Independent Governance Review

Metro North Hospital and Health Services – Caboolture Hospital – Surgery

October 2021

Contents

Background

Caboolture is a busy outer metropolitan hospital and health service providing, amongst other services, elective and emergency general surgery for the expanding surrounding community. Currently the hospital has 187 beds (26 funded surgical beds able to flex up by six beds) but is undergoing an extensive rebuilding process which will almost double its total bed capacity and increase its theatre capacity from four to six theatre suites plus procedural suites, with completion due towards the end of 2023. Like all hospitals in Australia the COVID pandemic has stretched resources and significantly affected the ability of hospitals and staff to provide consistent care.

This review was commissioned because of recent media publicity regarding adverse outcomes for patients having surgery at Caboolture Hospital. The review was commissioned by the Board Chair of Metro North Hospital and Health Service and the terms of that review are listed below.

- **Review the allegations of unsatisfactory surgical outcomes at the Caboolture Hospital.**
- **Undertake an assessment of the current patient selection criteria and review of the scope of practice of surgery undertaken at Caboolture Hospital against the current approved Queensland Health and Metro North Health Clinical services capability framework (CSCF) for the Caboolture Hospital.**
- **Review and assess the current surgical medical staff credentialing process and current surgeons approved scope of practice compared with their qualifications.**
- **Examine Hospital Acquired Complications (HACs) including surgical infection rates and other infection or surgical outcome data collected by the hospital of patients who have undergone surgery at the Caboolture Hospital from 2020 to present.**
- **Undertake a comprehensive review and analysis of surgical incidents from 2020 to present.**
- **Undertake a comprehensive review and analysis of previous Human Error and Patient Safety (HEAPS) and Root Cause Analysis (RCA) recommendations of surgical cases at the Caboolture Hospital from 2020 to present.**
- **Review the Caboolture Hospital's perioperative mortality and morbidity data since 2020 to present and benchmark this data with like services.**
- **Assess the current data reporting capability and review ongoing system of monitoring of safety and quality indicators and Key Performance Indicators (KPI's) for the Surgery and Intensive Care department at the Caboolture Hospital.**

The composition of the review team was:

- Dr James Sweeney (JS), MBBS FRACS, Chair Patient Safety and Quality Committee St Andrews Hospital Adelaide and retired colon and rectal surgeon.
- Tracey Bessell (TB), BPharm, MPH, PhD (Health Services Research), Director Clinical Governance, Patient Safety and Quality Unit, Cairns and Hinterland Health Service.
- Ms Regina Harrison, (RH), Acting Director of Nursing, Gatton Hospital, West Moreton Health.
- Mrs Patricia Hall (PH), consumer representative.

The review team would like to acknowledge the enormous amount of work and effort in the facilitation of documents and material required for this review by the Executive Director of

Clinical Governance, Safety, Quality and Risk (ED CGSQR), Metro North Hospital and Health Service (MNHHS), Ms Michele Gardner, and her team. That task was not easy.

Readers of this document are referred to Appendix 1: Measuring and Monitoring Patient Safety and Quality of Care in Hospitals (TB), the understanding of which is important in considering the matters discussed herein.

Summary of Recommendations

1. Educate all Caboolture Hospital operating room staff on Metro-North intranet page and credentialing information that is available – https://qheps.health.qld.gov.au/metronorth
2. Caboolture Hospital to ensure a Caboolture Hospital surgical consultant is available using an on-call roster that is centrally accessible to all staff
3. Caboolture Hospital to establish a surgical clinical development facilitator (CDF) to improve education/training for nursing staff and provide support to less experienced staff.
4. Encourage more multidisciplinary team members (MDT) to attend the Morbidity and Mortality (M&M) monthly meetings held, to identify achievements and opportunities for improvement related to surgical outcomes and performance.
5. Develop a flow chart/process for new employment of medical officers (MOs) defining and communicating the scope of practice.
    a. MNHHS Medical Services and MNHHS Surgery and Intensive Care Stream implement a more detailed level of individual surgical procedure training and mentorship for Senior Medical Officers (SMOs) in smaller MNHHS hospitals in partnership with the tertiary hospitals Royal Brisbane and Women's Hospital (RBWH) and The Prince Charles Hospital (TPCH).
6. Establish a peer review process across the MNHHS Surgery and Intensive Care Stream of surgical complication cases and document actions for improvement.
7. Executive Director CGSQR, MNHHS and Executive Director Caboolture and Kilcoy Hospitals and Woodford Corrections Health Centre (for the purpose of this report, this position will be referred to as Executive Director Caboolture Hospital) to ensure the Patient Safety Officer and Service Improvement Unit team of Caboolture Hospital are provided with clinical incident management and report writing training, supervision, networking opportunities and quality assurance, improvement, consumer complaint management and audit training.
8. Ensure that past RCAs and HEAPS analyses between 2020 and 2021 are re-reviewed independently by MNHHS CGSQR to identify and strengthen recommendations for improvement.
9. MNHHS CGSQR provide Serious Incident Review committee members and senior clinicians with clinical incident management and open disclosure training.
10. MNHHS CGSQR amend and standardise Caboolture Hospital and all MNHHS Facilities and Directorates:
    a. HEAPS and RCA templates to include a 'contributing factor' box above each 'recommendation' box so that factors are clearly linked to recommendations and to include a 'Timeline' section. The use of contributing factor diagrams (e.g. 'fish' diagram, tree diagram etc.) is strongly encouraged.

b. The Metro North Clinical Incident Management Procedure be amended by MNHHS CGSQR to include a system of sharing of incident analysis findings/recommendations across the whole MNHHS.

c. The Initial Briefing Document – Severity Assessment Classification 1 (SAC1), be amended to include the question, 'Has a similar SAC1 event occurred previously?'

d. The approval of recommendations includes a process to check if previous recommendations have been duplicated and ensure MNHHS policy is followed by Caboolture Hospital and all MNHHS Facilities and Directorates and all RCA, SAC and HEAPS reports are sent to MNHHS CGSQR unit for review before finalisation.

11. MNHHS Surgical and Intensive Care Stream committee collaboratively develop, implement and monitor additional surgical process and outcome measures benchmarked across all surgical sites, to inform and drive safety and quality improvements in partnership with MNHHS CGSQR unit.
12. MNHHS establishes a protocol for access to health information data to ensure it remains secure and is not used for unauthorised dissemination.
13. Metro North centralise to MNHHS CGSQR team existing Caboolture Hospital and all local Safety and Quality facility data roles and resources to develop and support a contemporary, standardised, mature clinical health informatics system that provides transparent, timely, consistent and accountable "Ward to Board" Safety and Quality performance measures that can be benchmarked for all of its hospitals and across clinical streams, including surgical services.
14. Improve the content of the safety and quality reports produced by and for Caboolture Hospital through the inclusion of critical analysis and links to improvement actions at Caboolture Hospital and the Surgical and Intensive Care department Safety and Quality committees respectively.
15. Review and restructure the Service Improvement Unit, Caboolture Hospital to provide contemporary support of safety and quality systems and reporting. Change the Director's position to operational, and professional reporting to the Executive Director CGSQR, MNHHS in partnership with the Executive Director Caboolture Hospital with embedded day to day reporting to enhance professional and operational support and a level of transparency and independent objective leadership aligned to the MNHHS Safety and Quality Strategy.
16. Ensure that collated consumer feedback and experiences data and information is monitored and used by the Surgery and Intensive Care department to improve the safety and quality of services and care, including:

    Develop consumer feedback summaries across MNHHS from a range of resources including RiskMan, PREMS, OHO requests, Ryan's Rule requests, and analyse the frequencies and free text data about consumer complaints to regularly inform communication, staff attitude and timeliness with consumers and their families.
17. Consider ways to educate and address the underlying culture issues prevalent throughout Caboolture Hospital. This may include implementation or refresher empathy training, leadership mentoring, Communication and Patient Safety (CaPS) and Communication, Respect, Accountability = Safe Healthcare (CRASH). Also enhanced opportunities for collaboration with multidisciplinary teams through attendance at safety and quality committee meetings.
18. Ensure that Quality Action Plans include non-clinical aspects of care.
19. Implementation of empathy training and improved patient communication/feedback for all staff at Caboolture Hospital to enhance patient and staff health literacy skills.

- **Review the allegations of unsatisfactory surgical outcomes at the Caboolture Hospital.**

The review team spent three days on site at Caboolture Hospital, with ongoing analysis remotely, and interviewed multiple medical, nursing, and allied health staff including some staff who no longer work there. It became clear to the review team that staff had been affected by the disruption in leadership positions over the preceding 18 months and that factions had developed which produced an underlying bias in some of the opinions expressed. The review team discussed these divergences of opinion and reached a balanced conclusion where evidence was not available one way or the other to be definitive.

Racial and gender discrimination have been mentioned in correspondence and conversations about Caboolture Hospital and whilst the review team has identified isolated instances of this occurring there is no evidence that this is a widespread problem within the institution. Isolated incidents however are unacceptable, and the Administration needs to take further steps to ensure that this does not occur.

Parallel to this review a hotline was set up by MNHHS to facilitate any past or current patient of Caboolture Hospital, regardless of timeframe, to register their complaints. All cases where identification was possible have been reviewed (JS) and triaged into three categories, and all cases reported via this mechanism will be followed up to a conclusion.

The three categories are:

1. Medicolegal
2. Review within the Metro North reporting framework
3. Clinical review external to Caboolture Hospital.

In addition, prior to the commencement of the review an anonymous letter alleging inappropriate and unnecessary surgery in seven clearly identified patients was delivered under the door of the Acting Director Medical Services (DMS). The case notes of these particular patients were reviewed (JS) to test the veracity of these allegations. In his opinion, in five of the cases the clinical decision-making was well within acceptable standards and patient outcomes satisfactory. In the other two cases the case-notes contained insufficient information to establish whether the clinical decision-making and surgery was inappropriate as alleged. In those cases, the decision-making may have been appropriate.

There have been two reviews of the Surgical and Intensive Care department at Caboolture Hospital in the last seven years. A review in 2014 followed by a Part 9 review in 2016. The review in 2014 has not been made available to the review team. The recommendations of the Part 9 review which may be relevant to this current review are listed along with a commentary on the actions taken as a result.

Part 9 Recommendations (2016)

Actions one to three are not relevant to this review

4. Establish a consultant led acute surgical unit to improve continuity of care and responsiveness to the acute surgical patient.

   Action: No documentation was provided but the review team were advised that this option was not proceeded with because it was considered non-viable in a hospital of this size.

   Comment: There appears to be some current concerns amongst some staff around the level of consultant led ward rounds. It is noted that not all surgical consultants are contracted to attend Caboolture Hospital every day. Where a consultant is not engaged to attend, the review team is comfortable that satisfactory alternative arrangements are currently in place for continuity of care. This may not have been so in the past. The

junior staff medical roster has also been changed to reflect the need for continuity of care. Currently the level of consultant engagement in patient care is appropriate.

5. Ensure all department surgery consultants, registrars, and Principal House Officers (PHOs) complete the Royal Australasian College of Surgeons (RACS) Care of the Critically ill Surgical Patient (CCriSP) course.

   Action: This recommendation was considered by the administration and not pursued as it was not budgeted for. It is noted however, that it is a requirement of surgical advanced trainees to successfully complete this course within the first two years of their training program.

6. Multidisciplinary training sessions (emergency department and general surgery) on shared surgical topics including acute surgical presentations, contraindications for imaging, novel oral anticoagulants, and timely action on investigation results.

   Action: There is no information as to whether this has been actioned or not.

7. The Caboolture Hospital executives review their own governance processes with respect to patient safety and quality issues.

   Action: This has been commenced and is ongoing.

8. The Monday to Friday morning department of surgery clinical handover meeting to be limited to critical components of patient care e.g. overnight admissions, operational concerns for the day, inpatient problems.

   Action: The review team (JS) attended one of these clinical handover meetings and this recommendation appeared to have been successfully actioned.

9. The non-critical components of the existing Monday to Friday morning department of surgery clinical handover meetings to be tabled at a separate forum.

   Action: This resulted in a regular general surgery consultants' meeting which is ongoing and apparently occurs on a monthly basis, but the latest minutes provided to the review team were October 2020.

10. Monthly department of surgery morbidity and mortality meetings with a formal agenda and action tracking register.

    Action: This has been completed however the minutes do not allow anyone who was not present to interpret the discussion around patient morbidity. The terminology "displayed and discussed" does not give any indication of the issues and therefore whether there may be developing trends leading to more analysis. More fulsome documentation should be considered. The general surgery unit do participate in a three monthly joint clinical audit with Redcliffe and The Prince Charles Hospitals.

11. A formal hospital-wide multidisciplinary morbidity and mortality review process to be initiated involving multiple departments including, but not limited to intensive care, internal medicine, and emergency medicine, under the leadership of Caboolture Hospital Critical Incident and Mortality Review Committee.

    Action: There is no evidence that this has been implemented.

Surgical Training

Caboolture Hospital has two recognised advanced training positions in general surgery. This training program is administered by the RACS. In 2016 this training program was withdrawn from Caboolture Hospital by RACS but subsequently reinstated in 2017 (the documentation for this process has not been viewed). The most recent inspection was in July 2021 and

accreditation was approved for a further four years. This accreditation process considered the following areas:

Standard One – Building and Maintaining a Culture of Respect for Patients and Staff.
Standard Two – Education Facilities and Systems Required.
Standard Three – Quality of Education, Training and Learning.
Standard Four – Surgical Supervisors and Staff.
Standard Five – Support Services for Trainees.
Standard Six – Clinical Load and Theatre Sessions.
Standard Seven – Equipment and Clinical Support Services.
Standard Eight – Clinical Governance, Quality and Safety.

All of the standards were assessed to be met.

The summary and conclusions of that inspection were that there was a very supportive training environment in the Surgery and Intensive Care department at Caboolture Hospital with minimal overtime and excellent exposure to endoscopy, colonoscopy caseload.

- **Undertake an assessment of the current patient selection criteria and review of the scope of practice of surgery undertaken at Caboolture Hospital against the current approved Queensland Health and Metro North Health Clinical services capability framework (CSCF) for the Caboolture Hospital.**

Clinical review of the practice of general surgery at Caboolture Hospital against the current approved Queensland Health and Metro North Health CSCF for Caboolture Hospital was undertaken.

This review has confirmed that Caboolture Hospital performs surgical procedures/operations within the CSCF for Surgical Unit and Perioperative Services.

- **Review and assess the current surgical medical staff credentialing process and current surgeons approved scope of practice compared with their qualifications.**

Findings and Discussion:

In conjunction a review and assessment of current medical staff credentialing processes and current surgeons approved scope of practice compared with their qualifications has been undertaken.

All medical staff undergo a credentialing process conducted by the Caboolture and Kilcoy Hospital Medical Credentialing Committee. Documentation from that committee has been reviewed and the process is sound.

The curriculum vitae, qualifications and Ahpra registrations of all consultant surgeons have been reviewed and this has been compared against their credentialed scope of practice. All consultant surgeons regardless of where their basic medical qualifications were obtained have undergone assessment and training in programs administered by the Royal Australasian College of Surgeons (RACS) before they were awarded fellowship of that body (FRACS). All consultant surgeons possess the FRACS. The scope of practice for all surgeons has been reviewed alongside the operations performed at Caboolture within the specified period and there is no evidence that any surgeon has practised outside of their scope of practice within the area of general surgery at Caboolture Hospital.

More junior medical staff work under direct supervision of a consultant surgeon and practice within the scope of that consultant surgeon.

The title of “Fellow” as used at Caboolture Hospital is confusing with staff unclear as to the “Fellow” role and responsibility within the Surgery and Intensive Care department. The post may or may not be occupied by a person with FRACS and it is suggested that consideration be given throughout MNHHS to restricting this title within surgery to medical staff who have completed training and been awarded the FRACS.

The practice of surgery is an ever-changing environment with knowledge and technical expertise continuing to improve, allowing for surgery to be conducted in new and innovative ways with a goal for better patient care and shorter hospitalisation. It is an obligation for continued medical practice that surgeons engage in a program of continuous professional development (CPD). For surgeons this process is monitored by the RACS and is a requirement for continued Ahpra registration. Whilst there is no evidence that surgeons at Caboolture Hospital have not participated in these programs, there were isolated opinions (not necessarily informed) that some surgeons were not up to date with some of the more recent developments. It is important that the administration ensure that the continuing medical education processes generally throughout Caboolture Hospital are adhered to. Just because a particular procedure occurs within the broader area of scope of practice does not mean that a particular individual is capable of or should be performing the procedure. There is an obligation on the administration to ensure that the individuals are adequately trained in the procedure being performed. This equally applies across all Metro North hospitals. The Caboolture Hospital Surgery and Intensive Care department should be commended on the recent concept submission for the introduction of the procedure of laparoscopic fundoplication which should be used as a template for the future introduction of new technologies.

There appears to be no triaging of referrals at the outpatient level with all surgeons seeing a range of clinical conditions. There are surgeons working at Caboolture who have some subspecialty training in the various aspects of general surgery, such as breast surgery, and consideration should be given to triaging outpatient referrals to take advantage of this expertise (this would also enhance the provision of allied services). The recent resignation of a specialist colon and rectal surgeon (a joint appointment with RBWH) has removed the clinical and teaching experience in this area and consideration should be given to re-establishing this link with RBWH in this subspecialty area.

Change is a difficult concept for some. Whilst some individuals can readily adapt others can struggle and some remain resistant. Cooperation in a multidisciplinary setting can be difficult for those used to a more hierarchical structure. The review team has no doubt that this has been a problem at Caboolture Hospital in the past and continues to be an issue which must be addressed. Respect for the opinion of others particularly where others are experienced in the area of care is paramount to establishing a harmonious environment for the benefit not only of the patients but also the staff. This is a cultural shift which must be embraced by all members of staff at Caboolture Hospital.

During the review, concerns were raised by staff about inappropriate behaviours, attitudes, and performance aside from the MOs scope of practice which also need to be highlighted. Inappropriate behaviours in the workplace can have a direct link to poor surgical outcomes and performance. (see Culture)

Recommendations:
Caboolture Hospital to:

1. Educate all Caboolture Hospital operating room staff on Metro-North intranet page and credentialing information that is available –https://qheps.health.qld.gov.au/metronorth
2. Caboolture Hospital to ensure a Caboolture Hospital surgical consultant is available using an on-call roster that is centrally accessible to all staff
3. Caboolture Hospital to establish a Caboolture Hospital surgical clinical development facilitator (CDF) to improve education/training for nursing staff and provide support to less experienced staff.
4. Encourage more multidisciplinary team members (MDT) to attend the morbidity and mortality (M&M) monthly meetings held, to identify achievements and opportunities for improvement related to surgical outcomes and performance.

MNHHS to:

5. Develop a flow chart/process for new employment of MOs defining and communicating the scope of practice.
    a. MNHHS Medical Services and Surgery and Intensive Care Stream implement a more detailed level of individual surgical procedure training and mentorship for Senior Medical Officers (SMOs) in smaller MNHHS hospitals in partnership with the tertiary hospitals Royal Brisbane and Women's Hospital (RBWH) and The Prince Charles Hospital (TPCH).

- **Undertake a comprehensive review and analysis of surgical incidents from 2020 to present.**
- **Examine Hospital Acquired Complications (HACs) including surgical infection rates and other infection or surgical outcome data collected by the hospital of patients who have undergone surgery at the Caboolture Hospital from 2020 to present.**

Findings and Discussion:

Between January 2020 and September 2021, there were four critical incident reviews in surgery conducted. These incidents are considered under the RCA and HEAPS discussion.

During the same review period, there were 31 surgical patients who had a return to theatre (RTT). These patients have all been reviewed in the appropriate forum at Caboolture Hospital but unfortunately the surgical M&M minutes are not of sufficient detail to determine cause or allow analysis of any trends. It was noted that for approximately 30% of these cases RTT was for post-operative haemorrhage/haematoma. However, there were 4,894 operations performed for the period making this rate 0.006%. These RTT cases were analysed based on the primary surgeon and no particular surgeon was an outlier.

Relevant Health Round Table data from April 2020 to March 2021 were available for review (Table 1).

Table 1: Health Round table (April 2020 to March 2021)

	Caboolture	Peer group
HAC /episodes	0.7%	2.0%
HAC /patient	1.1%	2.9%
Surg Comp /10,000 episodes	3.5	11.7
Healthcare Assoc infections /10,000 episodes	29.4	74.9
Surgical Site Infections /10,000 cases	3.3	7.4
Blood stream infections / 10,000 cases	8.2	17.0
Infection prosthesis/implantable devices / 10,000 cases	0.7	6.1
Surgical Wound dehiscence /10,000 episodes	2.7	5.9
Post op haematoma/haemorrhage /10,000 episodes	1.1	5.4
Anastomotic leak /10,000	0	0

In the categories of surgical complications and health care associated infections, Caboolture Hospital was the second-best performing hospital out of its peer group of 20 hospitals.

However, the review team are aware of patient complications within this period, which have not yet appeared in Health Round Table (HRT) reports.

More specific surgical complication data would allow better analysis but was not available.

Recommendation:

6. Establish a peer review process across the MNHHS Surgery and Intensive Care Stream of surgical complication cases and document actions for improvement.

- **Undertake a comprehensive review and analysis of previous Human Error and Patient Safety (HEAPS) and Root Cause Analysis (RCA) recommendations of surgical cases at the Caboolture Hospital from 2020 to present.**

Findings and Discussion:

A clinical incident is an event or circumstance (not reasonably expected as an outcome of health care) which could have, or did, lead to unintended harm to a person. Clinical incidents include near misses and adverse events.

Clinical incidents may be identified by any staff member or by patients, their relatives, or carers. It is the responsibility of all staff to identify and report clinical incidents, whereby:

- all clinical incidents are to be reported using RiskMan as soon as possible following the incident or within one business day of becoming aware of the incident, and
- reporters of clinical incidents are encouraged to verbally notify their line manager / team leader, as well as documenting the incident and the outcomes of actions taken in the patient health record

The inbuilt RiskMan incident management workflow will automatically escalate the incident to appropriate levels of staff based on the SAC rating of the clinical incident.

The SAC ratings are:

- SAC1: Death or harm that is likely to be permanent and not reasonably expected as an outcome of health care.
- SAC2: Harm that is likely to be temporary and not reasonably expected as an outcome of health care.
- SAC3: Minor harm not reasonably expected as an outcome of health care.
- SAC4: No harm, or “a near miss” event

All SAC1 reports and other serious incident reports are initially reviewed by the Caboolture Hospital Serious Clinical Incident Review Committee (SCIRM) to identify key review questions, method of review, immediate safety actions or patient follow-up required, patient / consumer concerns, staff welfare, open disclosure are discussed.

Following the review undertaken by a team facilitated by the Patient Safety Officer a draft report is considered by the SCIRM and subsequently authorised by the Executive Director Caboolture Hospital with a target timeframe of 90 days.

The findings of the final report may be shared with the Coroner’s Office, OHO and the patient or family via open disclosure.

Lessons learnt and recommendations can be shared with the relevant clinical areas for implementation.

It is important to protect the integrity of the systems-based incident analysis process from a situation where there is potential for administrative, disciplinary, or criminal action. If concerns about individual performance arise during the course of a system improvement review an appropriate accountability review should be set up as a separate process to deal with the identified issues.

The QH Best Practice Guide to Clinical Incident Management states that the following types of incidents are not recommended under the *Hospital and Health Boards Act 2011* for a system based analysis.

1. A ‘blameworthy act’ which means any of the following:
   • an intentionally unsafe act
   • deliberate patient abuse
   • conduct that constitutes a criminal offence.
2. An event in which the capacity of a person who was directly involved in providing the relevant health service to safely and effectively provide the service was impaired by alcohol consumed, or a drug taken, by a person.

If the above incidents are identified they should be immediately reported to the relevant professional director at Caboolture Hospital ie Director Medical Services (DMS), Director of Nursing (DoN) or Director Allied Health (DAH).

Twenty-three clinical incident analyses were reviewed (16 HEAPS, one of which was a cluster analysis and seven RCA). Three cases involved emergency surgical intervention in obstetric patients, and four were general surgical cases, two of which required return to theatre for iatrogenic bowel perforation/anastomosis leak. It was not evident if all cases reviewed were SAC1, it was also questionable in some instances whether a clinical incident had actually occurred.

The review of these incident analyses covered time to completion, review methodology, identification and documentation of contributing factors, the strength, relevance, and quality of recommendations made and the overall quality of the report writing.

Nineteen reviews were completed within the SAC1 90-day KPI, however some of the documentation reflects commissioning dates that are later than the date the RCA was completed. Given that not all cases reviewed had the SAC rating identified, if they were SAC2 incidents they would have been outside the 60-day KPI.

The review methodology for both types of review appeared to be the same, although the report writing for the RCA analyses was generally of better quality and followed a more chronological path than the HEAPS. It was unclear from the content of the reports and the cases, why a particular type of review was chosen. Although many of the reviews indicated that a timeline was used as part of the analysis, these were not documented, and the flow of events was not always clear. This made it hard to establish how the causal factors were identified and this may have contributed to the RCA and HEAPS teams missing important elements of the incidents which should have been included in the analysis.

In 11 of the cases, in the opinion of the reviewer, the HEAPS or RCA teams missed important contributing factors that would have benefitted from further analysis. Of significance: three instances where staff failed to recognise that the patient may have been experiencing sepsis; two instances of missed diagnosis and one instance of delay in appropriate testing causing a delayed diagnosis.

Fourteen of the cases had recommendations that were not relevant to the incident or contributing factors that had been discussed. It was noted that the templates used do not have a ‘contributing factor’ section for the review teams to complete. Only one case had a recommendation that was considered to be ‘strong’. All the others ranged from weak to moderate, with the majority being in the ‘weak’ category. (Comment: This is a State-wide issue and one that is being addressed by the clinical incident management reform led by the Queensland Health Patient Safety and Quality Unit).

Most of the reviews identified ‘lessons learned’ many of which, in the opinion of the reviewer should be part of standard practice given the patient’s presentation or condition.

Thirteen incidents had four or more recommendations (overall range 2-8). Of these 13 cases, 11 had recommendations that were duplicated, and 12 cases had one or more (range 1-5) that were not relevant (i.e. not linked to an identified contributing factor). By removing

recommendations that were not relevant, the total number of recommendations made, would decrease from 85 to 41.

Of concern, in four cases identified, in the opinion of the reviewer, none of the recommendations made would prevent a similar event from occurring. One of these cases related to failure to follow the paediatric sepsis pathway and lack of appropriate response to escalation.

The most commonly duplicated 'recommendation' was to share lessons learned via various meetings/forums. This is not a recommendation (i.e. it is not linked to a contributing factor), but the reviewers recognise that it is good practice to do this, provided the recommendations and lessons learned reflect the causative factors identified in the analysis.

Three incidents included a recommendation for ROTEM (Rotational Thromboelastometry, a test used to manage massive blood loss) training for relevant staff. The first of these was made in March 2020, for completion by September 2020. The other two incidents occurred in 2021 and the HEAPS teams identified in both cases that staff used the ROTEM correctly. Two obstetric HEAPS analyses were conducted on the same day by the same HEAPS team and both cases had three duplicate recommendations (two of which were for ROTEM which was not identified as an issue). Additionally, each case had a recommendation that did not have an associated causative factor identified in the review. Both cases had a significant causative factor that were missed by the team which represent missed opportunities to prevent similar incidents occurring in the future.

Two cases, relating to iron infusions, included recommendations that were not related to causative factors, one of which was to seek permission from Queensland Health Informed Consent Unit to use the State-wide iron infusion consent form (there is currently no state-wide form, one is under development). Staff had used a form from another Queensland Health facility; lack of informed consent was not an issue in this case.

In the second case, two recommendations were made that did not relate to causative factors identified, including removing iron polymaltose from ward impress, and the employment of a clinical nurse facilitator on every ward to assist with drawing up iron infusions (amongst other duties). There were no causative factors identified that would justify either of these recommendations, both of which have cost and workload implications.

In both cases it was identified that the iron infusion may not have been clinically indicated but there were no recommendations made in relation to this issue.

Of the general surgical cases that were reviewed, clinical decision-making and a lack of supervision by consultants were identified as causative factors in more than one case. These are professional issues that should be managed by the relevant professional lead. It is not clear when issues such as these are identified at Caboolture Hospital whether there is communication to facilitate appropriate action, however the DMS is a member of the SCIRM.

The reviewers noted what appeared to be a 'siloed' approach to several recommendations whereby site-specific procedures were recommended and where lessons learned are not shared across the whole HHS. This is reflected in the complexity of the governance of the recommendations reflected in the current Metro North Clinical Incident Management procedure.

The Caboolture Hospital overall quality of the reports could be improved, all of them contained basic spelling and grammatical errors, inconsistent formatting, and lacked structure, making them difficult to read.

Furthermore, the repeated use of the phrase "all core staff members of Caboolture hospital are competent and confident to perform this procedure" was subjective, without basis, and unnecessary.

Recommendations:

7. Executive Director CGSQR, MNHHS and Executive Director Caboolture Hospital ensure the Patient Safety Officer and Service Improvement Unit of Caboolture Hospital are provided with clinical incident management and report writing training, supervision, networking opportunities and quality assurance, improvement, consumer complaint management and audit training.
8. Ensure that past RCAs and HEAPS analyses between 2020 and 2021 are re-reviewed independently by MNHHS CGSQR to identify and strengthen recommendations for improvement.
9. MNHHS CGQSR provide Serious Clinical Incident Review committee members and senior clinicians with clinical incident management and open disclosure training.
10. MNHHS CGQSR amend and standardise Caboolture Hospital and all MNHHS Facilities and Directorates:
    a. HEAPS and RCA templates to include a 'contributing factor' box above each 'recommendation' box so that factors are clearly linked to recommendations and to include a 'Timeline' section. The use of contributing factor diagrams (e.g. 'fish' diagram, tree diagram etc.) is strongly encouraged.
    b. The Metro North Clinical Incident Management Procedure be amended by MNHHS CGSQR to include a system of sharing of incident analysis findings/recommendations across the whole MNHHS.
    c. The Initial Briefing Document – SAC1, be amended to include the question, 'Has a similar SAC1 event occurred previously?'
    d. The approval of recommendations includes a process to check if previous recommendations have been duplicated and ensure MNHHS policy is followed by Caboolture Hospital and all MNHHS Facilities and Directorates and all RCA, SAC and HEAPS reports are sent to MNHHS CGSQR unit for review before finalisation.

- **Review the Caboolture Hospital's perioperative mortality and morbidity data since 2020 to present and benchmark this data with like services.**
- **Examine Hospital Acquired Complications (HACs) including surgical infection rates and other infection or surgical outcome data collected by the hospital of patients who have undergone surgery at the Caboolture Hospital from 2020 to present.**

Key Findings:

- Caboolture Hospital undertakes more than 4,300 surgical procedures a year: approximately 30% emergency and 70% elective. However, there are limited reporting of comparative perioperative and mortality and morbidity outcome data.
- The seven self-reported surgical SAC1 events at Caboolture hospital from 2020 to 2021 is greater than other Metro North hospitals.
- The number of unplanned returns to theatre spiked in April 2020 and February 2021 and rates appear to be greater than other MNHHS hospitals. This requires further investigation.
- Comparative data regarding surgical complications are difficult to verify but required further investigation and potential action for improvement.
- Comparative achievements include:
    - 91% (384/424) surgical transfer of care summaries completed within 48 hours,
    - 97%< compliance with Surgical Safety Checklist consistently maintained
    - no poor performing Variable Life Adjustment Display (VLADs) identified

- minimal long waits for surgical outpatients.

Discussion:

Within Metro North there are large quaternary and tertiary hospitals with highly specialised surgical services, as well as smaller hospitals that undertake lower acuity general surgery. The robustness of surgical outcome data tends to improve as the number of cases increases, making comparisons between large and small facilities sometimes difficult to interpret.

Surgical outcomes are often related to relevant professional training and volume of the specific surgical procedures performed by clinicians. In November 2020, the Metro North Streaming Outpatient Referral Team (SORT) commenced streaming and screening Metro North surgical outpatient referrals. The MNHHS Surgery and Intensive Care Stream has collaborated closely with the SORT project team, facilitating engagement with surgical specialties to ensure improved quality patient referrals are directed to the correct specialty and facility.

Most commonly reported safety and quality measures are those in the Queensland Health Metro North Service Agreement, these primarily focus on activity and access, not outcomes of surgery.

The reporting of benchmarked surgical performance measures against similar peers are limited but include Queensland Audit of Surgical Mortality (QASM) 2015-2020, monthly Queensland Health System Performance Reporting, quarterly HRT and the monthly MNHHS Surgery and Intensive Care Stream Report.

The ORMIS (operating room management information system) can also be used to generate detailed surgical outcome reports for local services. The most recent MNHHS Surgery and Intensive Care Stream Report (April 2020-March 2021) was tabled at the Metro North Board meeting in July 2021 but it is not clear when this was tabled at the relevant safety and quality meetings of Caboolture Hospital or the local surgical and intensive care department meetings.

The Caboolture Hospital Safety and Quality performance reports cover the performance of the entire Hospital, while the service line reports address surgical and intensive care services, both have some access and process data and information but limited outcomes about surgical services.

Queensland Audit of Surgical Mortality (QASM) Report – Caboolture Hospital 2015-2020

QASM started in 2007, it identifies preventable clinical management issues identified via the review of deaths subsequent to surgery.

Between 1 July 2015 and 30 June 2020, 37 cases were reported for Caboolture Hospital and of these 16 cases (mean age 82 years) underwent a full peer review process. The remainder did not meet the criteria for a full review. In 15 of the 16 audited deaths, patients were admitted as emergencies with acute life-threatening conditions.

Table 2: Clinical Management Comparisons

Variable	Caboolture Hospital	Like state hospitals	Like national hospitals
Audited deaths with delay in surgical diagnosis	12.5% (2/16)	7% (11/157)	6.7% (31/463)
Audited deaths with transfer to your hospital with delay	(0/0)	0% (0/10)	15.7% (8/51)

Audited deaths without use of intensive care or high dependency unit	68.8% (11/16)	67.5% (106/157)	52.9% (245/463)
Inappropriate DVT prophylaxis treatment as viewed by the assessor	0% (0/16)	1.9% (3/157)	1.3% (6/460)
Proportion of elective admissions with elective surgery performed	100% (1/1)	66.7% (4/6)	88.9% (32/36)
Operation with the consultant surgeon present in theatre	83.3% (10/12)	60% (84/140)	80% (361/451)
Audited operative deaths with postoperative complications	33.3% (4/12)	26.1% (31/119)	25.1% (90/359)
Audited operative deaths with unplanned return to theatre	0% (0/12)	5.9% (7/119)	8.6% (31/361)
Audited deaths with unplanned admission to ICU	12.5% (2/16)	12.1% (19/157)	15% (69/460)
Audited deaths with unplanned readmission	0% (0/16)	5.1% (8/156)	4.3% (20/460)
Audited deaths with fluid balance issues	6.3% (1/16)	7.7% (12/156)	8.9% (41/460)
Audited deaths with a clinically significant infection	50% (8/16)	37.6% (59/157)	39.4% (182/462)

Note: Denominator varies due to different criteria for each row.

Among the 16 audited deaths at Caboolture Hospital from 1 July 2015 to 30 June 2020, QASM assessors identified only one preventable clinical management issue, 'decision to operate' that caused the death of a patient who otherwise would have been expected to survive. This case occurred sometime between 2015-2018.

QASM assessors also identified:

- three cases that may have benefited from ICU or High Dependency Unit care,
- two cases with an unplanned admission to ICU,
- two cases with delays and/or errors in the confirmation of surgical diagnosis (in 2015-16 and 2018-19 respectively),
- one case where fluid balance could have been better,
- nil cases of inappropriate use or non-use of DVT prophylaxis, and
- nil cases of unplanned readmissions

Although eight of sixteen cases had health care infections at the time of death, none of these cases were identified as preventable.

In addition, there were 61 audited deaths involving a transfer from Caboolture Hospital to another hospital, and 18.0% of those were reported to have had delays in the transfer. The reasons for the delayed transfers are not reported.

Queensland Health System Performance Reports

The Clinical Excellence Division, Queensland Health are currently developing a core set of safety and quality indicators for Queensland hospitals that will enable measurement and monitoring of comparative performance across HHS and hospitals.

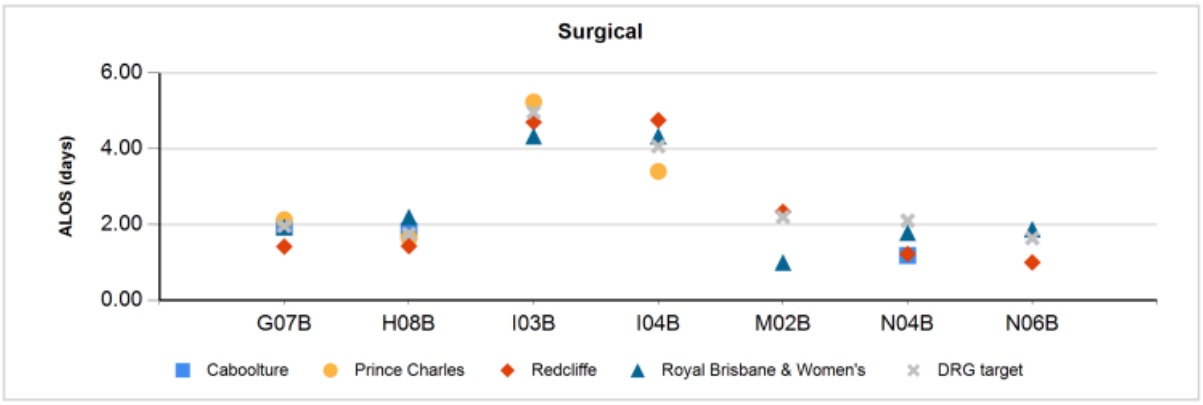
The current safety and quality measures in Queensland Health SPR system are limited, with surgical data primarily focussed on waiting times. The SPR demonstrate variance with the last month reporting period however it is difficult to determine whether the change is statistically significant and would be improved using Statistical Process Control charts. Furthermore, the reports have significant time lags which may be overcome with the introduction of improved health informatics systems that deliver real time ward to board reporting.

Caboolture Hospital performs high volume less complex surgery and the following parameters are favourable or similar to other Metro North hospitals for July and August 2021 (report auto-generated on 1 October 2021). Refer to the following:

- Table 3 – Figure 4 - Average length of Stay (days) per Surgical Diagnostic Related Group
- Table 4 – Figure 10 - Specialist Outpatients Treated in Time by Category 1, 2 and 3
- Table 5 – Figure 22 - Elective Surgical patients treated in time by category 1, 2 and 3
- Table 6 – Table 60 – Elective Surgery (ES) Measures by HHS
- Table 7 – Table 65 – ES per cent patients treated in time by facility.

Table 3: Figure 4 - Average length of Stay (days) per Surgical Diagnostic Related Group

Figure 4: Average length of stay (days) per Surgical, FYTD (Jul-2021)

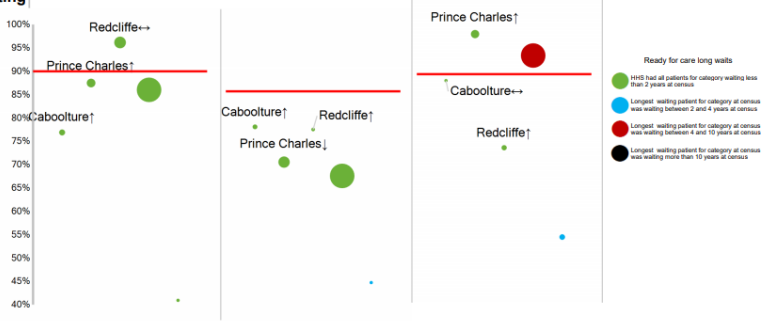


GO7B – Appendectomy (minor complexity)
HO8B – Laparoscopic Cholecystectomy (minor complexity),
IO3B- hip replacement minor complexity,
MO2B Transurethral Prostatectomy – minor complexity,
NO4B hysterectomy for non-malignancy – minor complexity,
NO6B Female reproductive system – reconstructive minor complexity.

Table 4: Figure 10 - Specialist Outpatients Treated in Time by Category 1, 2 and 3

Figure 10: SOPD: Per cent treated in-time Category 1-3, FYTD August 2021

	Category 1	Category 2	Category 3	Total
Target	≥90%	≥85%	≥85%	N/A
HHS	86.4 % ↑	68.3 % ↓	84.2 % ↑	N/A
RFC long-waits	878 ↔	4,566 ↓	2,931 ↓	8,375 ↓
RFC 2+ year wait	0	1 ↓	93 ↓	94 ↓
RFC 4+ year wait	0	0	1 ↑	1 ↑
RFC Total Waiting	2,962 ↓	14,057 ↓	23,747 ↑	40,766 ↑



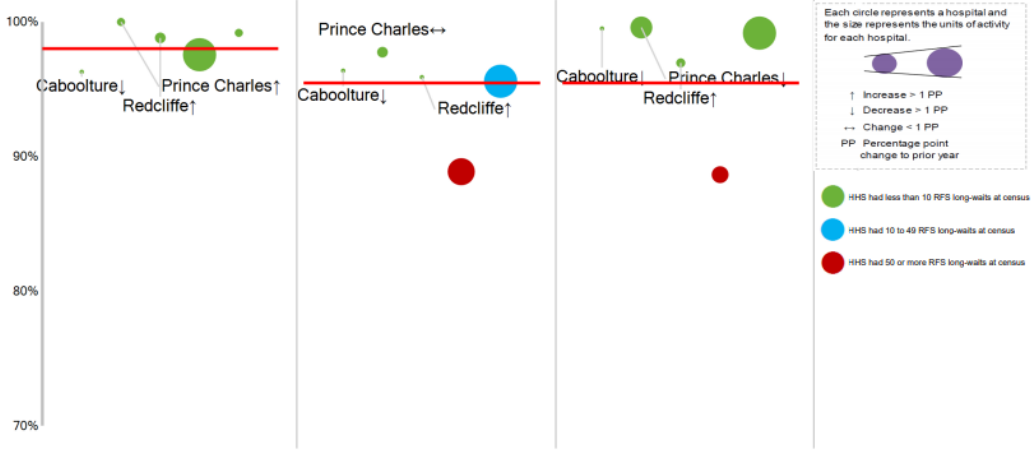
Notes: Volumes of waiting and treated are based on care provided/waiting at a Queensland Public Hospital and do not include outsourced activity.
Source: Queensland Health Specialist Outpatient Data Collection 13/09/21

Table 5: Figure 22 - Elective Surgical patients treated in time by category 1, 2 and 3

Elective Surgery performance

Figure 22: ES per cent treated in-time Category 1-3, by facility, FYTD Aug-2021

	Category 1	Category 2	Category 3	Total
Target	≥98%	≥95%	≥95%	N/A
HHS	98.2 % ↑	93.7 % ↑	96.4 % ↑	N/A
RFS long-waits	2 ↓	127 ↑	80 ↓	209 ↑
RFS Total Waiting	632 ↓	2,506 ↑	6,412 ↑	9,550 ↑



Notes: Volumes of waiting and treated are based on care provided/waiting at a Queensland Public Hospital and do not include outsourced activity.
Source: Queensland Health Elective Surgery Data Collection 09/09/21.

Table 6: Table 60 – Elective Surgery Measures by HHS

Table 60: Elective surgery measures by HHS, FYTD August-2021

Timely Access Summary		Target	MNT	Caboolture	RBWH	Redcliffe	STARS	TPCH
Seen in time	All Categories		96.0%	96.6%	93.7%	97.3%	96.9%	98.6%
	Category 1	98.0%	98.2%	96.3%	97.6%	98.8%	99.2%	100.0%
	Category 2	95.0%	93.7%	95.9%	88.7%	95.4%	95.1%	97.2%
	Category 3	95.0%	96.4%	98.9%	88.5%	96.4%	98.5%	98.9%
Referrals treated	All Categories		5,311	441	1,948	697	1,376	849
	Category 1		2,078	135	1,111	339	247	246
	Category 2		2,085	218	611	218	718	320
	Category 3		1,148	88	226	140	411	283
Median Wait Time	All Categories		38	26	29	29	63	41
	Category 1		18	19	18	21	17	9
	Category 2		63	40	79	70	63	43
	Category 3		188	100	288	288	209	118
Waitlist RFS	All Categories		9,550	455	3,579	1,414	2,826	1,276
	Category 1		632	57	347	100	66	62
	Category 2		2,506	177	1,118	355	577	279
	Category 3		6,412	221	2,114	959	2,183	935
Treat In Turn	Cat 2 & 3		53.6%	73.2%	53.6%	51.7%	54.2%	43.8%
RFS Longwaits	All Categories		209	5	163	11	30	0

Table 7: Table 65 – ES per cent patients treated in time by facility.

Table 65: ES per cent patients treated in time, by facility and category, FYTD Aug-2021

Facilities	Categories	LY FYTD	FYTD	Variance (p.p.) *	Change	LY FYTD Volume	FYTD Volume	Variance	Change	LY FYTD Volume In Time	FYTD Volume In Time	Variance	Change
Total HHS		**89.6%**	**96.0%**	**6.5**	▲	**4,826**	**5,311**	**485**	▲	**4,322**	**5,100**	**778**	▲
Caboolture	**Total**	**99.8%**	**96.6%**	**-3.2**	▼	**516**	**441**	**-75**	▼	**515**	**426**	**-89**	▼
	Cat 1	99.4%	96.3%	-3.1	▼	156	135	-21	▼	155	130	-25	▼
	Cat 2	100.0%	95.9%	-4.1	▼	228	218	-10	▼	228	209	-19	▼
	Cat 3	100.0%	98.9%	-1.1	▼	132	88	-44	▼	132	87	-45	▼
Prince Charles	**Total**	**98.6%**	**98.6%**	**0.0**	▲	**900**	**849**	**-51**	▼	**887**	**837**	**-50**	▼
	Cat 1	98.0%	100.0%	2.0	▲	255	246	-9	▼	250	246	-4	▼
	Cat 2	97.5%	97.2%	-0.3	▼	239	320	81	▲	233	311	78	▲
	Cat 3	99.5%	98.9%	-0.6	▼	406	283	-123	▼	404	280	-124	▼
Redcliffe	**Total**	**77.8%**	**97.3%**	**19.5**	▲	**716**	**697**	**-19**	▼	**557**	**678**	**121**	▲
	Cat 1	84.7%	98.8%	14.1	▲	274	339	65	▲	232	335	103	▲
	Cat 2	77.1%	95.4%	18.4	▲	279	218	-61	▼	215	208	-7	▼
	Cat 3	67.5%	96.4%	28.9	▲	163	140	-23	▼	110	135	25	▲
Royal Brisbane & Women's	**Total**	**87.7%**	**93.7%**	**6.0**	▲	**2,694**	**1,948**	**-746**	▼	**2,363**	**1,826**	**-537**	▼
	Cat 1	97.2%	97.6%	0.3	▲	1,297	1,111	-186	▼	1,261	1,084	-177	▼
	Cat 2	84.8%	88.7%	3.9	▲	886	611	-275	▼	751	542	-209	▼
	Cat 3	68.7%	88.5%	19.8	▲	511	226	-285	▼	351	200	-151	▼
Surgical Treatment and Rehabltn Service	**Total**	-	**96.9%**	-			**1,376**	**1,376**	▲		**1,333**	**1,333**	▲
	Cat 1	-	99.2%	-			247	247	▲		245	245	▲
	Cat 2	-	95.1%	-			718	718	▲		683	683	▲
	Cat 3	-	98.5%	-			411	411	▲		405	405	▲

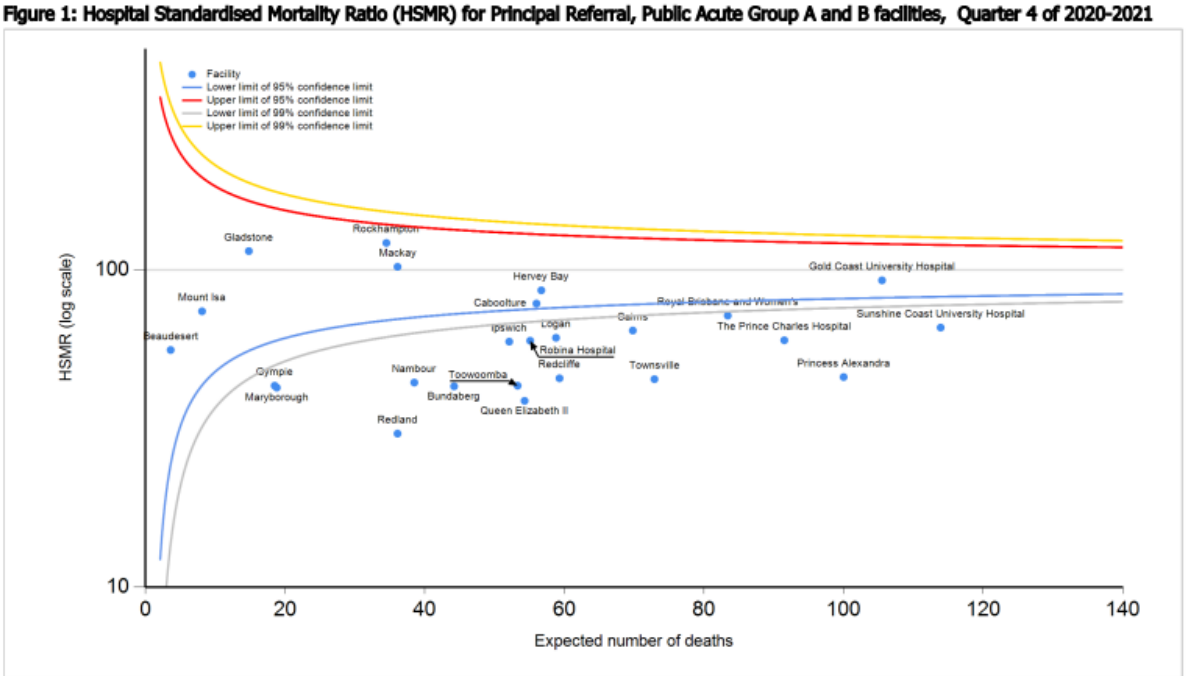
Source: Queensland Health Elective Surgery Data Collection 09/09/21.

The most recent SPR report August 2021 includes comparative Hospital Standardised Mortality Ratios (HSMR) for larger Queensland public (Group A and B) hospitals. Between the first quarter of 2019-20 and the last quarter of 2020-21, the HSMR for Caboolture Hospital ranged from 50.1 to 82.5 always well below the national average of 100, which is an overall positive indicator of safe quality services and care across the entire hospital (not limited to surgical services).

Table 8: Fig 1 HSMR for Principal Referral, Public Acute Group A & B facilities, Quarter 4 of 2020-2021

HSMR

Figure 1: Hospital Standardised Mortality Ratio (HSMR) for Principal Referral, Public Acute Group A and B facilities, Quarter 4 of 2020-2021



Notes: HSMR results for Queensland Children's Hospital are not produced as it is a specialist hospital and the risk adjustment is not adequate. Statistical Control Charts are available via the Clinical Excellence Queensland Patient Safety portal to identify whether a review is warranted. The funnel plot is comparing the HSMR results with the national average (100). For details and limitations about the indicator please refer to the indicator attribute sheet (Hospital Standardised Mortality Ratio).
Source: Patient Safety and Quality Improvement Service, 21/09/21

Health Round Table Reports

HRT membership provides originations with reports designed to assist in finding improvement and opportunities using peer comparisons. HRT reports are usually hospital wide, but area specific reports can be commissioned across most areas of health services. Many Queensland public hospitals participate in HRT performance indicators and opportunities for collaboration and to share innovations.

The review team were made aware and provided with information which appeared to have been retrieved from HRT data addressing comparative incidence of surgical complications at Caboolture Hospital between January 2020 and Dec 2020 without benchmarking information. This report did not match the official information provided. It appears this information had been circulated within some select groups at the hospital. Whilst similar to a HRT report, how the data was retrieved and analysed and its status was not established. Access to such data should be restricted to official channels as misinterpretation of data may lead to inaccurate conclusions.

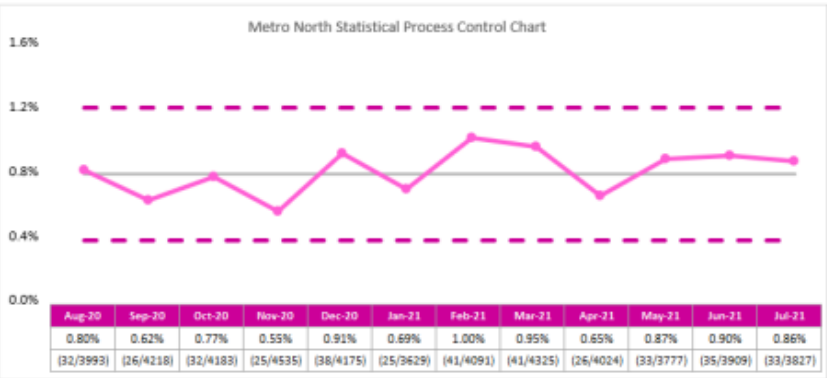
Metro North HHS and Clinical Directorate Safety and Quality Performance Report July 2021

This report includes multiple comparative measures across hospitals within the HHS. Notably it reports rates of unplanned returns to theatre. While there is no predetermined target for this indictor, it appears that Caboolture Hospital has significantly higher returns to theatre than other hospital which requires further investigation and possible action.

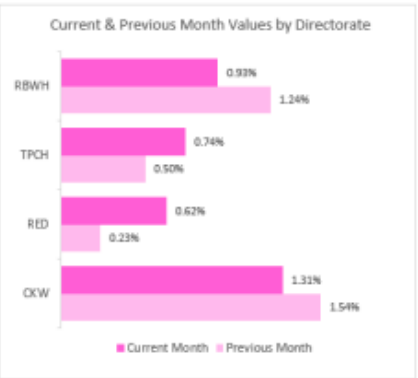
Table 9: Unplanned returns to theatre as % of total operations

Unplanned returns to theatre as % of total operations

Source: QHERS Returns to Theatre Report ***Targets: n/a***



Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
0.80%	0.62%	0.77%	0.55%	0.91%	0.69%	1.00%	0.95%	0.65%	0.87%	0.90%	0.86%
(32/3993)	(26/4218)	(32/4183)	(25/4535)	(38/4175)	(25/3629)	(41/4091)	(41/4325)	(26/4024)	(33/3777)	(35/3909)	(33/3827)



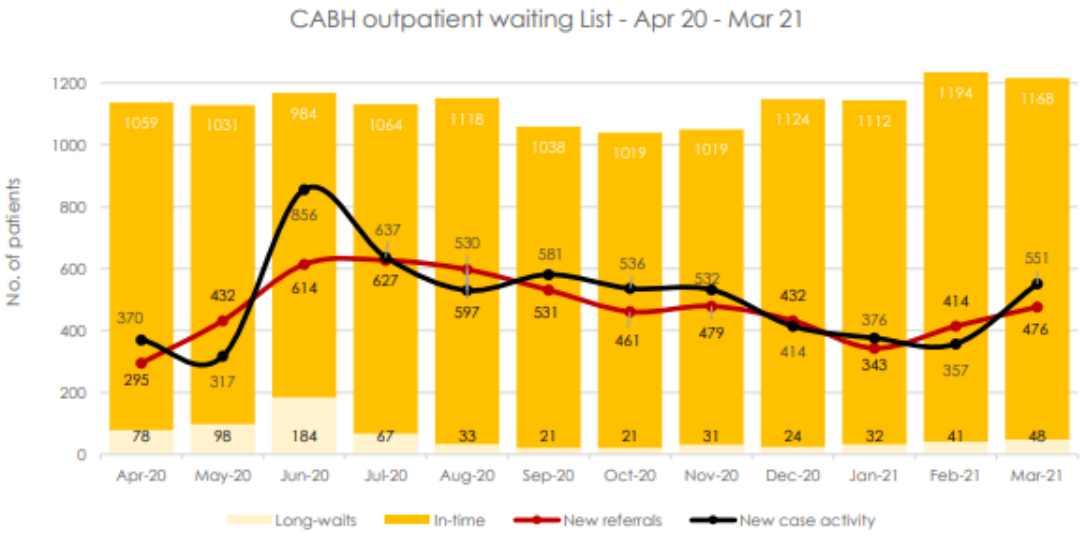
MNHHS Surgery and Intensive Care Stream Report (reporting period April 2020 to March 2021)

This report provides a broad range of information about all surgical services within the MNHHS primarily about access and activity. Some of the information is provided in the figures below. This report also includes the number of SAC1 events by facility and total number of patients treated, it demonstrates that Caboolture Hospital has a higher number a self-reported SAC1 event than other hospitals. It also shows that Caboolture Hospital had peaks of unplanned returns to theatre in April 2020 and February 2021 respectively. Refer to the following:

- Table 10 – Caboolture Hospital, Surgical Outpatients – Outpatient Waiting List – Apr 20 – Mar 21

- Table 11 – Caboolture Hospital, Surgical Procedures – Elective Surgery Waiting List – Apr 20 – Mar 21
- Table 12 – Elective Surgery Waiting List by Category – Apr 20 – Mar 21
- Table 13 – Total Patients Treated – Apr 20 – Mar 21
- Table 14 – Surgery by Day of the Week
- Table 15 – Surgical Outcomes – Unplanned Returns to Theatre as Percentage of Total Operations – Apr 20 – Mar 21
- Table 16 – SAC1 Events – Elective Surgical Specialties

Table 10: Caboolture Hospital, Surgical Outpatients – Outpatient Waiting List – Apr 20 – Mar 21

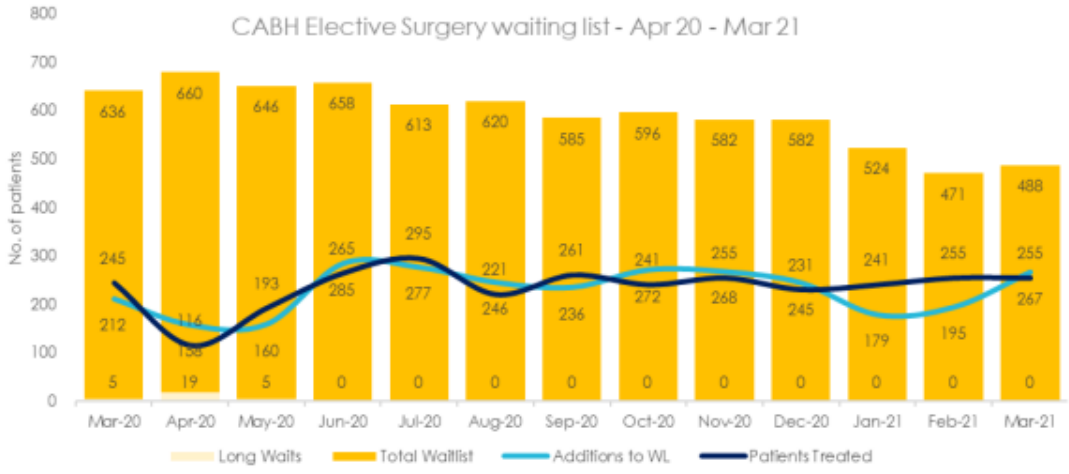


***Data source system**: HBCIS*
***Reporting source**: QHERs report with the following location: Public Folders / Metro North HHS / Metro North / Clinical / Outpatients / MNCO35 – Outpatient WL Static Report (Source SaTR)*

Specialty	New Cases (Medical)	Referrals	% of total referrals
ENT	16	45	36%
General Surgery	3,916	3,621	108%
Gynaecology	2,042	2,035	100%
Grand Total	5,974	5,701	105%

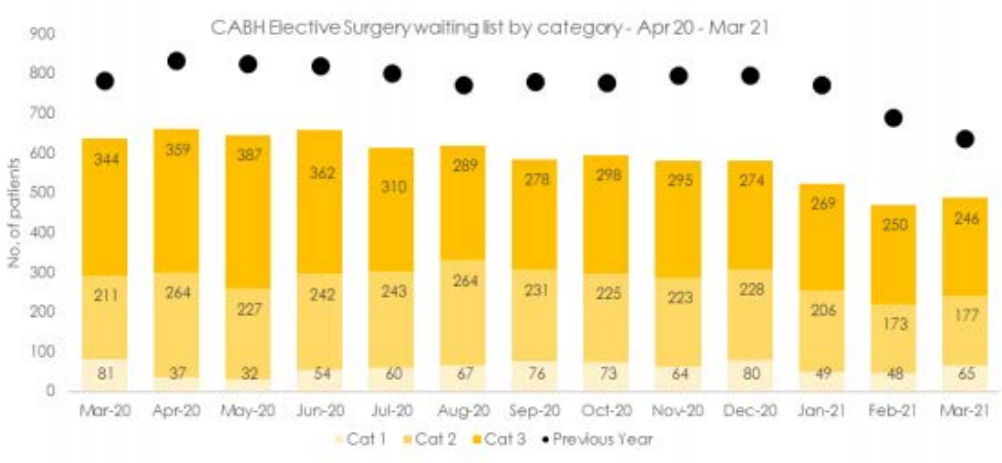
**% of total referrals may exceed 100% due to timing of new case appointments and referrals accepted. Additionally, patients may be waitlisted against one particular CCC but seen in another relevant clinic.*

Table 11: Caboolture Hospital, Surgical Procedures – Elective Surgery Waiting List – Apr 20 – Mar 21



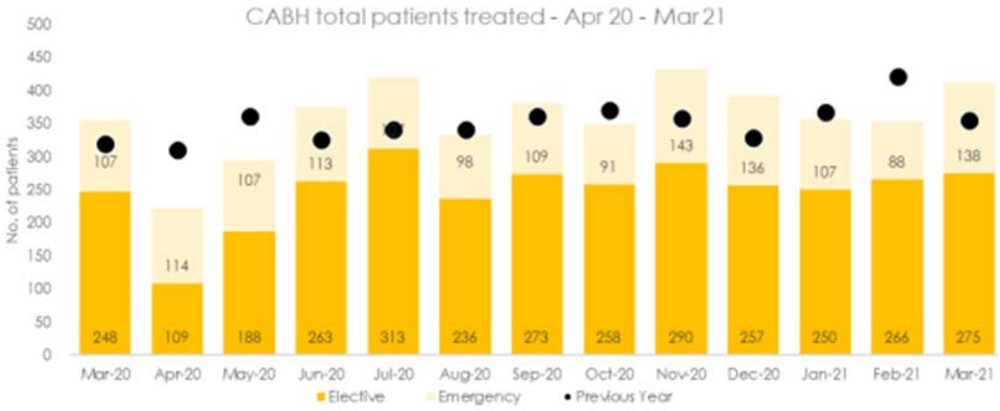
***Data source system**: HBCIS (EAM)*
***Reporting source**: QHERs report – Public Folders / Clinical Access & Redesign / Elective / Folder B Wait list management / B-01 List of patients currently on the elective surgery waiting list*

Table 12: Elective Surgery Waiting List by Category – Apr 20 – Mar 21



***Data source system**: HBCIS (EAM)*
***Reporting source**: QHERs report – Public Folders / Clinical Access & Redesign / Elective / Folder B Wait list management / B-01 List of patients currently on the elective surgery waiting list*

Table 13: Total Patients Treated – Apr 20 – Mar 21



Elective Procedures	Emergency Procedures	**Total Procedures**
2,978	1,351	**4,329**

***Data source system**: ORMIS*
***Reporting source:** Public Folders / Metro North HHS / Metro North / Clinical / Surgery/Business Manager Report.*

Table 14: Surgery by Day of the Week

Surgery by Day of the Week

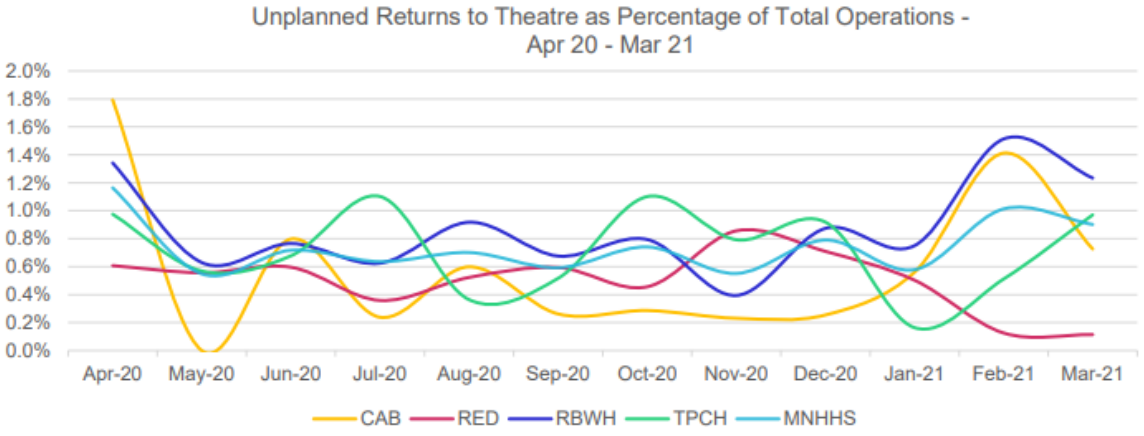
April 2020 to March 2021

Facility	Elective Weekday	Elective Weekend	Emergency Weekday	Emergency Weekend
CABH	2,811	1	977	324
REDH	5,257	24	3,272	968
RBWH	13,570	409	7,069	1,484
TPCH	5,044	1	2,264	596
STARS*	796	0	0	0
TOTAL	**27,478**	**435**	**13,582**	**3,372**

***Note**: STARS commenced activity February 2021*
***Data source system**: ORMIS(except STARs); STARs (SaTR)*
***Reporting source:** Public Folders / Metro North HHS / Metro North / Clinical / Surgery/Business Manager Report.*

Table 15: Unplanned Returns to Theatre as Percentage of Total Operations – Apr 20 – Mar 21

Surgical Outcomes

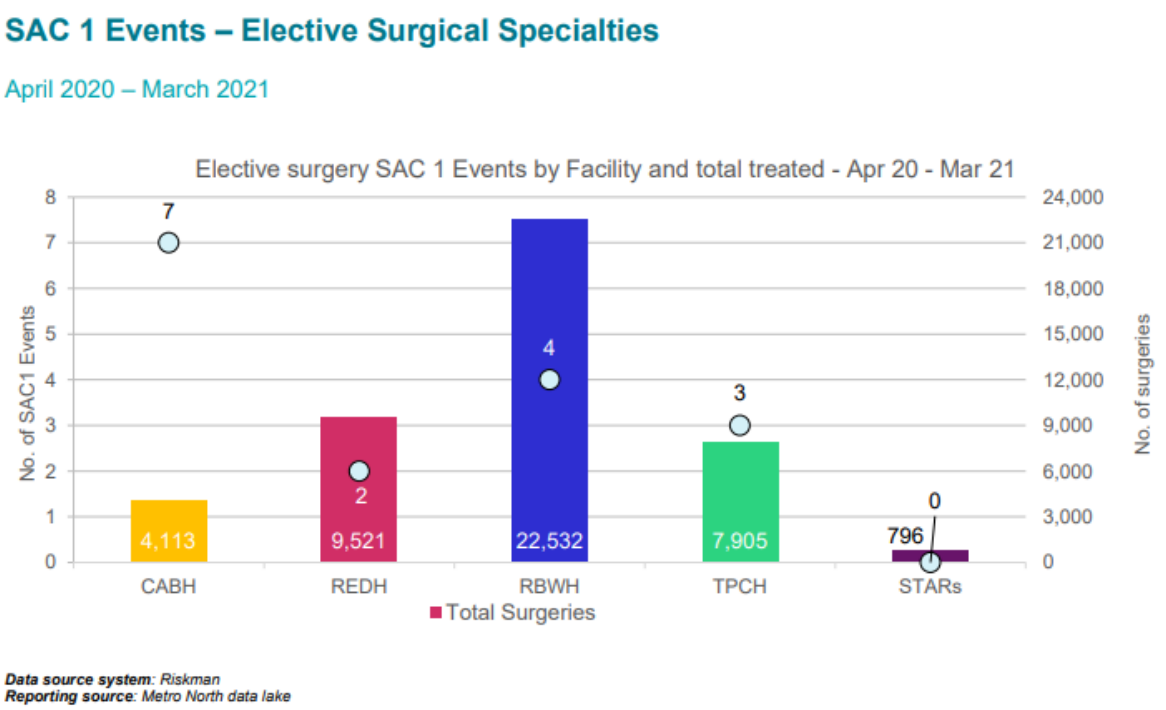


UNPLANNED RETURNS TO THEATRE	CABH	REDH	RBWH	TPCH	MNHHS*
Apr20 – Mar21 - Total unplanned returns (emergency)	24	47	201	68	340
Apr20 – Mar21 – Total average %	0.55%	0.49%	0.83%	0.73%	0.72%
Apr20 – Mar21 - Total unplanned returns – (elective)	0	1	5	0	6
Apr20 – Mar21 – Total average %	0.00%	0.01%	0.02%	0.00%	0.01%

* MNHHS total currently excludes STARs unplanned returns to theatre as data was not available at the time of reporting.

***Data source system**: ORMIS*
***Reporting source**: Unplanned numbers (numerator) QHERS: Public / Metro North HHS /Metro North / Clinical / Clinical Streaming / Surgery / Returns to theatre 3110201. Total Treated (denominator): Public Folders / Metro North HHS / Metro North / Clinical / Surgery/Business Manager Report.*

Table 16: SAC1 Events – Elective Surgical Specialties



Caboolture Hospital Safety and Quality Performance Report

Reporting period Aug 20 to July 21, tabled in August 2021.

The key performance measures in the Caboolture Hospital Performance Report covers the overall performance of Caboolture Hospital with limited critical analysis and narrative. Surgical outcome measures such as unplanned returns to the operating theatre or unplanned admissions to ICU, are not reported. Limited surgical specific data was included in a few of the indicators pertaining to National Safety and Quality Health Service Standards (NSQHSS) as shown below.

- Table 17 – Table 65 – ES per cent patients treated in time by facility.
- Table 18 – Hospital Acquired Complications Dashboard
- Table 19 – Standard 6 – Communicating for Safety
- Table 20 – Compliance with Surgical Safety Checklist
- Table 21 – VLAD Dashboard

Table 17: Table 65 – ES per cent patients treated in time by facility.

Safety & Quality Indicator Dashboard

Legend Performance: Red Alert / Amber Alert / Met Target Target: State Target / MN Target Exceeds State Target / MN Target or No Target	Target	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
1. Clinical Governance													
Compliments received	n/a	105	108	86	107	68	47	41	71	39	68	81	106
Complaints received	n/a	60	55	76	55	49	54	65	76	74	52	82	77
Feedback acknowledged within 5 days	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Complaints resolved within 35 days	85%	96.6%	96.6%	100.0%	98.0%	95.7%	96.4%	83.6%	83.8%	95.8%	92.7%	94.1%	-
Sentinel Events (Australian List)	0	0	0	0	0	0	0	0	1	0	0	0	0
Hospital Acquired Complications (HACs)	<=2SD	39	42	10	35	45	42	45	44	39	41	43	-
SAC1 events reported for the month	0	0	2	0	1	1	1	3	1	0	1	2	2
% SAC1 Analysis Completed in 90 calendar days	70%	#N/A	100.0%	#N/A	#N/A	50.0%	#N/A	100.0%	0.0%	0.0%	33.3%	0.0%	#N/A
% SAC1 Recommendations completed in time	80%	#N/A	25.0%	0.0%	#N/A	12.5%	0.0%	0.0%	#N/A	#N/A	#N/A	100.0%	#N/A
SAC2 events reported for the month	20	7	2	3	1	2	10	6	5	10	6	3	10
No. of Death Reviews open > 2 weeks	0	12	9	8	12	0	1	0	0	2	0	3	2
Credentialing and Scope of Practice Breach	0	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of policies and procedures in date	95%	85.0%	80.8%	83.1%	83.3%	78.9%	75.3%	72.2%	69.7%	73.1%	73.3%	74.4%	69.5%
Percentage of registered risks in date	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospital Standardised Mortality Ratio	100	76.75	73.47	64.09	61.66	50.05	48.51	54.16	77.86	83.60	75.37	-	-
3. Preventing & Controlling Infection													
Hand hygiene 5 moments overall compliance	80%	#N/A	#N/A	81.2%	#N/A	#N/A	#N/A	#N/A	78.6%	#N/A	#N/A	77.3%	#N/A
Carbapenemase Producing Enterobacteriaceae (CPE) Cases	n/a	0	0	0	0	0	0	0	0	0	0	0	0
Healthcare Associated Clostridium Difficile Cases	n/a	0	0	0	0	0	1	0	1	2	2	1	0
Healthcare Associated Staph. aureus Bacteraemia Rate	1.0	0.00	0.00	0.00	2.73	0.00	0.00	4.11	0.00	0.00	0.00	0.00	0.00
4. Medication Safety													
SAC1 medication incidents	0	0	0	0	0	0	0	0	0	0	0	0	0
5. Comprehensive Care													
Skin inspection within 8 hours of admission	90%	95.5%	93.8%	95.0%	96.9%	97.0%	97.7%	100.0%	98.0%	89.7%	100.0%	92.7%	#N/A
Coded stage 4 pressure injury- hospital acquired	0	0	0	0	0	0	0	0	0	0	0	0	0
Coded stage 3 pressure injury - hospital acquired	0	0	0	0	1	0	0	0	0	0	0	0	0
Coded unstageable pressure injury - hospital acquired	0	0	0	0	0	0	0	0	0	0	1	0	0
Falls with Harm	1	0	0	0	0	0	2	1	0	2	2	1	0
Rate of seclusion per 1,000 patient days (adult acute)	10	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	-
Rate of seclusion per 1,000 patient days (child/adolesc acute)	15	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	-
6. Clinical Handover													
Compliance with Surgical Safety Checklist	TBC	98.5%	99.3%	99.5%	99.8%	98.5%	99.8%	98.5%	97.5%	98.3%	99.5%	99.1%	97.8%
Transfer of Care reports within 48 hrs of discharge	90%	77.9%	80.0%	76.2%	77.6%	76.0%	75.8%	76.4%	74.5%	74.9%	72.8%	74.9%	75.4%

Table 18: Hospital Acquired Complications Dashboard

Hospital Acquired Complications Dashboard

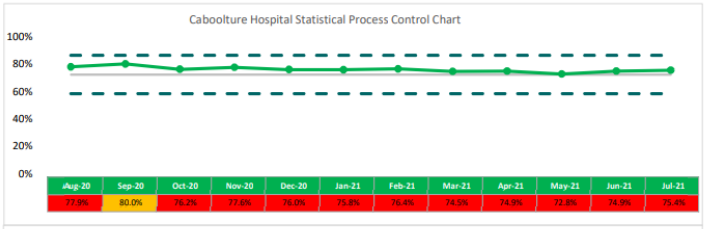
HAC Flag Legend <= 2 Standard Deviations above mean > 2 Standard Deviations above mean (95% band) > 3 Standard Deviations above mean (99% band)	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	FYTD 2019/20	FYTD 2020/21	Variance
HAC Categories															
All	44	39	42	10	35	45	42	45	44	39	41	43	305	426	39.7%
Pressure injury	0	0	0	0	3	1	0	1	1	1	2	0	9	9	0.0%
Falls resulting in fracture or other intracranial injury	1	0	1	0	3	2	1	3	1	1	1	0	10	14	40.0%
Healthcare associated infection	18	9	18	5	8	15	18	20	20	13	11	18	107	155	44.9%
Respiratory complications	4	1	6	0	2	6	2	3	2	2	4	5	33	32	-3.0%
Venous thromboembolism	1	1	3	0	1	1	0	1	0	2	1	0	8	11	37.5%
Renal failure	0	0	0	0	0	0	0	0	0	1	0	0	1	1	0.0%
Gastrointestinal bleeding	0	1	3	0	1	2	1	0	1	3	4	1	8	16	100.0%
Medication complications	7	9	3	3	6	9	8	2	4	4	4	4	29	59	103.4%
Delirium	5	6	4	0	3	6	5	8	6	6	7	5	33	56	69.7%
Persistent incontinence	0	0	0	0	1	0	0	0	0	0	0	0	2	1	-50.0%
Malnutrition	0	0	0	0	0	0	0	0	0	1	0	1	2	1	-50.0%
Cardiac complications	4	8	0	2	2	2	4	2	7	4	4	5	25	39	56.0%
Perineal laceration during delivery	3	4	2	0	2	0	2	4	2	0	2	2	30	21	-30.0%
Neonatal birth trauma	1	0	2	0	3	1	1	1	0	1	1	2	8	11	37.5%

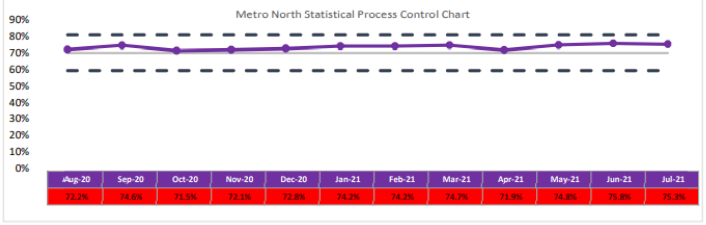
Table 19: Standard 6 – Communicating for Safety

Standard 6 – Communicating for Safety

Transfer of Care reports completed within 48 hrs of discharge

Targets: ≥ 90% ≥ 80% < 80%





Comment:

The overall compliance for completed transfer of care reports within 48 hours for the Caboolture Directorate was 76%. Caboolture's compliance was 75% (n=1026/1360). and Kilcoy's compliance was (n=29/31) 94%

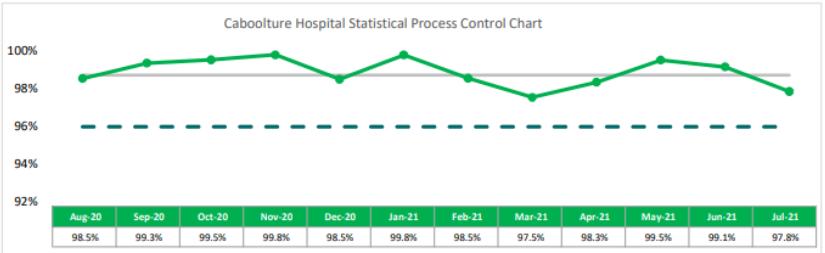
The Service-Line Specific results are as follows:

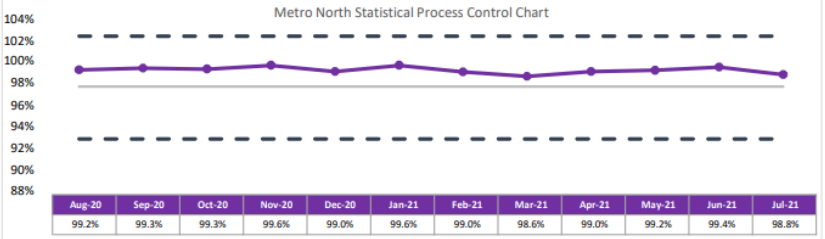
Medical SL - 58% (316/549)
Surgical SL - 91% (384/424)
Women, Children & Families SL - 84% (326/387)

Table 20: Compliance with Surgical Safety Checklist

Compliance with Surgical Safety Checklist

Targets: n/a





Comment:

Ten emergency procedures. Three procedure abandoned:
293979 Repair of wound of skin and subcutaneous tissue right axilla.
212577 Left scrotal explorationProcedure Abandoned
501375 Prolonged preoperative anaesthetic assessment

482231 classical caesarean section Sign in not performed Verbal consent performed cat A
251623 upper segment classical caesarean section under GA (32+4)Not Done as Cat A
447302 lower segment caesarean section Preop Checkin not done as Cat A
250115 LSCS + Cystoscopy CAT 1 cord prolapse, patient came to Theatre via ambulance. Verbal check done in OT as patient was being transferred onto OT Bed
467943 Gynaecological examination under anaesthesia Sign in not completed due to Cat 1 Emergency
017023 Exploratory laparotomy + formation of jejunotomy and mucous fistulaSign in not completed due to patient transferred from ICU to Theatre Intubated
487541 TRIAL OF INSTRUMENTAL IN THEATRE + MANUAL REMOVAL OF PLACENTA + REPAIR OF PERINEUM CAT A Emergency

Table 21: VLAD Dashboard

VLAD Dashboard

Surgical	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Colorectal Carcinoma Complications of Surgery												
Fractured Neck of Femur Complications of Surgery												
Fractured Neck of Femur In-hospital Mortality												
Hip Replacement Complications of Surgery												
Hip Replacement Longstay												
Hip Replacement Readmissions within 60 days												
Knee Replacement Complications of Surgery												
Knee Replacement Longstay												
Knee Replacement Readmissions within 60 days												
Laparoscopic Cholecystectomy Longstay						UL2			UL1		UL2	
Laparoscopic Cholecystectomy Readmissions				LL1				UL1				
Prostatectomy Complications of Surgery												

VLAD is a type of indicator used to measure healthcare quality and patient outcomes. The statistical tool predicts the likelihood of a patient outcome, and then plots the difference between the predicted and actual outcome.

Caboolture Hospital Surgical and Intensive Care Service Line Report

Reporting period Aug 2020 to Aug 2021.

This report provides little useful insight into the safety and quality of surgical services, with relevant data shown below. It is not benchmarked against other services. Furthermore, it is not clear to the reviewers how and when clinical audit results are presented or discussed.

Table 22: Excerpt of Caboolture Hospital Surgical and Intensive Care Service Line Report

	Indicator	Target	2020/21FY average	Monthly trend
Safe Care	All relevant Hospital Acquired Complications *Log due to coding*	< previous month	16.1	
	Discharge summaries completed within 48 hours of discharge	> 80%	1%	
	New confirmed SAC 1 events	0	0.2	
	New confirmed SAC 2 events	0	1.5	
Benchmarking	Clinical Weekly Audit Results			To be presented by service line
	Recommendations that are endorsed at CIRM are entered in the Quality Action Plan and are completed by the due date			To be presented by service line

Recommendations:

11. MNHHS Surgical and Intensive Care Stream committee collaboratively develop, implement and monitor additional surgical process and outcome measures benchmarked across all surgical sites, to inform and drive safety and quality improvements in partnership with MNHHS CGSQR unit.
12. MNHHS establishes a protocol for access to health information data to ensure it remains secure and is not used for unauthorised dissemination.

- **Assess the current data reporting capability and review ongoing system of monitoring of safety and quality indicators and KPI's for the Surgery and Intensive Care department at the Caboolture Hospital.**

Findings:

The safety and quality reports provided by Metro North and Caboolture Hospitals do not adequately inform the reviewer about the safety and quality of services and care delivered by the Surgical and Intensive Care department at Caboolture Hospital. Currently many safety and quality performance measures for Caboolture Hospital and the Surgical and Intensive Care department are provided in the safety and quality reports.

Quantitative and qualitative data and information are extracted from multiple sources within and across the organisation. The current safety and quality health informatics systems used at Caboolture Hospital (and many other hospitals) are 'clunky' and lack the maturity of

financial reporting systems used for the purposes of corporate governance. They appear fragmented and duplicative. There is no rational flow of key information from Metro North to the local hospital, which are then further supplemented by local surgically relevant key performance measures.

At Caboolture Hospital, the collation of key performance measures appears to be one person dependent and reliant on some bespoke health informatics systems that have evolved inconsistently across Metro North hospitals. The safety and quality data officer operates in isolation and may benefit from being part of a broader more holistic health informatics team using more mature and consistent health informatics reporting systems. The single officer is currently responsible for maintaining the RiskMan system in addition to the collation of safety and quality measures.

Other concerns include:

- HRT and clinical audit data do not appear to be reported at Safety and Quality meetings at Caboolture Hospital.
- There appears to be no routine reporting of local surgical indicators such as unplanned return to operating theatre and unplanned readmission to ICU at Caboolture Hospital or within the Surgical and Intensive Care department.
- Attendance at Safety and Quality meetings at Caboolture Hospital is sub-optimal at times
- Only one risk was identified specific to the Surgical and Intensive Care department regarding limited access to specialist allied health support in intensive care which may lead to suboptimal patient outcomes, increased length of stay, reduced quality of care and dependence on alternative care models for ICU patients.
- Consumer feedback is primarily presented in frequency measures only, with Ryan's Rules Requests and OHO referrals not included at all in safety and quality data reporting.

It is unclear from the respective Metro North and Caboolture safety and quality reports, meeting agendas, papers, how members put the pieces of the complex safety and quality puzzle together then prioritise and target action for improvement both at the department, executive or board level. Notable staff who were interviewed could not state the safety and quality priorities of the Surgical and Intensive Care department, Caboolture Hospital or Metro North, respectively.

Caboolture Hospital promotes and supports consumer partnership and involvement through consumer representatives on the Standard 2-Partnering with Consumers Committee and the Caboolture Hospital Safety and Quality Committee, but this does not appear to extend to the development, monitoring and review of key performance indicators for safety and quality. Furthermore, the sharing of key safety and quality performance results are not displayed openly throughout Caboolture Hospital on 'Safety and Quality' or 'Standards' display boards in wards and service delivery areas. There is an excellent information board with some key activity and staff data in the main entrance.

Recommendations:

13. Metro North centralise to MNHHS CGSQR team existing Caboolture Hospital and all MNHHS quality and safety facility data roles and resources to develop and support a contemporary, standardised, mature clinical health informatics system that provides transparent, timely, consistent and accountable "Ward to Board" Safety and Quality performance measures that can be benchmarked for all of its hospitals and across clinical streams, including Surgical and ICU.
14. Improve the content of the safety and quality reports produced by and for Caboolture Hospital through the inclusion of critical analysis and links to improvement actions at Caboolture Hospital and the Surgical Services and ICU Service Safety and Quality committees respectively.

15. Review and restructure the Service Improvement Unit, Caboolture Hospital to provide contemporary support of safety and quality systems and reporting. Change the Director's position to operational, and professional reporting to the Executive Director CGSQR MNHHS in partnership with the Executive Director Caboolture Hospital with embedded day to day reporting to enhance professional and operational support and a level of transparency and independent objective leadership aligned to the MNHHS Safety and Quality Strategy.

Consumer Feedback and Experiences

Consumer experiences and feedback forms part of the qualitative or self-reported data about service performance that informs safety and quality improvement. It is a key domain in the implementation of the MNHHS Safety and Quality Strategy 2019-2023 and as such has its own KPIs and safety and quality indicators.

It is noted that as part of the development of the MNHHS Safety and Quality Strategy 2019-2023:

"Consumers told us they want care that recognises them as individuals, with lives beyond their illnesses. They want staff to engage with them respectfully, with compassion and kindness and to partner with them in their care and in the planning of services more broadly. They also want to know that they will be safe in our care, through increased transparency of safety and quality information."

The overarching policy and procedure documents underpinning consumer feedback are the MNHHS Consumer feedback (compliments, complaints & suggestions) policy (002045) and procedures (003851).

There are multiple entry points to the feedback process for consumers, families, or others:

- "Your Hospital Your Voice" feedback brochures and a submission box on each ward
- QR code Your hospital Your Voice
- Email: Your Hospital Your Voice https://forms.office.com/r/Gb3nnGTvCH
- Verbal report to staff
- Telephone: (07) 5433 8888
- Email: CabH-Feedback@health.qld.gov.au or CAB_CLO@health.qld.gov.au
- Website: Caboolture Hospital or Metro North HHS https://metronorth.health.qld.gov.au/caboolture/contact-us

The steps in the feedback process are a four-step escalation procedure; first talk to the nurse or care team, second to ask to speak to the Nurse Unit Manager or Manager, third give formal feedback to the Consumer Liaison Officer and fourth, take the feedback to an external agency such as the Office of the Health Ombudsman if still dissatisfied. It is also possible to make a direct referral to the Minister for Health or via the local Member of Parliament.

There are two groups of consumers for whom customised access for consumer feedback at Caboolture Hospital is warranted.

- Caboolture Hospital provides health care for prisoners at the Woodford Corrections Health Centre. The prison population is seen as part of the broader community that the MNHHS supports. Prisoner complaints are usually about access to medications and access and timeliness of appointments with health practitioners and services.
- Caboolture Hospital has the highest number of Aboriginal and/or Torres Strait Islander consumers in South East Queensland; 5% of the Caboolture catchment. As part of a culturally appropriate feedback process, Aboriginal and/or Torres Strait Islander

consumers have access to both an Indigenous Nurse Navigator who reports to the Director of Nursing and three Indigenous Health Liaison Officers (IHLO) who report to the Executive Director of the hospital. There are two female and one male IHLOs available seven days per week. The surgical ward usually brings to the attention of the Indigenous Nurse Navigator and the IHLOs that Indigenous consumers have been admitted so that they can be approached in a culturally safe way. Most feedback from these consumers comes via the Your Hospital Your Voice brochure, the majority about the Mental Health Unit, about communication and attitude (judgemental, lack respect, not feeling heard).

Reporting Consumer Feedback

The main ways of recording consumer feedback and experiences are via two data sets; RiskMan and PREMS, both of which have a free text section.

- PREMS is initiated via a Short Message Service (SMS) to the consumer three days after an outpatient appointment. A link to a survey with a standard de-identified questionnaire is attached. The survey is completed via phone or internet. PREMS was only initiated at Caboolture Hospital in December 2020 and the reviewers found that it was not well known or not yet fully integrated into safety and quality reports.
- RiskMan, on the other hand, is an embedded safety recording system, available to all staff. Ideally all consumer feedback is logged into RiskMan by the staff member who receives it. In reality some consumer concerns are dealt with immediately by front line workers and may not be logged.

The review panel found that the RiskMan data about consumer feedback was collated into KPI measures for the monthly Directorate safety and quality reports, the safety and quality indicator dashboard and the Metro North safety and quality monthly performance reports. Four KPI measures include the frequencies of consumer complaints and compliments received, their acknowledgement within five days, and complaint resolution within 35 days, The Performance Report has a ‘Voice of the Patient’ section outlining selected compliments and complaints.

A monthly Consumer Feedback Report combines the RiskMan and PREMs data for the Caboolture Hospital Safety and Quality Committee. It lists the frequencies of the four KPIs for the Directorate as well as for each service line. It also lists the frequencies of enquiries and OHO communication. It categorises compliments and complaints and lists the Top 10 complaint issues identified for the reporting month. The most frequent compliment and complaint categories are ‘communication’, ‘humaneness/caring’ and ‘treatment’. The four highest complaint issues are communication breakdown, staff attitudes, respect, dignity and caring, and waiting time.

CGSQR reports for Caboolture and Kilcoy Hospitals and Woodford Corrections Health Centre (CKW), as well as specifically the Caboolture Surgery and Intensive Care department, drawn exclusively from RiskMan data, summarise Consumer Feedback.

- From July 2019 – June 2020 there were 128 compliments and 77 complaints for Surgical and Intensive Care Department, representing 13.5% and 10.5% for total CKW.
  - total compliments were 946 and total complaints 734 for CKW
- from July 2020 – June 2021 there were 124 compliments and 98 complaints for Surgical and Intensive Care Department, representing 12.4% and 11.7% for total CKW.
  - total compliments were 1002 and total complaints 836 for CKW

The majority of feedback was about surgical ward 2A. Most are responded to within five days and resolved within 35 days. The two most frequent classification of both compliments and

complaints were humaneness and caring and treatment. Most complaints were rated moderate severity, although there were several in 2019/2020 that rated major (significant issues causing lasting detriment). The rate of compliments decreased in 2021 which mirrored the increasing number of complaints, compared with 2020.

Other Sources of Consumer Feedback

Outside of RiskMan and PREMS, there are other sources of consumer feedback about the Surgery and Intensive Care department.

Ryan's Rule Requests

Ryan's Rule is a systemic three step process for a patient, carer, or family member to escalate concerns if a patient's condition is worsening or has not improved as expected. A 13 HEALTH telephone process is provided if escalation at the bedside does not yield action. Ryan's Rule applies to all patients admitted to any Queensland Health public hospital. Of the 64 requests received, primarily from family members for the period September 2019 to September 2021, 13 were about the Surgery and Intensive Care department. This amounts to 20% of the Ryan's Rules Requests.

Office of the Health Ombudsman: https://www.oho.qld.gov.au/make-a-complaint

Many of the complaints received by the OHO are a result of poor communication or a misunderstanding between the health service provider and the consumer. Apart from serious complaints such as misconduct or ongoing risk to public health and safety, local resolution is encouraged. In this context the Chief Executive at MNHHS is notified of any complaints made to the OHO and alerts the Executive Director of Caboolture Hospital of same. The complainant may choose to be identified. There are a number of resolution actions available to the OHO including investigation, disciplinary action, conciliation, consultation, and referral to another entity such as Ahpra.

Of the 19 complaints to the OHO about Caboolture Hospital in 2021, four were about the Surgery and Intensive Care department. In 2020 out of 22 complaints to the OHO five were about the Surgery and Intensive Care department. These figures equate to more than 20% of OHO complaints generated about surgical issues. The responses from the OHO to Metro North were a combination of monitored and unmonitored suggestions to engage the complainant in the local resolution process. In a few the OHO closed the case after assessing that the Metro North response was appropriate. The reviewers assessed how many of the complaints to the OHO had already journeyed through the Caboolture Hospital complaints system with an adequate response and improvement update to the Surgery and Intensive Care department. It appears that most were not known to the department as *complaints or potential complaints* prior to the OHO referral, but there were clinical notes about the events referred to in the subsequent complaints. The subsequent responses to the OHO acknowledged communication deficits between surgical staff and patients.

There was one OHO complaint that was listed as a sentinel event by the Surgery and Intensive Care department only after the OHO initiated an investigation. The subsequent risk assessment found that the incident was identified by the private radiology provider, situated in Caboolture Hospital. Because the radiology provider did not have access to the internal RiskMan in order to immediately flag the incident, there was a delay in reporting it and therefore a delay in Caboolture Hospital responding to the consumer and rectifying the issue. As a result of this incident an agreement between the radiology provider and the Caboolture Hospital to immediately report any concerns to the Executive Director of the hospital, the Director Medical Services and the treating team / referring medical officer has been reached.

Another avenue of feedback or complaint open to consumers and/or the OHO is the referral of a particular health practitioner to the health regulator for attention if public safety is at risk. Australian Health Practitioner Regulation Agency (Ahpra): https://www.ahpra.gov.au/ These referrals are called notifications and Ahpra may triage, investigate and respond in ways to ensure public safety including suspending or applying conditions to registration. The reviewers checked the Ahpra register and found no surgeons at Caboolture Hospital currently subject to conditions.

Safety and Quality Improvements from Consumer Feedback

The review panel found that the reporting of collated consumer feedback and experiences data and information, and its monitoring and use by the Surgery and Intensive Care department to improve the safety and quality of services and care provided, was unsatisfactory.

The critical analysis of the data to identify and action safety and quality issues was unsatisfactory, in part due to the lack of acceptance by the surgical staff of the link between the gathering of consumer feedback and its use in developing action plans for improvement. The KPIs focused on frequency data regarding number/type of compliments and complaints and their resolution within a five day or 35-day response. The majority of recorded complaints were about communication, staff attitude, humaneness and caring, and timeliness, anecdotally the 'customer service' aspect of care was poor and included surgical staff being blunt, patronising, judgemental, lack of respect, use of jargon. The Ryan's Rules Requests and the OHO referrals confirmed poor communication/staff attitude as significant drivers. Despite being identified, the reviewers did not see these issues reflected in the Surgery and Intensive Care department's Quality Action Plans (QAP) or other rectification strategies such as staff training in patient communication.

The consumer feedback obtained from the variety of methods described, that is RiskMan, PREMS, Ryan's Rule Requests, Hotline, and OHO is valuable information to be collated and monitored to inform safety and quality improvement by the Surgery and Intensive Care department of Caboolture Hospital.

This is in keeping with various Metro North policy and procedures:

- The Safety and Quality Strategy states that safety and quality performance should be monitored and reported at all levels of the organisation and poor performance should be identified and monitored or mitigated by action for improvement or escalated.
- The MNHHS Standard 2- Partnering with Consumers states that complaints and compliments should be the feedback mechanism to identify areas where improvements can be made to improve consumer outcomes.
- The MNHHS Standard 6 – Communicating for Safety implements and monitors systems and processes and applies quality improvement methods to ensure communication, documentation and patient identification and procedure matching occurs.
- The Metro North Consumer Feedback policy states that rectification of a complaint is the responsibility of the Clinical Directorate or the person responsible for the detriment to the complainant. It is intended that, following a complaint, actions may be taken to apply changes to processes, services or products to ensure the problem does not reoccur and to ensure compliance with obligations and correct the records. As well, to ensure complainant satisfaction it is expected that communication may include an admission of fault, an apology, or an undertaking to improve systems, procedures, or practice. At the very least data recorded about each complaint may assist in responding to any further reviews or appeals, as well as lead to quality improvements.

The reviewers examined a selection of the agenda and minutes of the Caboolture Hospital safety and quality committees and Standard 2 meetings where consumer feedback was a

standing agenda item to assess if such feedback informed decisions regarding safety and quality actions. The reviewers identified two issues with regards to the use of safety and quality reporting: the data itself and the attitude of the clinical staff in the Surgery and Intensive Care department.

Safety and Quality data

Whilst the data for consumer feedback in the safety and quality dashboard, performance reports and consumer feedback reports were collated against KPIs, it consisted of basic frequencies and there were no clear summaries of improvement actions in response to it. There was no data recorded on any of these reports about Ryan's Rules Requests or OHO referrals.

At the Caboolture Hospital Safety and Quality Committee monthly meetings, which includes a representative of the Surgical and Intensive Care department, more detailed safety and quality reports are tabled, their contents intended to triangulate other information with performance measures to assist to identify and prioritise actions for improvement, including QAPs. However, these reports are sourced from multiple parts and positions of the broader safety and quality function at Caboolture Hospital (for example, Consumer Liaison Officer, Service Improvement Officer, Patient Safety Officer, Culture and Engagement Manager, Standards Committees, Clinical Weekly Audits) and their utility relies on coordinating the reported data to avoid duplication and enhance risk assessment. Again, OHO referrals and Ryan's Rules Requests were not included in the safety and quality reports or analysis.

Although the data is recorded on RiskMan and PREMS, safety and quality reports varied in their summaries of frequencies or percentages of compliments and complaints due to variances in timeframes selected and the services included in each report, for example whether the report was for MNHHS, CKW, Caboolture Hospital only or the Surgical and Intensive Care department. It is therefore difficult to compare and benchmark services, identify trends and add to the safety and quality of surgical services.

Engagement of surgical staff

The reviewers found that the link between safety and quality data and departmental improvement was hampered by a lack of engagement by clinical staff. It was unclear how regularly Clinical Weekly Audits were undertaken, or the results tabled at safety and quality meetings. QAP action items seemed to be related to management of clinical incidents and no other safety and quality domains. Surgical service representatives were often absent from Standards and safety and quality committees with the consequence that no service line update was provided, nor improvement actions delegated.

The reviewers also found that clinical staff were reluctant to engage in complaint resolution citing clinical priorities and through-put. This left the rectification of most complaints, including contacting the complainant with a response, to the Consumer Liaison Officer, the NUM or the Nursing Director of the Surgery and Intensive Care department. Although this is entirely appropriate as a response to immediate concerns, for the >35 day complaints, there was no evidence that the internal investigations of such complaints were used to flag improvements, or that surgical staff engaged in explanations to complainants, even where it would be preferable; particularly with indigenous consumers. This means that complaint resolution is not as consistent or effective as it could be.

The exception is responses to the OHO which are prepared by the Consumer Liaison Officer in collaboration with the Surgery and Intensive Care department and cleared by the Executive Director prior to submission to the Chief Executive for signing and submission. If the OHO request a written response back to the complainant this will be prepared by the Consumer Liaison Officer in collaboration with the Surgery and Intensive Care department and signed

and submitted by Executive Director Caboolture Hospital. However, the OHO referrals also highlighted the tardiness with which the Surgery and Intensive Care department responded to consumer complaints *at the time* of the incidents. On at least two occasions no critical incident recording was completed until the OHO referral, some months following the incidents.

Consumer participation

The reviewers noted the existence of the Caboolture Caring Together Consumer Network and the Caboolture Caring Together Community Advisory Council. Caring Together is the partnering mechanism for MHHS for Your hospital Your Voice and is consistent with Standard 2 Partnering with Consumers.

There are Standards Committees in place at Caboolture Hospital, including one for Standard 2. Chaired by the Manager of Culture & Engagement this Committee meets monthly and includes the Consumer Liaison Officer, a consumer representative and a Surgery and Intensive Care department representative. It is noteworthy that, in examining the minutes of the Standard 2 Committee for 2020 and 2021 the representative for the Surgery and Intensive Care department was most often absent. Consequently, there were no topics introduced or discussed that were specific to the department. Committee agenda items included the consumer engagement experience, consent documentation, and the long-awaited introduction of PREMS. Safety and quality data by way of compliments/complaints were tabled. Plenty of relevant consumer-affected issues were raised and discussed and the project log for 2021 summarises the relevant actions that flowed from them.

Recommendations:

16. Ensure that collated consumer feedback and experiences data and information is monitored and used by the Surgery and Intensive Care department to improve the safety and quality of services and care, including:

    Develop consumer feedback summaries across MNHHS from a range of resources including RiskMan, PREMS, OHO requests, Ryan's Rule requests, and analyse the frequencies and free text data about consumer complaints to regularly inform communication, staff attitude and timeliness with consumers and their families.

References

MNHHS Caboolture and Kilcoy Hospitals Your hospital Your Voice

MNHHS Policy Consumer Feedback (compliments, complaints, and suggestions) 002045

MNHHS Procedure Consumer feedback (compliments, complaints & suggestions) 003851

MNHHS Safety and Quality Strategy 2019-2023

MNHHS Standard 2- Partnering with Consumers

MNHHS Standard 6 – Communicating for Safety

Metro North Aboriginal and/or Torres Strait Islander Feedback 12-month Review 7.2020 - 7.2021

Caboolture Surgery and Intensive Care Department Consumer Feedback - July 2020 – June 2021, a Clinical Governance Safety Quality & Risk report

Culture

Media reports have been strident in alleging a toxic culture for staff in the Surgery and Intensive Care department. The reviewers' impressions follow:

There is a clear process in MNHHS if staff wish to initiate complaints about other staff.

The Queensland Health Human Resources Policy on individual employee grievances E12 (QH-POL-140) document outlines what is and is not a grievance and the process for a Queensland Health staff member making a complaint. It is a three-step process; local action (line manager or Human Resources), internal review of a decision made following local action and where applicable, external review of a decision made at internal review. An employee who submits an employee grievance may be supported by a person of their choosing, and/or represented by a union representative or member of a professional association.

An employee may choose to lodge their complaint, particularly if uncomfortable about approaching the local manager via:

- access complaints webpage https://www.health.qld.gov.au/employment/conditions/staff-complaints/how-to
- report directly to Staffcomplaints@health.qld.gov.au or phone 1800 195 240.

If the employee grievance relates to the employee's immediate supervisor, the grievance can be referred to the supervisor's reporting officer. Concerns or matters about patient care relating to the behaviour or clinical practice of individual clinicians should be reported to the relevant Clinical Director. There is a separate process if the grievance is regarding the conduct of the Director-General, Department of Health. If the complaint involves corrupt conduct it may be escalated to the Integrity Unit of Metro North who will investigate and may refer further to the Crime and Corruption Commission. The time frame for resolving complaints is within 28 days of receipt of the complaint. There are appeals processes if the staff member is unhappy about the outcome of the local resolution.

There were a number of indicators of dissatisfaction in the Surgery and Intensive Care department.

There is a MNHHS 'Have your Say' survey every two years and a report called "At a Glance" is produced. Comparative "At a Glance" reports for the Surgical ICU Medical at Caboolture Hospital in May 2019 and for the Surgical and Intensive Care department at Caboolture Hospital in May 2021 were examined. A breakdown for surgical only at Caboolture Hospital was not provided. The data, although not complete, does indicate a greater level of dissatisfaction in the Surgery and Intensive Care department in May 2021 than in May 2019.

During the review, it was recognised that there were instances where the incomplete understanding by staff of their roles and personal and professional boundaries affected their professional judgment. This may contribute to a negative workplace culture and a destabilised governance structure.

The constant flow of confusing and varied information from the various teams e.g. Service Improvement Unit, M&M committee and CLO made it difficult to recognise important information that would signal cause for concern for those with the most responsibility to react appropriately. This reluctance to react to matters of concern fosters a culture of tolerance for negativity rather than a culture of critical analysis and openness.

There appeared to be a degree of passivity about difficult personnel issues, with clinicians not vigorously pursuing with management any concerns they may have, nor listening to the concerns of others. It became clear that clinicians in leadership roles paid insufficient attention to the risks in relation to quality of service delivery because of their lack of responsibility and focus within roles.

Comments heard during the review indicated that poor leadership, lack of trust and transparency lead to poor morale and ineffective representation of concerns from clinicians in all areas of the multidisciplinary team. As a result of poor leadership, and fear of retribution because of past bullying and harassment, responses to staff surveys and suitable representation at meetings saw ineffective participation and inadequate information and feedback about safety and quality in particular. This lack of enthusiasm resulted in safety and

quality perceived as meaning more work for staff, so actions were minimized rather than being viewed as opportunities for improvement.

Recommendations:

17. Consider ways to educate and address the underlying culture issues prevalent throughout Caboolture Hospital. This may include implementation or refresher empathy training, leadership mentoring, Communication and Patient Safety (CaPS) and Communication, Respect, Accountability = Safe Healthcare (CRASH). Also enhanced opportunities for collaboration with multidisciplinary teams through attendance at safety and quality committee meetings.
18. Ensure that Quality Action Plans include non-clinical aspects of care.
19. Implementation of empathy training and improved patient communication/feedback for all staff at Caboolture Hospital to enhance patient and staff health literacy skills.

Appendix 1: Measuring and monitoring Patient Safety and Quality of Care in hospitals

Patients, consumers, and communities trust that Queensland Health hospitals, services and staff provide high-quality health care, together with an expectation that systems are in place to safeguard them, and routinely improve care and service delivery.

However, no two patients are the same, and care delivery involves administrative officers, doctors, nurses, pharmacists, allied health, food, and cleaning staff and more in acute, primary and community health facilities. Health care providers and the individual patients contribute to the delivery of quality care and positive outcomes. Health care is complex.

Clinical Governance – a systems approach

Despite significant investment in patient safety and quality, the Australian Commission for Safety and Quality in Health Care estimated in 2013 that approximately 12% to 16.5% of total hospital activity and expenditure was the direct result of adverse events. It is also estimated that at least one in ten people suffer harm during a hospital admission, yet only a small proportion of people make a complaint.

Over the past twenty years, the primary approach to improving safety and quality has focused on closing 'safety gaps' by increasing standardisation to reduce variability in clinical practice and decision making and risk avoidance, through a range of common activities including, but not limited to:

- complying with legislation, regulation,
- accreditation – complying with healthcare standards,
- retrospective clinical audit and registries,
- measuring key performance indicators,
- real time digital dashboards (and health informatics to inform point of care [emerging]),
- reporting and investigating clinical incidents and consumer complaints, and
- using improvement methodologies often adopted from aviation, and manufacturing industries.

However, change is required to shift the 60:30:10 challenge, whereby 60 per cent of care is delivered in accordance with evidence or consensus based guidelines, 30 per cent is wasteful, and 10 percent results in harm (*Braithwaite et al BMC Medicine 2020:18:102*).

Alternate approaches to patient safety have emerged around the world, often underpinned by a sociological perspective of patient safety and improvement. These alternate approaches are seeking to go beyond a consideration of harm and system failures to examine what works well and what goes wrong in the delivery of clinical care and services.

Clinical Governance is a collective term for systems that must be in place to ensure the delivery of safe, effective, efficient, and sustainable care. Safety and Quality Units are the teams that facilitate the monitoring, reporting and continuous improvement of the quality of care and services provided to individuals and local communities.

Since 2020, Queensland Health have been undertaking the current priority actions through the Directors of Clinical Governance and Improvement Group, together with the Patient Safety and Quality Improvement Service, Clinical Excellence Division:

- Improving Clinical incident management – better integration with clinician / open disclosure, new methods and tools, consumer involvement, aiming for stronger recommendations and effective quality improvement.
- Implementing Patient Reported Experience Measures (PREMS) and Patient Reported Outcome Measures (PROMS),

- Reducing unwarranted Variation in Care,
- Improving Public Safety and Quality Reporting, and
- Implementing Child Death and Serious Injury Reviews.

Current and emerging clinical governance practice changes must be planned for and accommodated across the Hospital and Health Service (HHS). Moving forward, there should be consideration of which current functions and activities could be centralised within the HHS and those that should be undertaken at the local hospital level to reduce duplication of effort and improve systems, consistency, transparency, and accountability.

Roles and responsibilities

The Australian Institute of Company Directors describes the role of the board as including governing, directing, and monitoring an organisation's business, affairs, and operations in two broad areas: organisational performance and compliance/conformance. Both areas are applicable to the Safety and Quality Committees of Hospital and Health Boards (HHB).

- Organisational performance: ensuring the organisation develops and implements strategies and supporting policies to enable it to fulfil the objectives set out in the organisation's constitution. Commonly the board delegates the day to day operations of the organisation to the management team via the Chief Executive but remains accountable to the members and shareholders for the organisation's performance. The board monitors and supports management in an on-going way.
- Compliance/conformance: ensuring the organisation develops and implements systems, processes and procedures to enable it to comply with its legal, regulatory and industry obligations (complying with the law and adhering to accounting and other industry standards) and ensure the organisation's assets and operations are not exposed to undue risks through appropriate risk management.

The differing emphasis of these two areas of organisational performance and conformance/compliance responsibilities can result in conflicting pressures on boards and their members. Boards must balance these roles and give appropriate attention to both.

There are several challenges for Board Directors in health care in undertaking their duty of care:

- Health care is a high-risk business with one in ten patients suffering an adverse event. Only about half of the harm to patients is deemed preventable.
- The high complexity of healthcare makes for many risks that cannot be wholly eliminated.
- This high complexity also reduces the transparency of accountability.
- The identification and the management of patient safety and quality risks are a particular challenge: significant potential and actual risks can occur at a hospital, ward, clinical unit, or individual level.
- There is rarely a 'silver bullet' report for risks and each risk usually needs to be assessed by the triangulation of available data, qualitative and quantitative.
- The collection of data around many of these potential risks is expensive and hence frequently not done.
- The high rates of patient harm make essential the Board's role in setting the ethical tone, the moral compass of the organisation, and ensuring a just culture and ethical decision making. A blame culture is detrimental to patient safety.
- Many of the risks encountered in healthcare are unique for which there are no 'correct' and agreed rules, procedures, and precedents for management.

- The Board's role is to add value by testing plans to deal with risks, through constructive and curious questioning. At the same time, if the Board micromanages, the Executive will be disempowered.

Hence, the extent and nature of HHB safety and quality committee reports and the Board's response to these reports needs to reflect this high risk and complexity, and the need for a just and ethical approach. The Board's acceptance of risk must also include that all risks may not either be assessed and/or provided to the Board.

The following model by Professor Robert Tricker provides a useful guide to the performance and compliance dilemma for boards and their directors and information required for consideration and decision making by Board members.

Figure 1: Tricker's framework for Board Functions

Legislative functions

In Queensland the *Hospital and Health Boards Act 2011* (the Act) and the *Hospital and Health Boards Regulation 2012* identify the legislative functions of the following entities pertaining to patient safety and quality functions:

- Department of Health
    - Monitor and promote improvements in the quality of health services,
    - Monitor the performance of Services and take remedial action when performance does not meet the expected standard, and
    - Receive and validate performance data and other data provided by Services.
- HHB
    - Controls the services for which it is established and
    - Must prescribe a safety and quality committee.
- HHB Safety and Quality Committee
    - Advise the Board on the safety and quality of health services provided by the HHS, including strategies for:
        - minimising preventable patient harm,
        - reducing unjustified variation in clinical care,
        - improving the experience of patients and carers,
        - ensuring compliance with national and state strategies, policies, agreements, and standards such as the NSQHSS.
    - Monitoring HHS safety and quality governance arrangements.
    - Monitoring safety and quality and promoting improvements.
    - Collaborating with other safety and quality committees, the department, and state-wide groups.
    - Any other function given to the committee by the Board.

- HHS
    - Monitor and improve the safety and quality of health services.
    - Develop local clinical governance arrangements.
    - Manage the performance of the Service against performance measures in the Service Agreement.

Although not stated in the Act, in practice hospitals should manage the operations and implementation of clinical governance systems at the local level in a consistent manner within and across the HHS to enable transparency and accountability.

Board Considerations

To fulfil the expectations and obligations of their respective organisations and communities, the directors of HHB Safety and Quality committees should consider the following concepts and processes regarding their current reports & responses to same:

1. Concepts:

- What is the acceptable risk tolerance level, given the extent of patient harm in health care? Has this been communicated to the Executive and are the Board's actions consistent with this?
- How will the Board account for complexity in both understanding the reports and the response to risks?
- How will the Board utilise the factors in decision making to help them asses risks and plans to address these risks.
- Is the Board prepared for uncomfortable discussions, given the high level of ongoing risk and often unclear path to resolution/mitigation of the preventable risks?
- How will the Board ensure there is a just and ethical treatment of both patients and staff in its response to risks?

2. Reporting and response process:

- How can I ensure that we discuss the important issues, risks, and improvements at committee meetings?
- What systems identify, report, monitor and improve safety and quality? Are the systems robust and working well in practice?
- Do I understand the information I receive? Is it meaningful? Are data reliable, replicable, and informative? What are the limitations of the information? Is an expert narrative provided? Is this information adding value to my decision making?
- Consider what information am I not receiving? There is much relevant clinical, and clinical governance information across varying levels and professions: it is arguably too much for any Board to be able to consider. Have my Board considered this from a risk perspective? How do I prioritise which information I receive?
- Are safety issues and risks escalated, triaged, and actioned appropriately? Or does the Board want reporting by exception? If so, what is the risk tolerance for these exception reports? Is this communicated to Executive?
- How will I ensure the Board closes the loop?
- How can I make informed decisions to prioritise actions for improvement?
- How are Safety and Quality reports linked to Strategy?
- What systems are used to support Quality Improvement in patient care? Are people trained, resourced, and supported to undertake sustainable measurable positive change in patient care performance?
- How can I promote and build a positive safety culture?

3. Accreditation

To increase awareness of the governing body's accountability for safety and quality and clinical governance processes (as set out in the NSQHSS), the governing body of Health Services along with the Chief Executive of the HHS is required to sign an attestation statement annually to their accrediting agency, commencing January 2019.

According to HHS Service Agreements, all Queensland public hospitals, day procedure services and health care centres are to maintain accreditation against the Australian Commission on Safety and Quality in Health Care's (the Commission), NSQHSS. The first version was introduced in January 2013, followed by the current second version introduced in January 2019, whereby hospitals and health services must meet the five elements in the National Clinical Governance Framework (the Framework):

- Governance, leadership, and culture
- Patient safety and quality improvement systems
- Clinical performance and effectiveness
- Safe environment for the delivery of care
- Partnering with consumers.

The Commission has published a factsheet and user guide to assist members of a governing body to fulfil their role in meeting these standards. Neither the national standards nor framework specifies how an organisation should develop or implement its clinical governance systems, however to meet the intention of the current standards requires a significant shift and continuous improvement in patient safety culture and engagement, and a willingness to update some of our existing clinical governance systems and tools, including Safety and Quality Board reports.

4. Strategy

The Metro North Hospital and Health Service Board's vision for safety and quality is documented in the Metro North Hospital and Health Service Safety and Quality Strategy 2019-2023 that aims to improve the outcomes of care, prevent harm and increase reliability, support better communication and strengthen patient safety and quality improvement culture.

Safety and Quality Strategy
2019 – 2023

In Metro North, we are committed to providing health care that is person centred, safe and effective. Throughout our organisation, our people make a difference every day for patients, consumers, families and each other. Our values guide the way we work, and it is through this lens that the Safety and Quality Strategy has been developed.

Our Safety and Quality Strategy aims high. We are committed to partnering with consumers when we provide care and when designing services. We are targeting continued improvement in the outcomes of our care. We are supporting better measurement of clinical outcomes and patient experiences so that our staff can shape care that is even more effective.

Patients expect to be safe in our care and our staff want nothing less. We are committed to preventing patient harm by scientifically designing safety and reliability into the processes of our care.

The experience and safety of patients and staff is improved through great communication. We plan to improve how we talk to and share information with patients, their families and each other. Creating psychological safety by the way we communicate and behave, improves outcomes for patients and supports staff to do their very best work.

Having an organisational culture that is committed at every level to patient safety and quality improvement makes a difference. We support consumers to better understand their health care and to work with us, so we understand their needs and preferences better. We support our staff, at all levels, to shape a culture grounded in our values and informed by the best research and education so that each person and team can make a difference to the safety and quality of our care.

Improve outcomes of care

1.1 Promote a culture where goals of care are clear, informed by what matters to patients, consumers and their families and consistent with evidence based practice.

1.2 Foster partnerships in care and services through improved health literacy for patients, consumers and families.

1.3 Leverage our digital strategy to increase timely access to useful data and analysis, to improve the safety and quality of care at individual patient and system levels.

1.4 Facilitate the measurement and reporting of, and response to agreed clinical, patient experience and patient reported outcomes.

1.5 Strengthen the analysis of, and response to health outcomes for Aboriginal and Torres Strait Islander people in Metro North, in partnership with Indigenous consumers and health care agencies.

1.6 Foster research and the translation of research into practice, in the areas of diagnostics, digital, therapeutics and health services.

We will measure:
- Patient experiences
- Patient reported outcomes
- Clinical outcomes

Prevent harm and increase reliability of care

2.1 Promote highly reliable care through standardisation, simplification of care processes and the monitoring of variation from agreed ways of working and evidence based practice.

2.2 Engage clinicians and consumers in our value based health care program to reduce low value (benefit) care including procedures and tests.

2.3 Embed high reliability and reduce low value care through the design of digital workflows and decision support.

2.4 Prevent and learn from harm by applying systems and safety science to technology, processes and workflow design.

2.5 Promote the co-design of care systems with consumers and staff to increase clinical and psychological safety.

We will measure the impact of:
- Care processes that use co-design, digital workflows, decision support and systems, and safety science to increase safety and reliability
- Data driven safety and quality improvement initiatives
- Reducing low value care for patients and the health service
- Our progress towards becoming a high reliability organisation

Communicate better

3.1 Promote communication which consistently reflects Metro North's values.

3.2 Engage with consumers in ways that respect and promote their rights, dignity, cultural diversity, levels of health literacy and health information needs.

3.3 Foster a culture of shared decision making and collaborative negotiation by engaging with consumers to understand what matters to them.

3.4 Facilitate transparency for consumers and staff by increasing access to meaningful safety and quality measures and analysis.

3.5 Foster better communication of timely and relevant information throughout and across episodes of care and particularly at care transition points.

3.6 Promote systems of communication that improve safety for patients, including safety huddles, rounding and escalation pathways for patient safety risks.

We will measure:
- Staff and consumer experience of communication in Metro North
- Participation in communication skills development training
- Access to safety and quality information for staff and consumers
- Effectiveness and timeliness of handover of care within our services and with care partners including primary care providers.

Strengthen our patient safety & quality improvement culture

4.1 Promote a culture of leadership that is self-reflective, just, transparent, applies improvement and reliability science, and fosters trust, psychological safety and values alignment.

4.2 Embed our Values in Action program to foster a culture where staff are confident to speak up and are supported to challenge the status quo and innovate.

4.3 Build capability and resilience throughout Metro North by implementing contemporary safety and quality programs which are co-designed with clinicians and consumers.

4.4 Promote a culture of organisation wide learning by strengthening systems that share successes and learn from harm.

4.5 Support staff and consumer engagement in patient safety and quality improvement by developing and implementing a digital media strategy.

We will measure:
- Our patient safety and quality improvement culture
- Participation in education and training opportunities which strengthen our culture of leading for patient safety and quality improvement
- Digital media strategy impact

Safety and Quality Units

In Queensland Health, Safety and Quality Units implement, manage, monitor, and report on safety and quality systems to facilitate the realisation of the strategy and to support clinicians, executive and boards to meet community expectations of safe and quality care. These Units can operate at the HHS and or local hospital level.

In 2021, a Safety and Quality Unit should be a multidisciplinary team that is knowledgeable, skilled, flexible, adaptable, capable, and resilient to:

- Support frontline clinicians and managers to collaborate, innovate and improve the safety and quality of care and services provided,
- lead, develop, implement, and monitor more mature patient safety and quality systems based upon best practice and evolving state, national and global reforms,
- improve timely access and analysis of trended clinical data (ward to board),
- support and encourage better person-centred care and consumer engagement,
- employ a balanced approach to ‘what we do right’ and ‘what we do wrong’, in an open fair and just culture.
- model desired practices and behaviours – integrated, collaborative, professional multi-disciplinary team-based services,
- facilitate transparent and accountable ‘ward to board’ reporting of progress against the National Safety and Quality Health Service Standards.
- support the Board, Executive and clinicians to fulfil their statutory obligations and meet community expectations.

Key domains include, but are not limited to:

- Consumer experiences and feedback,
- Clinical incident management,
- Clinical indicators and audit,
- Clinical policies and procedures,
- Patient Safety Alerts (often equipment or medicine recalls) and
- Evidence of continuous improvement against the national Safety and Quality Health Service Standards.

Measuring Safety and Quality

Measurable, evidence-based indicators are used as safety and quality ‘screening tools’ to support clinical governance to identify potential areas of concern and areas of best practice.

Indicators should be regularly reviewed and may change over time as a reflection of the organisation’s evolving risk and service profiles.

Safety and quality performance measures are reported from ward to board reflecting the roles, responsibilities and information needs of the respective people within the organisation. They are monitored and reported at all levels of the organisation and

poor performance should be identified and monitored or mitigated by action for improvement or escalated.

Monitoring and reporting patient safety and quality performance measures informs:

- Ongoing improvement of safety and quality in the health system.
- Enabling comparisons to assist service providers improve their clinical performance.
- Facilitating greater patient choice through the provision of consumer-friendly information to assist with decision-making; and
- Improving efficiency and sustainability of services.

Performance measures include:

- Quantitative indicators that are valid (usually coded), trended and ideally be benchmarked with other health services, and
- Self-reported data or qualitative information.

Performance measures are not stand alone and must be triangulated with other information to identify and prioritise actions for improvement.

Best practice uses Statistical Process Control Charts (SPC) to identify whether the variation of indicators over time is real or by chance. Alternate approaches such as traffic light reports use set arbitrary thresholds for performance. Given that all indicators vary from month to month, traffic light reports can be difficult to interpret to determine whether the change is significant and meaningful. Caboolture and Metro North have a mixture of trended graphs (not always SPCs) and traffic light reports.

Whether SPC or traffic light reports are used to report indicators, unexpected variances should be discussed as part of the Safety and Quality Report at the relevant committee levels within the organisation. Considerations might include:

- potential contributing factors, including but not limited to, data issues, coding, case mix, access, competing service demands, resources, equipment, environment, skill-mix, processes of care, information flows and behaviours, involving clinicians and non-clinicians.
- choosing to monitor or take action for improvement (what is the risk of not acting?).
- documenting improvement actions, timeline, and person responsible as part of meeting minutes.
- providing information to the workforce and consumers eg Safety and Quality Boards.

Governance of Safety and Quality Indicators

The Board have oversight and responsibility for the monitoring of safety and quality systems including the reporting and monitoring of key performance measures and action plans, together with the risk register in accordance with the NSQHS Standards Attestation statement.

The Executive is accountable for leading and ensuring the systems, processes and reporting of safety and quality data is effectively established across MNHHS, and ultimately holds accountability for performance of the services. This accountability

includes ensuring appropriate corrective action is taken and monitored using Directorate and Standard committees action plans, and risks are appropriately managed or escalated in line with the Metro North Risk Management Framework.

The Service Level Director is accountable for ensuring the systems, processes and reporting of safety and quality data is effectively established at Directorate and Ward/ Unit levels. This accountability includes ensuring appropriate corrective action is taken and monitored, and risks are appropriately managed or escalated. Ongoing systems issues that cannot be resolved or mitigated at the local level should be escalated to a higher level of governance.

However, some measures reported to committees can provide false reassurance, including:

- rates of self-reported (not coded) data, such as clinical incidents that are inherently biased are not reliable measures of patient safety,
- trending small numbers is not a reliable measure of patient safety, as the confidence intervals (often not shown in these reports) is so wide that the data are not statistically robust, and
- staff or patient surveys with low participation rates or small numbers are also not likely to be representative of the population of interest and the resultant information is likely to be skewed and or biased.

While, all sources of data and information contribute to an understanding of the safety and quality of care and services provided within organisations, the nature and types of information collected have differing robustness, and replication. Committee members should also be cognisant of the limitations of the data that are presented in reports.

References

[1] Australia Institute of Company Directors. Director Tools. Role of the Board – Governance Relations. Available at: https://aicd.companydirectors.com.au/-/media/cd2/resources/director-resources/director-tools/pdf/05446-3-11-mem-director-gr-role-of-board_a4-v3.ashx

Appendix 2: Acronyms

Abbreviation	In full
MN	Metro North
Ahpra	Australian Health Practitioner Regulation Agency
CAPS	Communication and Patient Safety
CCriSP	Care of the Critically Ill Surgical Patient
CDF	Clinical Development Facilitator
CEO	Chief Executive Officer
CGSQR	Clinical Governance, Safety and Quality, Risk
CH	Caboolture Hospital
CKW	Caboolture and Kilcoy Hospitals and Woodford Corrections Health Centre
CLO	Consumer Liaison Officer
CPD	Continuous Professional Development
CRASH	Communication, Respect, Accountability = Safe Healthcare
DAH	Director Allied Health
DNS	Director Nursing Services
DVT	Deep Vein Thrombosis
ED	Executive Director
EDMS	Executive Director Medical Services
FRACS	Fellowship of RACS
HACS	Hospital Acquired Complications
HEAPS	Human Error and Patient Safety
HHB	Hospital and Health Boards
HHS	Hospital and Health Service
HRT	Health Round Table
HSMR	Hospital Standardised Mortality Ratios
ICU	Intensive Care Unit
IHLO	Indigenous Health Liaison Officer
KPI	Key Performance Indicators
M&M	Morbidity and Mortality
MDT	Multidisciplinary Teams
MNHHS	Metro North Hospital and Health Service
MO	Medical Officer
MP	Member of Parliament
NQSHS	National Safety and Quality Health Service
NUM	Nurse Unit Manager
OHO	Office of the Health Ombudsman
ORMIS	Operating Room Management Information System
PHO	Principal House Officer
PREMS	Patient Reported Experience Measures
PROMS	Patient Reported Outcome Measures

QAP	Quality Action Plan
QASM	Queensland Audit of Surgical Mortality
QH	Queensland Health
RACS	Royal Australasian College of Surgeons
RBWH	Royal Brisbane and Women's Hospital
RCA	Root Cause Analysis
ROTEM	Rotational Thromboelastomertry
RTT	Return to Theatre
S&Q	Safety and Quality
SAC	Severity Assessment Classification
SCIRC	Serious Clinical Incident Review Committee
SCSF	Clinical Services Capability Framework
SIRC	Serious Incident Review Committee
SMO	Senior Medical Officer
SMS	Short Message Service
SORT	Streaming Outpatient Referral Team
SPC	Statistical Process Control Charts
SPR	System Performance Reporting
TPCH	The Prince Charles Hospital
VLAD	Variable Life Adjustment Display