" from the previous directorship. It should be noted that the current Director is making earnest efforts to reinvigorate the department's position, and this should be acknowledged. If the desired FACEMs are employed by the District; a position of non-FACEM Director may be suitable for the current occupant. This model has worked successfully elsewhere.

The Review Team recommends the following in respect of medical staffing:

- **The department and the district make the accreditation of the Rockhampton emergency department as a training department for advanced training with the ACEM a priority issue.**
- **As part of the move to accreditation, there is a need to create a specialist workforce in the ED. A minimum number of 4 FTE Fellows of the Australasian College of Emergency Medicine, or equivalent, will be required to provide a stable sustainable quality service.**
- **As an interim measure until the department can attract and recruit registered emergency specialist staff, the review team recommends that the department seek to establish formal links with either individual emergency specialists on contract or another accredited ED. This could have the desired effect of providing a specialist input through quality assurance**

initiated X-rays, first aid management of injuries, and nurse initiated analgesia. This process has been well established in New South Wales in the form of the Clinical Initiatives Nurse. Appropriate management of this group of patients has been shown internationally to reduce waiting room aggression.

There are six cubicles in the acute section of the department. These cubicles should be allocated to the three remaining nurses on the shift. The allocation should be explicitly clear, such that each individual nurse is clearly accountable for the care given to patients. For example, nurse A is responsible for cubicles 4 and 5. This responsibility would extend to ensuring that the area is stocked and equipped appropriately. These three staff would be able to relieve each other for meal breaks, with the necessary clinical handover occurring.

Action

- Department has trialled and introduced Cubicle Allocation and restocking responsibilities for each shift.
- Stock in each cubicle has been reduced and all IV and venepuncture equipment for use in the acute care area is now located in 2 mobile trolleys.
- Currently in the process of reviewing the resuscitation cubicle.
- Nursing staff are now on call if the department requires additional nursing staff in an emergent or high workload situation.

Education for nursing staff was raised as an issue by many of the interviewees. There is no dedicated nurse educator for the ED, however there is a nurse educator shared between ICU, CCU and ED. The Clinical Improvement Unit staff are very keen to support the development of educational processes in the ED, and this should be encouraged and supported. As discussed in Chapter 4, the Triage Education Work Book has been recently introduced into the department, and this is to be commended.

Not all of the clinical nurses within the department have designated portfolios of responsibility. A lack of available time was given as the predominant reason for this occurrence. This is not an unusual circumstance in regional areas. Other areas have dealt with this issue by utilisation of a proportion of the nurse unit manager's time. For example, the nurse unit manager may work clinically for a shift, or part thereof, and replaces the clinical nurse on the floor, enabling that nurse to have the necessary time to meet the portfolio responsibilities.

Administrative staffing

On a positive note, the Central Admission Process (CAP) has made a significant improvement in the admission of patients since its inception in January of this year. Where formerly there were 11 admission points throughout the hospital, the CAP has reduced that to two, namely ED and Day Surgery. Furthermore, patient information services report a solid working relationship with all levels of Emergency Department. It is a belief that the advent of the CAP has played a significant factor in the strengthening of said relationship.

It must be noted that the administration staffing situation is non-existent, bar from the triage clerks. It is advisable for an increase in administration staff through an AO3 or several AO2's to alleviate current workload for triage clerks or more noticeably the removal of administration tasks currently performed by Nursing staff in the emergency

Department. Accordingly, this makes communication regarding waiting times difficult with waiting room patients. The geographical design of this Emergency Department would currently allow ambulant and ambulance patients (except for major resuscitations) to be triaged at the reception/triage area, and the Review Team believe this would be a preferable work practice. Resuscitation patients would appropriately continue to bypass the triage area and be delivered directly to the resuscitation area of the Department. This could be achieved by relatively minor changes to the entrance area adjacent to the triage/reception desk.

The second theatre area is utilised now as a staff tutorial area. The Review Team would suggest that this room be formally converted to a staff tearoom/tutorial area. This would enable the current small space utilised as a staff tearoom and relatives' room, to be used solely for distressed relatives, with appropriate furnishings. If there is a need to use the current second theatre area for any procedural work, for example suturing, the Review Team would suggest that a portable light be purchased to enable suturing to be undertaken in the acute and sub-acute areas.

The current plaster room should be relocated to the orthopaedic outpatient area of the facility. This relatively large space could then be utilised for the sub-acute patients. This may require curtains to be erected in the area to afford the patients some privacy. Doing this would also improve resource efficiency of both medical and nursing staff. Furthermore, it would give the Senior Medical Officer and the shift coordinator an enhanced ability to manage the workflow of the department. Even if this suggestion is not taken up, the sub-acute area should be closed between the hours of 2300 and 0700, and those ambulatory patients should be seen in the plaster room. The Review Team believe that the joint reductions currently undertaken in this area should be carried out in the resuscitation area of the department.

The Review Team were able to view the current plans for the redevelopment and are supportive of many of the proposed changes. We would suggest further consideration of a couple of issues. Given the suggestion elsewhere in this document that the ED concentrate on its core business, it would seem unnecessary to have two rooms identified for dressing clinic. Additionally, the planned procedure room is an area that would seem no longer relevant in an Emergency Department. Procedures such as suturing can be undertaken in any area, providing there is a suitable light source and, as previously discussed, procedures undertaken utilising conscious sedation should be performed in a resuscitation environment. The size of the current cubicles is very small and it would be hoped that the new plan would provide for care delivery areas of a suitable size. Finally storage solutions, such as compacters, should be explored to reduce the amount of floor space required.

Physical environment

- Minor works undertaken to create secondary acute area in the QAS entrance, second write up area and works commenced to create multifunction room and relative's room. Currently awaiting availability of workmen to complete multifunction room and relative's room before we can remodel triage area.

Chapter 6 The Way Forward

As outlined in this report, there are a number of issues that require addressing within the Rockhampton Emergency Department. The Review Team felt that addressing these issues required an overall strategic plan for the Emergency Department endorsed, and if necessary, enforced by the District Executive. The main points for consideration are:

- Recruitment of a critical mass of FACEM staff
- An education plan for all disciplines and all levels
- A performance management plan for all disciplines and all levels
- The introduction of quality initiatives, clinical indicators and process measurement, to drive practice change
- Strategies to reduce the professional isolation for staff within the ED

Recruitment of a critical mass of FACEM staff

The goal for medical staffing has been referred to elsewhere in this report, and work should actively begin on achieving this goal.

An education plan for all disciplines and all levels

There needs to be an educational framework for the department for all disciplines and at all levels. The Clinical Improvement Unit is in the ideal position to develop and implement such a program. The Review Team would suggest that a plan be developed that would see the following achieved in the next 12 months:

- all staff should complete the mandatory training requirements
- all staff should attend front-line customer skills and aggression management training

In addition to this basic framework, the following discipline specific education should be provided. All medical staff should undertake ALS training, and all PHO and SMO staff should complete Advanced Paediatric Life Support (APLS) and Emergency Management of Severe Trauma (EMST).

There needs to be the development of a competency based process for nursing staff. All nursing staff need to progress through this process and it should be supported by appropriate education. All nursing staff should undertake the Trauma Nursing Core Course (TNCC), Advanced Life Support (ALS) and complete the Triage Education Work Book, once they are deemed ready for this stage of development. Staff who are undertaking the *Queensland Health Transition to Emergency Nursing* should be appropriately supported through this process.

The Review Team recommend that there be the development of an educational framework for all disciplines and all levels of staff within the ED. This would encompass mandatory training including customer focus education, discipline specific emergency education, and a competency program for nursing staff. This program should be developed by the Clinical Improvement Unit and endorsed by Executive.

and mental health, and members are able to participate in these projects. Again, access is available via the NICS website, which is a Queensland Health allowed internet site.

The Review Team recommend that strategies be introduced to reduce the professional isolation of staff within the ED at Rockhampton Hospital.

The review team will undertake the following:

- Examine data relating to the emergency department;
- Conduct a site visit on 15 & 16 June 2004 to review the facilities, work practices and staff of the department;
- Interview relevant personnel within the Emergency Department and other key stakeholders where appropriate;
- Prepare a comprehensive report that provides an analysis of the findings from the review and providing recommendations for service enhancement.

Ms Hayley Horan	Support Officer/Complaints Officer, Clinical Improvement Unit
Mr Kevin Flockhart	Social Worker, Emergency Department
Ms Maureen Tobane	Aboriginal and Islander Liaison Officer
Dr Don Kane	Chairman, Rockhampton Medical Staff Association
Dr Michael Shoeman	Director of Medicine
Dr Melanie Nicolson	Director of Anaesthetics
Ms Barbara Swadling	Medical Eduction Officer
Dr Lou Davies	Director of Clinical Training, Rockhampton Hospital, Acting Head of the Rural Clinical School, University of Queensland
Dr Peter Reynolds	Senior Medical Officer, Emergency Department
Dr Darryl Hawken	Senior Medical Officer, Emergency Department
Nursing Staff (As a group)	Level 1 and Level 2, Emergency Department
Dr Peter Roper	Director of Paediatrics
Ms Fiona Bridges	Manager, Medical Support Services Unit
Dr Andrew Montague	Registrar, Medical Administration

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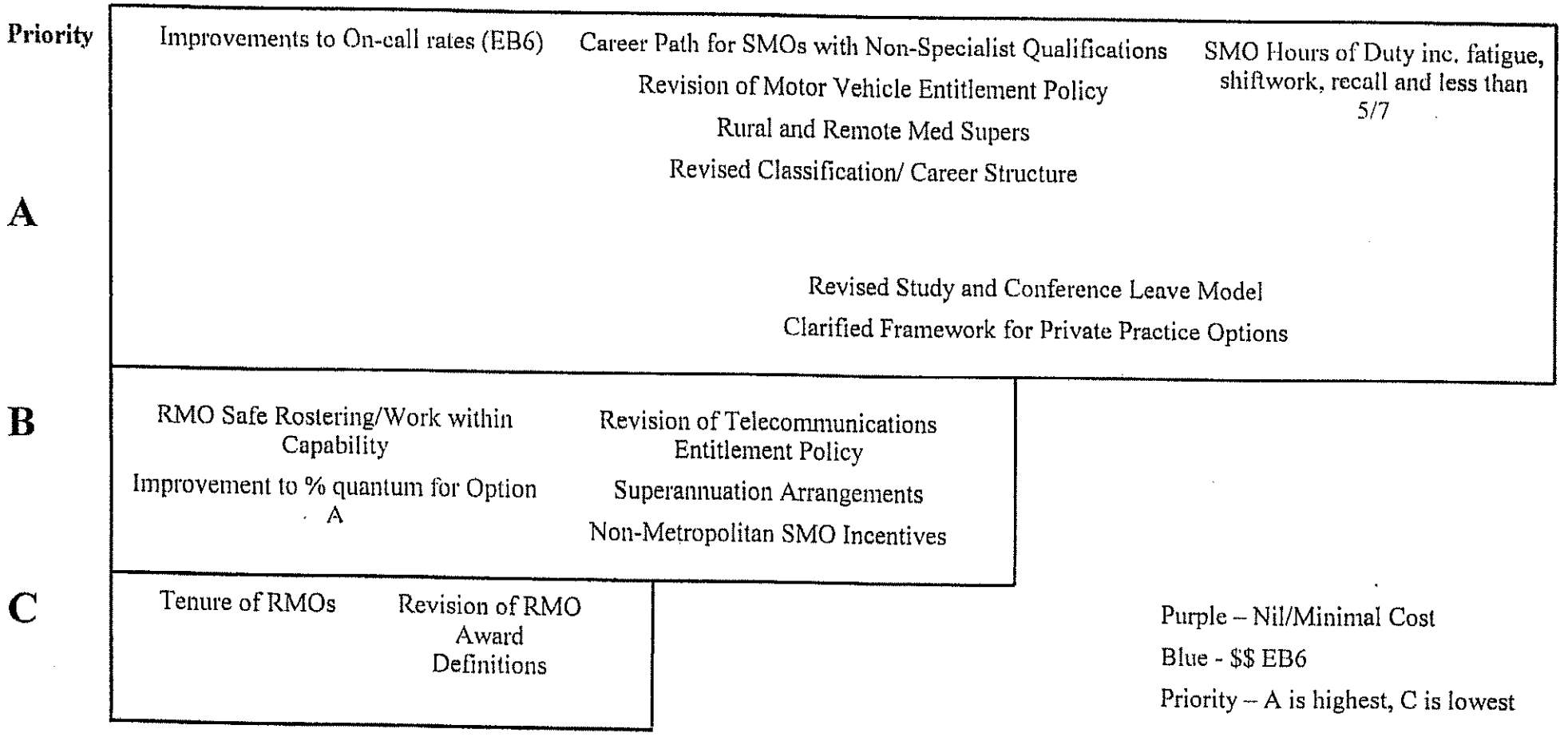
CHRIRPSC Medical Employment Framework Priorities



Proposed Plan for Managing Medical Workforce Issues

Improvements/Issues

Nil/Minimal Cost				**$$ (EB6)**			
Description	Sub-Description	Priority	Timeframe	Description	Sub-Description	Priority	Timeframe
Revised SMO Motor Vehicle Entitlement	. Cash out . Extend Range . Add hands free and other safety items as standard			Revised Classification/Career Structure	. future of Senior Specialist class . consider appropriateness of additional increments		
Revised SMO Telecommunications Package	. Remove standard mobiles and hands free from package . Add PDAs . Extend other allowable items			Improvements to on call rates	. equity with VMOs . proximate on call		
Tenure of RMOs	. Permanent employment for certain PHOs . Develop framework for 3 year contracts for Interns/JHOs/ SHOs			Hours of work	. reduction from 45 hours . expansion of shift work arrangements beyond traditional areas/modes . fatigue leave . fatigue penalties . 4 day week models, including those that increase $ through mixed employment (SMO/Contractor VMO) . clarify overtime		

Improvements/Issues

Nil/Minimal Cost				$$ (EB6)			
Description	Sub-Description	Priority	Timeframe	Description	Sub-Description multiplier	Priority	Timeframe
RMO safe rostering/work within capability	. Survey . Mechanism developed . Pilot and associated training for RMOs/SMOs			Revised model for SMOs Study and Conference Leave			
Revision of RMO Award Definitions (EB5)				RMOs Study and Conference Leave (known EB6 claim to be costed)			
Special Leave for Professional Duties				Improvements to % quantum for Option A			
Clarified framework for private practice options	. revised contracts . explanatory notes and FAQ for each type of contract . Review of Option B, Schedule D – cabinet submission required first			SMO superannuation arrangements	. Options A, P and B . Med Super Allowances		
Interim Study and Conference Leave	. preferred provider accommodation			Rural and remote Med Supers (EB5)	. skills development and maintenance (us??)		
					. consider innovative self-funding models		

Improvements/Issues

Nil/Minimal Cost				$$ (EB6)			
Description	Sub-Description	Priority	Timeframe	Description	Sub-Description	Priority	Timeframe
					. career paths . limited access to private practice . ability to access time off		
				Career Paths for SMOs with Non-Specialist Quals			
				Rural SMO Incentives			
					. identify those items that attract and retain SMOs in non-metropolitan areas . quantum and areas eligible for accommodation allowance . retention of accommodation allowance after purchase of a property		

Information required to facilitate progress of above improvements/issues

Information	Responsible Area	Timeframe
Comparison with remuneration arrangements for all other states	EFT – Alison	22 October 2004
SMO/RMO Recruitment and Retention Data	HRMIS and Workforce Planning and Analysis	
Historical comparison of changes in activity levels and staffing across medical specialties	TBD	