Case WT at Caboolture Hospital October 2022

External Review July 2023

Version 2.0 [clinicians deidentified]

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Metro North Health

Queensland Government

Metro North Health acknowledges the Traditional Custodians of the Land upon which we live, work and walk, and pay our respects to Elders both past and present.

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Part A: Key Events and Recommendations

Opening Statements

WT was nearly 6 months old at presentation to Caboolture Hospital Emergency Department (ED) on 17/10/22. He presented three times over 36 hours with periorbital swelling, a progressive rash, irritability and decreased oral intake. At his third presentation on 18/10/22, his skin was noted to be peeling. A working diagnosis of eczema with potential secondary bacterial infection was made. He was admitted to the Paediatric ward and Paediatric consultant review led to the diagnosis of Staphylococcal Scalded Skin Syndrome (SSSS). He was treated with intravenous antibiotics, nasogastric feeds, oral opioid analgesic, and discharged after 4 days to complete a course of oral antibiotics.

SSSS is a challenging diagnosis to make. It is a rare condition. The diagnosis is made clinically and while laboratory tests can be supportive, they are not diagnostic.

This review explores WT and his family's journey and experience through both their lens and the lenses of the treating clinicians, in order to identify opportunities for improved care. Where these opportunities have been identified, we have also considered what may have been barriers to care.

Key events in care of WT and his family

Clinical phase

Discharge from ED after 2nd presentation on the night of 17/10/22 and after ED assessment and Paediatric review.

3rd presentation on the morning of 18/10/22, delayed by direction at ED triage to attend ultrasound investigation first.

ED and Paediatric registrar review in ED but deferred decision making and delayed Paediatric consultant review on ward, accompanied by Ryan's Rule, and expediting definitive diagnosis and treatment plan.

Parental distress over WT's pain and related concerns that requests for analgesia were not attended to.

Subsequent parental concerns that experience has resulted in feeding difficulties and susceptibility to infections for WT, and to psychological distress for his mother.

Consumer feedback phase

- Family complaints to Caboolture Hospital raised in December 2022 received no response.
- Follow up enquiry by the family in January regarding December complaint was directed to Office of Health Ombudsman (OHO).
- OHO exchange with Caboolture Hospital resulted in a review [not sighted by reviewers] and action items including family meeting.
- Action items included compassion training (attended by three ED staff), recruitment strategy, ED re-design, Metro North Health values education, and case presentation by Paediatrics and ED team. [The objectives and outcomes of some of these actions were unable to be identified by the reviewers.]

Key recommendations

The following Key Recommendations are made:

Key Recommendation	Context and Rationale	Additional notes
Key Recommendation 1 **A fully functioning Paediatric ED as a priority:** **6 acute + 6 paediatric Short Stay Unit (SSU) beds,** **fully staffed by dedicated doctors, nurses and support staff, and without compromising remainder of ED**	On the day of WT's third presentation to Caboolture Hospital ED at 1143h, he was the 9th paediatric patient to present in 90 minutes, and the 12th to present since 0830. There are 6 beds in the Paediatric ED. There was an ED doctor able to be allocated to this area only from 1300h. Paediatric medicine, particularly emergency medicine, is very reliant on clinical observation during the illness journey. There is no space in the current Caboolture ED for extended observation of children. This contributes to challenging shared decision making of 'observe at home' vs 'observe in hospital', as it did for the care of WT at his second presentation. The availability of a Paediatric SSU would provide a safe additional option of extended observation in the context of diagnostic uncertainty and parental concern.	Caboolture saw 64,489 presentations during FY 22-23, 14,280 of whom were 16 years or younger (22.1%). The growth in general ED presentations over the past 5 years has been 18%, with a growth in paediatric presentations of 28.8%. Currently, Caboolture medical staffing does not allow for consistent allocation of medical staff to the Paediatric area. Addressing this deficit would provide consistent service as well as opportunity for staff upskilling in this specialised area. Resourcing of a Paediatric ED would include consideration of: • a waiting room nurse to commence assessment and the observation period, as well as to response to concerns and deterioration.
Key Recommendation 2 **Paediatric ED and ward service delivery to be supported by provision of, and access to, paediatric-specific education and training (including recognitions of Staphylococcus Scalded Skin Syndrome)**	Identified opportunities for improved care of WT included: • perceived delays to clinician engagement with patient and family in ED and on paediatric ward, with lack of early recognition of a prolonged and progressing illness journey • delay to commencing treatment and supportive care prior to definitive diagnosis being made:	The reviewers note that a high-quality education program exists for Emergency Medicine trainees at Caboolture ED, with dedicated teaching time allocated for this purpose, and committed FACEMs to deliver this program. Paediatric Emergency Medicine education for all clinicians is enhanced by the appointment of a FACEM PEM (paediatric emergency doctor). The reviewers also note that substantial enhancements have been made to the nursing education program. A new

	- delay to addressing pain (analgesia at home at 0830h; analgesia on ward 1718h) - delay to commencing antibiotics when working diagnosis made of eczema with secondary bacterial infection. The reviewers note clinicians' careful and repeated assessment focussed on sepsis, but note that the absence of fever may have distracted from recognising serious illness. Upskilling clinicians will also achieve the ability for the Paediatric ED to be staffed by clinicians who are knowledgeable, experienced and confident with paediatric illness, including the recognition of serious illness and deterioration in the absence of clear markers, and utilisation of parents/carers as a core component of the assessment and treatment team. This education and training will be further facilitated by the reinstatement of Paediatric ward-ED nursing rotations.	education framework has been developed through the ED and includes the following actions thus far: - Basic and Advanced workshops for Paediatric Care (3 July 2023) - OPTIMUS Core training is conducted monthly 14 nurse champions for paediatric excellence have been identified as a result of this training and are primarily allocated to the paediatric area in ED - The champions upskill other staff at the bedside using clinical assessment skills - Moving forward, Caboolture Hospital, Kilcoy Hospital and Woodford Corrections Health's (CKW) is an OPTIMUS Prime Directorate and can now provide extended paediatric critical care training in addition to core training. The first CKW-run OPTIMUS Prime course will occur on the 31 October 2023. The recommendation promotes the ongoing provision of this education as well as staff resourcing that provides clinicians with regular and protected clinical-support time to attend these sessions.

<u>Key Recommendation 3</u> **Pending opening of the new Caboolture Hospital ED, the deficit of Paediatric SSU (and ward) beds to be bridged by tight follow up of children who are discharged in following circumstances:** **- diagnostic uncertainly** **- irritable baby** **- worried parents** **- referred for admission by ED and discharged by Paediatric team** **- outpatient investigation booked by inpatient team.** **Resourcing the provision of this follow up will require review and support including funding.**	The experience of WT's family was that at the point of discharge after their second presentation, there was diagnostic uncertainty, a shift in disposition decision between ED assessment and Paediatric assessment, and ongoing parental concern. On the following day, they returned as directed for two purposes: an ultrasound scan, requested by the Paediatric team, and for ED re-assessment due to worsening illness. Despite doing as directed, they had a prolonged and distressing journey in their attempt to re-engage with the health service on their third presentation. Their journey may have been eased and shortened by: • a planned telehealth review of clinical condition • a robust plan for how, where and by whom the ultrasound scan result would be followed • a planned in-person review in ED or the paediatric ward • the formulation of a stream-lined pathway for a recurrent presentation with a progressing illness, with early re-review by the inpatient team.	The reviewers note that the challenge of careful follow up after a visit to Caboolture ED is compounded by restricted access to timely primary care options.

<u>Key Recommendation 4</u> **Patients waiting to be seen in ED Waiting Room to have clear direction (with signage) regarding how to escalate their concerns if their condition worsens.** **Resourcing ED to respond to these escalation e.g. Waiting Room Nurse will require review.**	WT's family had a prolonged and uncertain period of waiting for clinician assessment on their third presentation. They were very understanding of high ED workload and why a space inside the ED was not immediately available. However, they felt unnoticed and unsupported when they were unable to obtain a meaningful response to their voiced concerns, including a request for pain relief for WT. Because the current Paediatric ED is a modified space, in October 2022 there was no easy method for them to attract the attention of clinical staff inside the ED. There is now a doorbell and a Staff Alert button in that area. This recommendation promotes the provision of clear instructions to waiting patients/family on how to escalate concerns, as well as the resourcing of ED to enable responsiveness to these concerns, including re-assessment. The reviewers suggest this would **negate** the need for the proposed extension of Ryan's Rule to the pre-medical-review phase of care, the additional resourcing this would require, and the potential unintended disruption of existing ED triage.	It is recognised that 'poster fatigue' can dilute important messages. The following posters may be considered for the ED Paediatrics Waiting Room: • rashes in children • button battery • sepsis • Ryan's Rule • Indigenous Hospital Liaison Officer (IHLO) service Regarding the activation, response and systems supporting the Ryan's Rule call made in relation to the infant, our review has found no deficits with the process at Caboolture Hospital. Input from the IHLO and the family suggests that awareness of Ryan's Rule should be further promoted by use of permanent posters or signage. The response to the Ryan's Rule was timely and of high quality. The senior paediatric doctor states that he was *en route* to reviewing WT when he received the Ryan's Rule notification, having been delayed by another sick child.

Key Recommendation 5 **Indigenous Hospital Liaison Officer (IHLO) service hours and process to be reviewed and resolved:** **7-day service with extended hours, accurate identification of ATSI patients, reliable notification of ATSI patients to IHLO service.** **It is also recommended that the IHLO service continue to be actively involved in the post-clinical phase e.g. during follow up or complaints resolution.**	WT's family identified as Aboriginal upon their first presentation as well as when they completed the Patient Election Form upon admission. Unfortunately, the IHLO service was only made aware of them on day 3 of their admission, nearly 48 hours after their admission, which included enacting Ryan's Rule. There was also delayed inclusion of the IHLO service during the complaints handling phase. The service provided by the IHLO is vital to patients who identify as Aboriginal and/or Torres Strait Islander, including ensuring the provision of culturally safe and equitable healthcare to this cohort. WT's family have clearly described the benefit of this service during his admission and subsequently, including the linkage with their Child Health Nurse and their invitation to a Community Yarning Circle.	
Key Recommendation 6 **Review of process and resourcing of Complaints and Patient Liaison services at Caboolture Hospital.**	The consumer feedback process related to WT's case has been reviewed separately. The reviewers briefly note that the clinician experience of the WT story is one of doctors acting in good faith (including decision making) within system constraints that sometimes limit options for safe care, followed by lack of a robust and reliable complaint handling process, followed by health service correspondence that suggest causative and contributory factors in WT's care that did not subsequently align with the factors discovered by the review team. The comment that the doctors' actions don't align with health service values were not supported by the reviewers' extensive interviews with the doctors. The reviewers also observe that there appeared to not have been an opportunity for WT's family to tell their story and to feel heard until a late stage of the process.	The reviewers noted factors that may have contributed to the mismatch between the messaging in health service correspondence to the family and the clinician experience: • determining paediatric ward bed status at the time of WT's presentations was challenging (see below) • determining how this factor influenced the admit-discharge decision on WT's second presentation (the clinician feels strongly that it did not) may not have been clear upon initial review. The reviewers have not had the opportunity to further explore this phase of service provision due to staff absence.

	Active involvement of the IHLO service in the complaints phase should occur from the outset. The offer of another professional support person e.g. social worker, cultural support person should be considered in all complaints.	
Key Recommendation 7 **That there is a timely follow up of this review and recommendations to assess how the accepted recommendations have been operationalised and outcomes delivered by Metro North Health.**	WT's family have expressed support for the external review process and have requested that there be a follow up plan to ensure progress and improvements. A key point in their narrative has been the desire of a safe, reliable and high quality health service for their community at Caboolture and surrounds. They are encouraged by the reviewers' synopsis that staff who work at Caboolture hospital have the same desire to deliver and experience such a health service.	
Key Recommendation 8 **That a comprehensive orientation and training manual be developed, along with a defined program of 'onboarding' for all Caboolture Consumer Liaison Officers.** **Caboolture Consumer Liaison Officer are to be provided routine and regular supervision and mentoring.**	The Caboolture Consumer Liaison Officer role during late 2022 was filled by a series of short-term temporary acting incumbents with scant hand-over, particularly in relation to the complaints receipt and management process, the expectations and Key Performance Indicators for this process and the progress of current complaints. Creating a supported environment, including comprehensive onboarding will ensure that these important roles are enabled to be undertaken well at all times.	
Key Recommendation 9 **That Caboolture consumer complaints be routinely monitored by the Director Safety & Quality regarding:** • **the severity rating of complaints,**	The Caboolture Hospital complaints management process is not supported by a robust assurance or monitoring process. There is: • no monitoring of the accuracy of the severity rating of complaints,	

• **the progress of complaint investigation against defined time periods for investigation and response,** • **feedback being provided to the complainant within defined timeframes, including when there has not yet been resolution of the complaint,** • **recording of all actions taken within the clinical incident reporting system,** • **complaints that are still active at 28 days from the date of receipt to ensure that appropriate progress has been made,** • **complaints that are overdue for resolution, and** • **complaints that have been closed without a documented response to the complainant.**	• no tracking of the complaints management process including provision of regular feedback at defined periods, and • no escalation or reporting of deviation from Key Performance Indicators related to complaints handling. Good governance and oversight of the consumer complaints receipt and management system will ensure that the service is able to reflect, learn and respond to the needs of consumers at all levels.	
<u>Key Recommendation 10</u> **That the Caboolture, Kilcoy and Woodford Safety & Quality Committee receive routine reporting from the Director Safety & Quality regarding:** • **the percentage of complaints that are overdue for resolution, and** • **each individual complaint that is overdue for**	The Caboolture Hospital complaints management process is not supported by a robust assurance or monitoring process. There is: • no monitoring of the accuracy of the severity rating of complaints • no tracking of the complaints management process including provision of regular feedback at defined periods; and • no escalation or reporting of deviation from Key Performance Indicators related to complaints handling	

resolution and the reason(s) why, and the plan for finalising the complaint.	Good governance and oversight of the consumer complaints receipt and management system will ensure that the service is able to reflect, learn and respond to the needs of consumers at all levels.	
Key Recommendation 11 **That the Caboolture, Kilcoy and Woodford Performance Meeting routinely report to the Metro North Chief Operating Officer:** • **the percentage of complaints that are overdue for resolution, and** • **the number of complaints that have been closed without feedback to the complainant.**	The Caboolture Hospital complaints management process is not supported by a robust assurance or monitoring process. There is: • no monitoring of the accuracy of the severity rating of complaints • no tracking of the complaints management process including provision of regular feedback at defined periods; and • no escalation or reporting of deviation from Key Performance Indicators related to complaints handling. Good governance and oversight of the consumer complaints receipt and management system will ensure that the service is able to reflect, learn and respond to the needs of consumers at all levels.	
Key Recommendation 12 **That all patients and their families who identify as Aboriginal and/or Torres Strait Islander are to be offered support by the Indigenous Hospital Liaison Officers (IHLO) in the Emergency Department during IHLO service operating hours.**	There was no evidence of the offer of cultural support during any of the three emergency department presentations. Supporting Aboriginal and/or Torres Strait Islander people through the continuum of hospital care enables our patients and their families to use their voice, participate and be heard in their health care journey.	
Key Recommendation 13 **That every admitted patient who identifies as Aboriginal and/or Torres Strait Islander is to receive a visit by an**	There was no record of a referral being made for Indigenous Hospital Liaison Officer support for the family during the hospital admission of WT. There was no evidence of the offer of cultural support until day 4 of the admission of WT, and this occurred	

IHLO within 24-hours of admission. Where the patient is away from their bed, a 'pillow postcard' advising IHLO services available and contact details is to be left.	'incidentally' as the IHLO noticed that WT and the family were present when visiting the Paediatric Unit for another reason.	
<u>Key Recommendation 14</u> **That every complaint raised by a patient / family who identifies as Aboriginal and/or Torres Strait Islander is to be offered support to navigate the complaint process by the Indigenous Hospital Liaison Officers (IHLO).**	There was no cultural support offered to the family during the complaints management process, even when dealing with the OHO complaint. Supporting Aboriginal and/or Torres Strait Islanders through the full continuum of hospital care (including the complaints process when required) enables our patients and their families to use their voice, participate and be heard in their health care journey.	

In addition to the above key recommendations, the review team makes the following Additional Recommendations:

Additional Recommendations	Detail
Additional Recommendation 1 **Follow up for baby WT and bridging his family back to the hospital and health service.**	a. Paediatric OPD appointment/s Concerns include observed sensitivity and distress related to feeding, elements of oral aversion, increased susceptibility to infection, source of Staph that caused SSSS. b. Use of Virtual ED Information about opening hours, service provided, etc. c. Care Plan for WT in The Viewer (formulated by ED, Paediatrics, family and IHLO). *Suggested draft wording: WT presented at age 5 months (Oct 2022) with Staphylococcal Scalded Skin Syndrome. His illness journey was prolonged and difficult due to diagnostic uncertainty in recognising and treating this rare condition. If WT presents to hospital, please carefully consider early senior medical review as appropriate. Please also notify the Indigenous Hospital Liaison Officer (IHLO) of his presentation.* Note: it is NOT intended that the Care Plan direct indiscriminate urgent care – and this aspect has been discussed with and understood by the family.
Additional Recommendation 2 **Paediatric Ward bed capacity to be reviewed**	d. Contraction of Paediatric ward beds in recent months, from 16+ to 12. e. b. Visibility of capacity is opaque i. Occupancy/Capacity graph below (beds available from 2000h-2300h, with patient load increasing from 9-13 patients between 2300h-0000h) is unable to be reconciled with ward report (12 patients – ward at full capacity with 3 nursing staff including Team Leader taking patient load). ii. Capacity is related not only to absolute number of patients but care required: number of parents, ages of patient*, illness types and nursing skill mix. *Ratios are 1:4 for children, 1:2 for infants.

	Data Source: ePADT
Additional Recommendation 3 **Paediatric Ward staffing to be reviewed, especially after hours.**	1400h ED/Paediatric medical review with deferred clinical decision making to Paediatric consultant. Paediatric consultant covering Special Care Nursery + ward + new admissions and another sick patient caused delay in reviewing patient (1800h). Note further delays to oxycodone (1900) and IV cannulation (presumed 2000h), antibiotics (2030, 2100) - likely due to high resource tasks e.g. IV cannulation of sick baby, drawing up antibiotics vs staffing.
Additional Recommendation 4 **ED to establish consistent process to ensure that all patients presenting to ED must be triaged and appropriately assessed.**	
Additional Recommendation 5 **Consider family engagement in local and state-wide initiatives with respect to Staphylococcal Scalded Skin Syndrome e.g. Qld Health Rash poster.**	WT’s family have two stories to share: • their journey with this diagnosis, including their desire to raise clinician awareness, and • the vital importance of considering the parents’ assessment in the clinical assessment of a child (especially in pre-verbal children). Currently they are keen to use their story to promote illness awareness.
Additional Recommendation 6 **Consider guided tour of ED and Paediatrics in 6-12 months’ time to view and showcase improvements.**	Staff, family and community want to restore faith and confidence in their hospital. Opportunity for media outlets to promote the excellent care that is provided by Caboolture Hospital.

The reviewers highlight the following *Areas of Excellence* at Caboolture Hospital:

Paediatric ward care after diagnosis made and treatment commenced. The family described extensive nursing support and compassionate care including holding WT so that his mother could shower or take a break.
IHLO input after link was made. IHLO Stella was particularly commended for her support and advocacy.
An unidentified staff member who offered help/coffee to Brittany in main ED WR/corridor on WT's third presentation.
The family described the ultrasonographer as being kind, gentle and concerned (and reassuring re ultrasound scan preliminary result).
The review team observed active and positive collaboration between the Emergency and Paediatric departments with respect to interprofessional clinical interaction, service growth and development, and efforts to enhance education and processes.
Executive leadership at the level of the Chief Medical Officer in enhancing recruitment efforts in order to stabilise staffing and provide a more consistent and reliable service to the community.
Loyal, dedicated, passionate and committed clinicians within ED and Paediatric teams, including medical, nursing and support staff.

Closing statements

Diagnostic uncertainty is common in healthcare, especially emergency healthcare. Observation periods, serial evaluations and sometimes laboratory and imaging investigations are all useful in obtaining a final diagnosis. Paediatric medicine is particularly reliant upon clinical observation over time, especially for non-verbal children. For this reason, parental observations and concerns about their child's behaviour and demeanour are of vital importance in assessment. The capacity to extend this observation period and travel the illness journey with the patient and family cannot be substituted by intermittent snapshots by different clinicians during the hospital visit.

The safe location for this extended observation – hospital *versus* home – is based on shared and informed decision making between clinicians, patients and families. An ED SSU provides an additional safe option for an extended period of observation without formal inpatient admission.

Where discharge and home-based observation is deemed safe, barriers to follow up should be identified and mitigated. Currently there is limited access to timely primary care follow up, necessitating repeat contact with the hospital. Suggested options for accessible follow up include telehealth review, a clear plan to streamline a repeat ED assessment, and reliable access by ED to inpatient team review. These options, and the other recommendations made, require additional funding and resource to what is currently available at Caboolture Hospital.

When clinical care is compromised, this provides a valuable opportunity to review individuals, team, systems and processes in a just manner. Meaningful review extends to identifying barriers to good and safe care. From the patient perspective, a core objective is feeling heard and then receiving a response that includes an apology, appropriate accountability and a pragmatic and actionable plan for improvement.

The challenges identified by this case review are global health service issues, but are amplified at Caboolture Hospital due to additional and unique demographic and illness profiles, challenging access to primary care, inequitable funding, and barriers to staff recruitment. Despite these challenges, Caboolture Hospital is staffed by health workers who are hard-working, dedicated and committed to the provision of high level care to the community.

Part B: Comprehensive External Case Review

Objectives

The objectives of this review include the following scope:

Independent review of the care and support provided to the infant and his family and of any changes to care processes made since that time.

- Review the clinical care provided to the infant and his family, including timelines and appropriateness.
- Review the management of escalations, concerns and complaints made by the family of the infant.
- Review the activation, response and systems supporting the Ryan's Rule call made in relation to the infant.
- Review any changes made in respect of lessons learned relating to clinical review of the infant's case.

Through a detailed clinical governance analysis and review of the care and support provided to the infant and his family, this review will provide recommendations which focus on ensuring positive patient outcomes and inform ongoing continuous improvement of service delivery for the Caboolture Hospital.

Introduction

WT was nearly 6 months old at presentation to Caboolture Hospital on 17 Oct 2022. He presented three times over 36 hours with periorbital swelling, a progressive rash, irritability and decreased oral intake. At his third presentation on 19 Oct 2022, his skin was noted and documented to be peeling. A working diagnosis of eczema with potential secondary bacterial infection was made. He was admitted to the Paediatric ward and Paediatric consultant review led to the diagnosis of Staphylococcal Scalded Skin Syndrome (SSSS). He was treated with intravenous antibiotics, nasogastric feeds, oral opioid analgesics, and discharged after four days to complete a course of oral antibiotics. Outpatient review in November 2022 assessed him (for an unrelated and prior clinical issue) but noted him to be recovered and he was discharged from Paediatric Clinic.

This report has been formulated using information from the clinical medical record, pathology and imaging reports, documents related to the complaint (Riskman and OHO response), interviews with WT's mother, father and grandfather. The reviewers have also conducted interviews with key clinical staff in the Emergency and Paediatric departments, and a site visit to the relevant areas at Caboolture Hospital, including the Emergency Department, Paediatric Ward and Department of Imaging.

We have been provided with a series of photographs of WT taken by his mother during his acute illness.

SSSS is a challenging diagnosis to make. It is a rare condition. The diagnosis is made clinically and while laboratory tests can be supportive, they are not diagnostic.

Our aim has been to explore WT and his family's journey and experience through both their lens and the lenses of the treating clinicians, in order to identify opportunities for improved care. Where

these opportunities have been identified, we have also considered what may have been barriers to care.

It must be recognised when reading this report that we now have the benefit of knowing the final diagnosis and outcome for WT. Prudent and pragmatic review requires us to appreciate that this diagnosis evolved over a period of time.

It is therefore valuable for this report to include a brief overview of the epidemiology, presentation, diagnosis, and management of Staphylococcal Scalded Skin Syndrome (SSSS). Further information can be found here.

What is Staphylococcal Scalded Skin Syndrome

Staphylococcal Scalded Skin Syndrome (SSSS) is a rare, severe, superficial blistering skin disorder which is characterised by the detachment of the outermost skin layer (epidermis). This is triggered by exotoxin release from specific strains of *Staphylococcus aureus* bacteria. It gives the appearance of a burn or scalding, hence its name.

Its prevalence is reported to range from 0.09 to 0.56 cases per million people with most cases occurring in children less than 5 years (peak age 2 - 3 years).

The initial localised infection often starts from superficial broken skin sites. Toxins then spread haematologically to the skin and target the desmoglein-1 protein in the epidermis leading to blistering and sloughing.

SSSS typically starts with nonspecific symptoms in children e.g. irritability, lethargy, and fever. Within 24–48 hours, a painful widespread red rash develops on the skin followed by the formation of large, fragile, fluid-filled blisters (bullae) which rupture easily. Typical SSSS cutaneous features include:

- Typically starts on the face and flexural regions (groin, axillae, and neck), then spreads rapidly to other parts of the body including the arms, legs, and trunk.
- Following the rash, the formation of large fluid-filled blisters.
- Frequently occur in areas of friction (such as axillae, groin, and buttocks), the centre of the face and body orifices (such as the nose and ears).
- Gentle rubbing of the skin causes exfoliation (positive Nikolsky sign).

Despite the alarming appearance, children with SSSS generally experience complete recovery within two weeks. However, if treatment is significantly delayed or unsuccessful, complications can occur including scarring, water and electrolyte loss, hypothermia, secondary infections, and renal failure. Mortality from SSSS in children is low (1–5%), unless they develop secondary sepsis or have an underlying serious medical condition.

Diagnosis is clinical and based on history and examination. Tests are not diagnostic but may include skin swabs to confirm the presence of *S. aureus*. Respiratory PCR can be helpful to exclude other causes of non-specific symptoms and blood cultures are undertaken when sepsis is of concern.

Key events in the care of WT and his family

Clinical phase:

- Discharge from ED after second presentation on the night of 17/10/22 and after ED assessment and Paediatric review.
- Third presentation on the morning of 18/10/22, delayed by direction at ED triage to attend Ultrasound investigation first.

- ED and Paediatric registrar review in ED but deferred decision making and delayed Paediatric consultant review on ward, accompanied by Ryan's Rule, expediting definitive diagnosis and treatment plan.
- Parental distress over WT's pain and related concerns that requests for analgesia were not attended to.
- Subsequent parental concerns that experience has resulted in feeding difficulties and susceptibility to infections for WT, and to psychological distress for his mother.

Administrative/Complaints phase:

- Family complaints to Caboolture Hospital up to and including December 2022 received no response.
- Follow up enquiry regarding December complaint was directed to Office of Health Ombudsman (OHO).
- OHO exchange with Caboolture Hospital resulted in a review [not sighted by reviewers] and action items including family meeting.
- Action items included Compassion training (attended by three ED staff), recruitment strategy, ED re-design, Metro North Health Values education, and case presentation by Paediatric and ED team. [The objectives and outcomes of some of these actions were unable to be identified by the reviewers.]

Background and Context

Caboolture is a 265-bed hospital supporting Emergency Medicine Mental Health, General Medicine, General Surgery, Obstetrics and Gynaecology, Paediatrics, Intensive Care, and Coronary Care. It has a mixed general Emergency Department (both adults and children), and a paediatric service that supports admission (up to 12 beds) and outpatient appointments. The hospital operated a Paediatric Short Stay unit prior to COVID-19 response which was discontinued during the response to support transmission-based precaution requirements of children during this period. The Paediatric Short Stay unit has not been re-established after the COVID-19 public health emergency declaration was lifted (31 October 2022).

The Hospital Emergency Department saw 64,489 presentations during FY 22-23, 14,280 of whom were 16 years or younger (22.1%). The growth in general ED presentations over the past 5 years has been 18%, with a growth in paediatric presentation of 28.8%.

The Paediatric service delivered 17,163 outpatient occasions of service during FY 2022-2023, and supported 6,869 admissions. The outpatient and inpatient services have seen a growth rate of 31.6% and 20.1% respectively over the past 5 years.

Relevant clinical and treatment issues – see table below.

Composition of Review Team

Clinical Review Team

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Honorary Adjunct Professor, School of Health Science and Medicine, Bond University

Governance Reviewer

Mr Grant Carey-Ide
Executive Director, Clinical Governance, Metro North Health

Methodology

Review of documents:

- Medical records – electronic and written
- Pathology results including blood tests, cultures, and microbiology
- Imaging report
- Riskman entries and OHO response
- Document: SBAR by ED Deputy Director

Interviews with:

- WT's mother, father and grandfather (also attended by Indigenous Hospital Liaison Officer)
- Emergency Department Co-Deputy Director & Staff Specialist
- Paediatric Department Director and two Staff Specialists

Site visit of Caboolture Hospital, including the Emergency Department, Paediatric Ward and Department of Imaging.

Consultation with peer experts re SSSS epidemiology, diagnosis, and clinical course:

- Senior Paediatrician
- Professor of Paediatric Infectious Diseases Physician

Summary of Clinical Case and Subsequent Events

The Clinical Case and Subsequent Events are presented in a chronological timeline, with the reviewers' observations noted. This table can be found in the Appendix.

Summary Stakeholder Perspectives – as interpreted by the review team

WT and his family

WT's family were substantially impacted by the shift in disposition between ED review and Paediatric review at Presentation 2, the delays experienced on presentation 3 from stuttered triage to initial medical review to definitive diagnosis and treatment. This resulted in distress and worry over WT who was irritable and appeared to be in pain. During this time, they felt disconnected from care and unable to make themselves heard. They feel their trust in the healthcare team and system was misplaced. This has caused conflict between trusting their parental "gut instincts" and the judgement of the healthcare team. The lack of an opportunity to discuss ongoing concerns following WT's admission coupled with an ineffective complaints process system has had a significant emotional toll on WT's mother.

Clinicians

The clinicians involved in WT's care and their teams deeply regret WT's and his family's experience and distress during this illness journey. They have reflected and identified areas for improvement and have already commenced work in these areas. It is acknowledged that system constraints substantially influenced the care that was able to be provided, particularly on presentations 2 and 3. The clinicians and teams also described the demoralisation and injury felt as a result of the negative publicity around WT's case. Despite this, they remain committed and dedicated to working at Caboolture and striving to provide high level care to their community.

Summary of Findings and Recommendations

Please see Part A: Review Case WT at Caboolture Hospital – Key Events and Recommendations

Areas of Excellence

The reviewers highlight the following areas of excellence at Caboolture Hospital:

Paediatric ward care after diagnosis made and treatment commenced. The family described extensive nursing support and compassionate care including holding WT so that his mother could shower or take a break.
Indigenous Hospital Liaison Officer (IHLO) input after link was made. IHLO staff member was particularly commended for her support and advocacy.
An unidentified staff member who offered help/coffee to mother in main ED WR/corridor on WT's third presentation.
The family described the ultrasonographer as being kind, gentle and concerned (and reassuring re ultrasound scan preliminary result).
The review team observed active and positive collaboration between the Emergency and Paediatric departments with respect to interprofessional clinical interaction, service growth and development, and efforts to enhance education and processes.
Executive leadership at the level of the Chief Medical Officer in enhancing recruitment efforts in order to stabilise staffing and provide a more consistent and reliable service to the community.

Closing statements

Diagnostic uncertainty is common in healthcare, especially emergency healthcare. Observation periods, serial evaluations and sometimes laboratory and imaging investigations are all useful in obtaining a final diagnosis. Paediatric medicine is particularly reliant upon clinical observation over time, especially for non-verbal children. For this reason, parental observations and concerns about their child's behaviour and demeanour are of vital importance in assessment. The capacity to extend this observation period and travel the illness journey with the patient and family cannot be substituted by intermittent snapshots by different clinicians during the hospital visit.

The safe location for this extended observation – hospital *versus* home – is based on shared and informed decision making between clinicians, patients, and families. An ED SSU provides an additional safe option for an extended period of observation without formal inpatient admission.

Where discharge and home-based observation is deemed safe, barriers to follow up should be identified and mitigated. Currently there is limited access to timely primary care follow up, necessitating repeat contact with the hospital. Suggested options for accessible follow up include telehealth review, a clear plan to streamline a repeat ED assessment, and reliable access by ED to inpatient team review. These options, and the other recommendations made, require additional funding and resource to what is currently available at Caboolture Hospital.

When clinical care is compromised, this provides a valuable opportunity to review individuals, team, systems, and processes in a just manner. Meaningful review extends to identifying barriers to good and safe care. From the patient perspective, a core objective is feeling heard and then receiving a response that includes an apology, appropriate accountability, and a pragmatic and actionable plan for improvement.

The challenges identified by this case review are global health service issues, but are amplified at Caboolture Hospital due to additional and unique demographic and illness profiles, challenging access to primary care, inequitable funding, and barriers to staff recruitment. Despite these challenges, Caboolture Hospital is staffed by health workers who are hard-working, dedicated and committed to the provision of high level care to the community.

Appendix

The Clinical Case and Subsequent Events are presented in a chronological timeline, with the reviewers' observations noted, some of which have been highlighted for further consideration.

Date	Detail	Reviewers' comments
29/6/22 [unrelated] Riskman Received 27/6/22	?date of presentation Exposure to Covid in ED and subsequent baby and mother Covid + (resolved with phone call by staff member 6/7/22 explanation re infection risk processes wrt mixing patients and PPE – mother happy - complaint closed). Phone call 6/7/22. Added issue raised that follow up OPD not yet organised for baby and test results not given as yet. Followed up by staff member by email –arranged OPD appt for 18/7/22. Brittany advised of this, was happy, complaint closed. In interim, attended QCH on 3/7/22 who contacted Caboolture to expedite OPD. Phone call from mother 5/7/22 - not taking formula, unhappy with 24/7/22 OPD - moved to 17/7/22 We have not seen OPD notes.	This is an unrelated presentation but was referenced by the family in second meeting and appeared to have contributed to their perception of lack of coordinated care.
Mon 17/10/22 Presentation 1	Arrival 0821 Cat 3 Seen by ED SMO for RAT 0905 Then by ED RMO 6mo M PHx food intolerances, face eczema Rhinovirus 2 weeks ago Cheese for first time 3d ago	

	2-3d unsettled Eyelid swelling Slight decreased oral intake Rash torso, axillae, mouth, neck Mother concerned “something seriously wrong” CEWT 0 BSL 6.3 [Obs 0850 | 0930] Periorbital swelling Rash Dx allergic rash Considered DDx: Periorbital cellulitis, nephrotic syndrome Notes by ED RMO written at 1244h Consistent with SMO notes Mx Home Antihistamine PO 3d script Safety netted	
Mon 17/10/22 Presentation 2	1915 Time of presentation	**Documentation of observations** The heart rate (HR) is a very useful clinical sign in paediatric medicine. Clinical assessment should always seek to explain a

1915-2343h	Presenting complaint "18/4/22 representation from earlier..." (why is dob on PC? - auto-populates letter) Nursing obs done at 1930 HR 170 CEWT 2 Attempt to do further obs + weigh 3 times but parents refused as baby now settled 2235 final attempt at obs - report unsettled at time of review Medical notes also make reference to 'cluster cares': opportunistic observations in order to minimise distress in an unsettled child. As a result only one set of obs is obtained during this visit Primary Dx: erythematous condition Rapid assessment by ED SMO who did not document assessment and does not recall case 2030 "time seen" 2157 Note written by ED SHO ED assessment: Irritable, flushed Rash, periorbital edema, afebrile and other obs normal 2230 Refer to Paeds 2256 ED in-charge registrar for night shift Received handover and noted WT being reviewed by Paeds Reg	raised HR. It is highly probable on WT's first assessment that elevated HR was due to his irritability. It would have been helpful to measure his HR when he was asleep to check that it normalised. This could be achieved by leaving an oxygen saturation probe attached which can be either continuously or intermittently connected. Listening to the heart with a stethoscope and recording manually may be done without disturbing the child. Respiratory rate can also be documented without touching the child. Recommend clinician upskilling in Paediatric assessment in ED. S/B Paediatric Reg who was a very senior registrar, now a consultant: Advised by Paeds ward Team Leader at start of shift that there were no beds. Came to see patient anticipating admission. However, child settled and had had a feed. Discussed disposition options with family – home vs stay in an ED bed. Paed Reg's perception was that family engaged in shared decision making and opted to go home, with view to return for USS and return if condition worsened. *States that if she felt admission was indicated, lack of beds would have been a barrier*

	Notes irritable For admission Patient Election Form signed by WT's father for Paeds admission on 17/10/22 [Possible that this was initiated by ED on assumption that Paeds would admit W] 2345h Notes: Senior Paeds Reg RV Thorough examination Actively looking for cause of irritability documents no truncal rash, no MSK or abdo cause no features of sepsis Notes report recent rhino virus followed by regular paracetamol and ibuprofen Child is documented as being able to be settled by mother Likely viral ?adenovirus ?mes. adenitis ?intususseption ?gastritis Bloods won't add value [reviewers agree] Resp swab PCR USS tomorrow, form sent Parents keen for home Safety netted	Paeds Reg states she is very experienced with safety netting patients being discharged and would have done this carefully. States there did not appear to be resistance by parents to take child home. States rapport was good. States she had access to consultant but did not feel need to discuss patient as decision making was clear. Put patient details into handover sheet for morning team for awareness that a child was returning for USS (albeit with no clear plan for checking the result) and would re-present if condition worsened. Likely Dx viral illness. The review team note thorough examination documented by the Paediatric Registrar who is actively seeking to clinically exclude conditions which are causing the irritability. Importantly clinically meningitis, sepsis and an acute abdomen are excluded. It is documented that there is no extended rash. During this assessment, WT is initially settled, awakes crying but Mother can settle him back to sleep. The working diagnosis includes a viral infection such as adenovirus, mesenteric adenitis, intermittent intussusception. There are 2 types intussusception: one involves the small intestine (ileo-ileal) and needs no intervention and another type which involves the large bowel (ileo-colic) which may require early intervention. Diagnosis is made by USS, the urgency of which is determined by the clinical pre-test probability of an ileocolic intussusception. The documented assessment supported USS on the following morning and this is requested. The reviewers note that SSSS has not been considered in the differential by any clinicians on this second presentation. The review team feel this is understandable given SSSS is an

	DC at 2343h Mother's recollection of this Paeds consult was as follows: • states that WT seen by 'paediatric specialist doctor' in ED, that she saw the photos of W's progress • felt that ED nurses had expressed concern re W's clinical condition • states advised that there were no beds and could not be kept overnight • states father asked about blood test but told it would not be helpful • states mother asked about staying in, including in ED bed, and advised there were no beds • states they were advised there was "nothing wrong with him", impression that abdominal causes would be explored (USS), and that he was safe to go home • diagnosed with eczema, given script for steroid cream • left ED around midnight	uncommon diagnosis and the limited specific clinical signs present. Whilst there is perioral dermatitis there is no documentation of it appearing infected. In addition, there is no widespread sunburn rash and widespread skin peeling. In retrospect the family feel they had first noted peeling of skin on the face and body rash around this time. The Paediatric Registrar determines that blood tests will not aid in diagnosis. The reviewers agree as SSSS is a clinical diagnosis. The review team have observed a malalignment between the clinician and the family in the perception of the seriousness of WT's condition and the judgement of whether he requires admission. Shared decision-making re patient disposition was influenced by: 1. Lack of optimal option of paediatric ward bed and remaining options of observe at home vs observe in ED bed 2. Initial expectation by parents that WT was to be admitted on basis of 2nd presentation, ED referral to Paeds (documentation of irritable child and concerned parents; wider window of child's clinical evolution), completion of Patient Election form 3. Apparent ED decision to admit reversed after being seen by Paed Reg Recommendation of a Childrens ED SSU. Recommendation of an interim plan for comprehensive and reliable safety netting of children discharged with uncertain diagnosis and parental concern eg accessible paediatric

		review on following day via telehealth or in-person review on ward or ED. We note that this year the Paeds team have developed their Handover Folder to include tighter processes for follow up of patients or results.
Mon 17/10/22 2nd presentation to ED – DC letter	Letter written by ED SHO (as per print under signature line) and signed by Paed Reg Re-presentation: Swelling improved after antihistamine Facial rash (mouth and ears) Irritability Afebrile Feeding well PU, BM ?abdo pain: ?mesenteric adenitis ?intussusception ?due to ibuprofen Omeprazole Parents keen for home Live close by Will re-present prn	

	USS tomorrow GP letter given	
17/10/22	2356h Resp swab negative	
18/10/22 Mother's recollection of events (from her perspective)	Concerned that WT was worse on Tuesday morning, unsettled night, appeared to be in pain, decreased oral intake Expecting phone call from USS but not received. Contacted USS around 0800h – told no request received but would chase. Phone call from USS 0900h to attend scan at 1100h 1000h Attended ED ?seen by triage admin or nurse – told to go to USS as it was in different area and if she didn't attend there first, her episode of care would be complicated. Asked could she be seen in ED and then attend USS from there; told this could not be done Worried about WT being able to tolerate USS Sonographer was gentle, kind and concerned Reassured her that, pending report, USS exam was reassuring Returned to ED 1143h – triaged Cat 3 and sent to Paed ED WR Obs 1200 – upon BP check, noted skin peeling Struggled to settle WT, was pacing corridor, felt unable to get help or attention as their concerns for WT increased	Triage nurse on that day triages WT at 1143 Has been asked by NUM re earlier presentation at 10am - no recollection of this [unable to establish whether 10am interaction was with RN or AO] Agreement by ED that what should occur is re-triage: review, obs. Perceived inability to escalate concerns while in Paeds ED WR DW ED Co-deputy Director: Currently, if concern by triage or pivot nurse, taken to bed inside ED Previously, child would then wait in main ED WR for CIN prior to streaming to Paeds ED WR Pivot model: truncated triage (no obs), streamed to Paeds ED WR then CIN. ?merit of dedicated Paeds ED WR nurse Doorbell and staff alert button visible but no specific orientation of patient/family.

	Father "bashed on window" to get medical attention, snuck in while door was open, asked nurses for panadol/nurofen - advised would be done but nurses never came back S/B ED nurse 1350h Got bed 1403h S/B ED doc Moved from ED to Paeds ward by wardie Eye-balled by nurse, but no obs or assessment Placed into small room (in PeSSU), door shut, waited 1hr Father asked for panadol, nurofen – given 1800h saw Ryan's Rule poster – Father called the number SB Paediatric Consultant No exact Dx but ?SSSS "in 5 min": swab of pimple and eye, NGT, bloods, IV antibiotics, endone Due to Covid restrictions, state father could not stay overnight, grandparents could not visit [NB Covid restriction were not active at this time].	History of this area: Originally FT and FT WR 12 months ago, FT moved, 6 beds converted to Paeds ED
18/10/22 USS abdo	USS abdo Requested time on report: 1100h Signed at 1445h	Paeds team: if an USS is booked from ED for a patient being discharged, patient will typically return to ED for result and follow up. They will also put it on their team "to do" list for FU by team the next day. Unclear whether this was planned on this occasion.

	Limited scan – nad No intussusception No enlarged LN	Paed able to conduct a ward review but ED happy to accommodate patients post inpatient-team-requested investigation but with easy-access inpatient input as indicated. Agreement by ED and Paeds re above Strong recommendation that if a follow-up investigation is arranged by an inpatient team during a patient's ED visit, the inpatient team is responsible for communicating and co-ordinating with the patient/family the timing and results follow-up. Discharge instructions should include option to contact team via phone call if condition changes/worsens. 2023: Paeds now have a handover folder: Handover sheet at front of folder Allows documentation eg of phone calls to family Lists patients to be follow up; action items eg check micro
18/10/22 1143h – ED Triage and Care	1143 Triage PC: "18/4/2022 - representing with poor oral intake ?allergy with rash to mouth. Attended USS this AM. Mother requesting admit" W is documented to be bright and alert 1200 Obs/CEWT normal: afebrile, normal HR documents that paracetamol last given 0830	Possible that lack of fever plays contributes to lowered sense of urgency Likely knowledge gap here for ED (junior reg) and Paeds (PHO) who review in ED No medication/analgesia given in ED: Paracetamol at home 0830h

	1350 Next set of obs and report by RN Red rash and swelling to entire body – angry and spreading "crying ++ when skin touched" 1356h Notes by ED junior registrar ?Time seen USS report noted 1423 Notes by ED junior registrar Notes erythema Rash peeling around eyes Imp: ?severe eczema w potential secondary infection Paeds RV	Paracetamol on ward 1718h (opportunity to alleviate distress despite uncertain diagnosis)
18/10/22 1430h Paeds admission in ED	1430h Notes: Paediatric PHO and Intern Dx likely eczema to face and abdo with ?superimposed infection Decreased oral intake Rx admit Consultant RV of rash ?NGT Fluid balance chart ?bloods + antibiotics	WT seen in ED by a junior paediatric trainee. Consultant received phone call ?soon after review, requested to review patient. Was busy in SCN, checked that safe for patient to wait for an hour (advised yes); did not realise wait was actually 3.5h (was busy with sick baby in SCN). Was en route to ward to review WT around 1800h when got call from Bed Manager re Ryan's Rule.

	1500h PHO notes Notes for same review: Increased rash, irritability "No infective symptoms Non-toxic Well hydrated" ED Obs 1450 Paeds ward Obs 1650	Access to Paed consultant RV is typically easy: 2 x SMO on each day 1 covers SCN until lunch The other then covers At 1600h the day SMO may continue until morning, or another may take over
18/10/22 1718h Admitted to ward	Eye swabs and chlorsig commenced	ED to Paeds ward handover: Ideally, paeds RN will attend ED to receive handover of patient – this was variable last year due to Covid, etc. but is more consistent this year For sick patients, Reg/SMO will also review in ED prior to transfer NUM coordinates staffing and typically ensure nurse:patient ratios are standard including in PeSSU area
18/10/22 1800h Ryan's Rule	Ryan's Rule telephone record – documented as "around 6am" but actually around 6pm (Note, subsequent complaints state R/Rule called around 1630) Phone call by father: Child admitted	Consultant Paediatrician notified and reviewed On call Nursing Director notified and saw Father – stated he was happy with response

	Concern re no clear clinical picture No blood test Has not fed since 11am Last review was 2 hours ago Mother distressed Riskman Received 19/10/22 Entered 19/10/22 Feedback report: Ryan's Rule 6pm Clinical concern No specific Dx ?bloods, ?NGT No intake since 11am No timely action given this concern [presumably not effective to communicate with staff on ward so called R Rule?] Response: Paed consultant RV IVC Bloods IV ab's NGT	Follow up with father at 2100h – happy with result

	Parents happy with management and care	
18/10/22 1845h SMO review (Batista)	(Delay due to busy with another patient) Very unsettled, distressed HR 160 CR 1-2 sec Pustule R cheek, tender LA cream – skin peeled off easily Suggestive of Staph Scalded Skin syndrome NOT suggestive of allergy Rx: Oxycodone IVC Bloods Cheek swab NGT IV flucloxacillin + lincomycin	Paediatric consultant's assessment recognised parental concern + unexplained pain as marker of significant illness (works on Sepsis Collaborative) Paeds team internally discussed this case during WT's admission, given his relatively rare Dx: PHO approach to assessment seemed sensible Investigations may have been commenced earlier and not deferred to consultant Global delay to provision of analgesia: • Paracetamol given at home 0830 • Paracetamol 1700h • Ibuprofen charted but not given • Oxycodone 1900h IVC appears to be inserted 2000h (time of blood test) Antibiotics Fluclox 2030h Lincomycin 2130h Note time taken to cannulate a baby, insert NGT, draw up antibiotics – this is a resource intensive task that requires a number of skilled staff to complete

18/10/22 1630h R eye swab	S. aureus	
1930h BC	No growth	
1940h swab wound cheek	S. aureus	
2000h and 2013h VBG	Compensated metabolic acidosis with lactate 3	
18/10/22 2003h blood test	CRP < 0.5 WCC 19.7 Neut+ lymphocytes with normal film	
19/10/22	0120h Note by Paeds Reg from Presentation 2 in ED decreased frequency of BP checks to minimise W's distress "apologised for no bloods/antibiotics yesterday" Documented that mother states that there was rapid progress including evolution of rash between Presentation 2 and 3	
19/10/22 2243h blood test	CRP 0.7 WCC 15.7 [why were these repeated after 2.5h?]	

20/10/22 1319h Indigenous Liaison Officer chart entry	Contact numbers for cultural support given	Family identifies as Aboriginal on Patient Election Form. Process of transfer of this information to IHLO is being reviewed. IHLO delayed notification: NB nearly 48h since admission > 36h since Ryan's Rule Indigenous Hospital Liaison Officer (IHLO) service: 2 staff members Mon-Fri 0700-1600 + sometimes A/H cover to 2000h if staffed Saw WT on 20/10/22, d3 of admission No IHLO at meetings until last meeting with Grant and Jackie.
21/10/22 1015 Consultant WR	Rash improved Dietitian referral (?why) NG out	
22/10/22 Ward discharge	0845h WR Paediatrician DC on 10d oral cephalexin Return if concerns "decontaminate both [illegible]"	Was this "decolonise for staph"? Not mentioned in DC summary – Paeds states unlikely to have been done as meds not prescribed upon discharge. Typically conducted for MRSA/MSSA or recurrent infection.

	DC at 1045h	
Discharge Summary	Discharge Summary: Admitted 18/10/22 1438h Discharged 22/10/22 1000h Worsening facial rash, periorbital swelling, rash to torso and limbs, more irritable, decreased feeds Dx Staph Scalded Syndrome (underlying facial eczema) Rx IV flucloxacillin and lincomycin NGT feeds Analgesia incl oxycodone DC on cephalexin, QV cream, safety netted	
22/10/22 Riskman (compliment) Received 22/10/22 Entered 28/10/22	Mother: Thank you for outstanding care from nurses/paed team during 5d stay	
22/10/25 Riskman (query) Received 25/10/22	Mother Enquiry re blood test and ongoing ab's after DC on 22/10/22.	

Entered 26/10/22	Advised FU with GP for above after 1 week but unable to get GP appt and Mother quite distressed Response: Mother's details given to Paeds day reg to contact mother and discuss Mother advised of above [??response - MOTHERstates was advised not required]	
xx/10/22 CEO email (Kym Ball)	2d compassionate leadership workshop with Mary Freer 50 leaders from CKW Incl 3 from ED (ED DON, ED medical director, Dr Sean Clarke)	It is unclear how this related to the complaint. It precedes any formal complaint response process. What was the objective of this? Did Cab think that lack of compassion was a barrier to W's care? Was objective achieved? (Attended by 2 senior ED doctors, 1 senior ED nurse, 1 senior Paed doctor)
22/12/15 Riskman (complaint) Received and entered 15/12/22 [2 months post admission]	Summary: Missed Dx of Golden Staph 17/10/22 Px to ED 0821 Assessed 0910 Dx allergy Reviewed 1244 Antihistamine, DC, safety netted 17/10/22 Px 1915 Seen 2157	This is the first documentation of 'no beds'

	Referred to Paeds 2230 Notes to admit to Paeds but parents told there were no beds so felt they had to take WT home Re-Px advice for next AM if worse 18/10/22 USS attendance 18/10/22 Representation to ED 1143 Assessed 1356 1423 Asked for Paeds RV Skin peeling with obs Refusing bottles Called R/Rule mid afternoon after moving to Paeds ward: weak cries, eyes rolling in back of head Paed RV 5min after R/Rule Dx golden staph infection IV ab's Endone NGT Swabs Mother feels it took 3 presentations and R/Rule to be taken seriously Feels if hadn't called R/Rule (as seen on poster) pt may have had negative outcome or loss of life	

	Mother has had to organise psychology appointments and meds to manage anxiety when anything happens to WT after being dismissed because of ‘what ifs’ Original complaint closed as patient happy after R/Rule but Mother wants review of treatment received in ED Feels child different since illness: won’t take oral meds, difficulty with fees as doesn't like anyone near his face. Won’t take bottle. States Child Health Nurse has noticed difference States IHLO reviewed on ?day 4 [it was day3]; IHLO had not been notified they were there; encouraged by IHLO to make complaint Response: forward to ED for review and response Actual outcome: “Closed - refer to OHO case 4855734”	
?25/11/22 Paed OPD	Hand written notes by Paediatrician ?OPD ?date Notes with stamp 25/11/22 ?follow up	
1/12/22 OPD Correspendence	Correspondence from Paediatrician to GP from OPD visit 25/11/22	Paeds Team very willing to provide and coordinate follow up at Paeds Clinic

	• GOR, not on meds • recent Staph Scalded Skin Syndrome • well since • cough, GP placed on augmentin prior to OPD • 85-97th centile weight • discharged from Paeds OPD, happy to see if concerns Mother's recollection: Had Paeds OPD Dec 2022: focussed on previous medicated formula, no opportunity to discuss SSS, no further FU [Would value Paediatric clinic connection for ongoing monitoring and care] Visits from Child Health Nurse (via Indigenous services): monitors WT's development; referred mother to counselling. Mother has had dialogue with CE re ongoing care – has been offered whatever WT needs, but does not know what he needs or how to access it.	
31/01/23 Riskman (Complaint) Received 31/1/23 Entered 1/02/23 From OHO	24/1/23 Verbal complaint from mother Noted: • states told to get USS 18/10 before could be seen in ED [??] • Rx included IV fluids [?] • states complaint put in [?when ?15/12/23?] but no response by 19/1/23] • she followed up and was given OHO number to call	

Seeking

- compensation for undue stress and anxiety cause to a first time mother
- apology
- process change to avoid future harm to others
- hospital and doctors to be held accountable for decisions made

Response:

1/12/23

A/CNC CLO phone Mother to acknowledge OHO case and apologise for delay in response

Discussion covered:

- mother still having difficulties
- R/Rule good response
- had been requesting pain relief from nursing staff but no one was helping WT

Mother requested family meeting

Entry also says:

- response reqd by 3/2/23 (ie in 2d)
- original complaint Oct [we have no documentation of a complaint in Oct – only the Thank You and then the concern re access to GP; does this refer to the Ryan's Rule??]
- second complain Dec – no response

	Concerns re ED greater than Paeds (R/Rule resolved Paeds concerns) [this is curious as Paeds saw in ED at 2nd and 3rd presentations after referral made?] **14/2/23** Medical record and imaging sent to OHO **15/2/23** CNC CLO phoned Mother to advise responses are with OHO and should have feedback over next few weeks Advised processes would be implemented to prevent future such scenarios [what processes?] Offered family meeting – accepted by mother and advised would be arrange **15/2/23** "Closed - completed"	
22/2/23 Letter from CE	Letter from CE to father and mother Apology Dates of Px to ED 1 Oct [presumed typo] Full clinical RV has been conducted Should have been admitted 17/10 Dir of Paeds to present case at Unit meeting • early signs of SSS • how to escalate incl bed availability Discharging a patient that needs treatment is not in line with Metro North Health's values	Statement that organisation does not endorse clinician actions • were barriers explored? • what actions were taken to address this? • what would happen today if Presentation 2 were to occur Unable to be explored due to staff absence See notes under Recommendations re bed availability.

	Dir of Paeds and Dir of ED offer family meeting (CLO to contact and arrange)	
02/3/23 Outcome of OHO Review	Complaint review by OHO: no further action • Noted delay in Cab response to original complaint Oct 2022 due to failure in normal procedures -> CNC now appointed • [?which was complaint in Oct 2022; was it the Ryan's Rule?] • Re prevention of future cases: • case Px to increase awareness incl escalation/admission • noted nursing staff not escalating patient concerns -> Mary Freer compassion training • [this is unlikely to have been the barrier, or the solution] • ED undergoing change management -> Metro North Health Value team to deliver education [unclear re objective, plan and outcome] • - satisfied that Metro North Health has implemented improvements	[were family aware of this outcome prior to family meeting?]
29/3/23 Family Meeting	CLO Notes : Mother Grandfather A/Director of Medical Services Director of Paediatric Co-Deputy Director of Emergency Medicine Nursing Director A/CNC Consumer Liaison Officer Full clinical investigation including ED and Paeds was conducted [we have not seen documentation of Paeds RV]	

	Feedback presented at this meeting: • delayed Dx of SSS (and explanation re SSS) • R/Rule current process at CAB under review [why?] • concerns raised about staff attitude – advised Compassion workshops had commenced in ED for all staff in March and will be ongoing • identified staff shortages at time of Px -> recruitment process commenced Feb 2023 [?outcome of recruitment] • acknowledge Caboolture has high volume patient which impact waiting time – info provided re new ED • [not clear that ED wait time was a key concern? More concern re inaction after RV?] • ED and Paediatric doctors provided information re what actions being taken as result of Ix [what were these?] • education of staff, case presentation ED and Paeds to increase awareness of SSS • paediatric processes being reviewed within ED Actions: • mother provided details of CLO and to contact if needed • mother and GF expressed to CLO that they were satisfied with response received • mother provided with info re Right to Information and Privacy Access • A/DMS to refer to Brittany to counselling services [?curious re appropriateness of DMS referring person who is not a patient of the DMS in this context? More appropriate for GP to do this] Mother's recollection: Mother was offered advice on how to communicate with health professionals in future in order to have needs met.	

	Subsequently, advised by CE and Board Chair that they should have been made aware of the complaint prior to escalation. Feels "no one has said sorry"; "no one has taken responsibility".	
23/6/22 Review and Report by ED Co-deputy Director	Incident 17, 18 Oct 22 Review completion 9 June 2023 NB WT was 6mo, not 9mo as written on report [not significant for purpose of review] Report appears to have been written on basis of documentation RV and investigation results 3rd presentation to ED 18/10/22 Px to ED triage but advised to get their booked USS first [unable to obtain further clarity re this] Reference made to aspects that require Paeds input (*) denotes 'minor additions' as per foot note but they appear to be significant points that potentially impacted assessment and management	ED CHALLENGES Access block ++ Medical staffing: Low absolute numbers V low numbers within Metro North Health dashboard (reg + rmo per 10000 ED presentations) • no current workforce sharing Typically have 1-2 reg/shift between Resus|Acute|Paeds|FT|Patient TF for ICU/Cath/Subspec Do 1:2 nights Night has 2 reg, 3 sho Needs 4 reg per shift E/L Shortages are related to funding + recruitment Rely on locums + significant incentives by CMO (overtime + fuel + locum gap ($30); 15% above award payment for reg/PHO; $100/day for accommodation/access to house. Need stable reg numbers for 1-2 years to establish and consolidate training experience (already has excellent training program and education – need better rostering/workload/experience from operational viewpoint).

		Specific to WT: Currently no consistent nursing workforce that is skilled, experienced and comfortable with looking after children (work commenced e.g. ED RN rotation to Paeds ward, education packages and delivery). External challenges: High acuity; High prevalence chronic disease; Primary health and access not optimal. Also note DMS turnover has hampered ED from achieving traction or stability wrt staffing and general development. New ED is an opportunity for development of service Paeds ED - 12 beds 6 acute 6 PeSSU – to be opened later Need full function from outset wrt space and staff (Reg + SHO/NP with SMO oversight) SMO cover via general FACEM pool 1 x PEM 0.5 FTE (?need another PEM for building this service)

Part C: Consumer Feedback Process

Patients and their families are enabled to provide feedback about their experience of the care provided in Metro North Health through a variety of mechanisms, described in the Metro North Procedure 'Consumer Feedback (compliments, complaints & suggestions) – 003851'.

The procedure identifies the processes to be followed with prescribed timeframes when patients or their families make a complaint about the care provided. Part 4 of the procedure clearly articulates the principle that the organisation should "Respond swiftly and constructively to the feedback and concerns of consumers".

Two key timeframes are defined relating to complaints management:

1. Consumer complaints are acknowledged within 5 calendar days of being received.
2. Consumer complaints are responded to within 35 calendar days of being received.

The procedure also defines a severity assessment rating to be applied to the complaint, as follows:

a. *Negligible* – no impact or risk to provision of care or the organisation

b. *Minor* – Issues not causing lasting detriment that can be or should be investigated and resolved at the point of service

c. *Moderate* – Issue not causing lasting detriment that may require (for example, about organisation or professional issues, communication and practice management issues that are repetitive or not minor in nature)

d. *Major* – Issue causing lasting detriment that requires investigation (related to standards, quality of care or denial of rights)

e. *Extreme* – Issues about serious adverse events, sentinel event, long term damage or death that require formal investigation.

This procedure has been referenced as the authoritative document for this review of process relating to a complaint made to Caboolture Hospital by Mother of WT relating to the care provided to her son, WT in the Emergency Department over the period 17 October 2022 to 18 October 2022 (noting that WT remained an in-patient of the Caboolture Hospital Paediatric ward beyond that date).

The complaint to Caboolture Hospital

On 15 December 2022, Mother contacted the acting Consumer Liaison Officer at Caboolture Hospital by telephone to make a complaint about the care provided to her infant son, WT. The complaint related specifically to the Emergency Department at Caboolture Hospital, and to three separate Emergency Department episodes over two consecutive days – 17 and 18 October 2022.

Mother expressed her concerns about access to care and wait times for care, inadequate / inappropriate assessment of WT's illness, and treatment provided in the department. She also raised concerns that they had not been provided with the support of an Indigenous Hospital Liaison Officer until the fourth day of WT's in-patient admission, and not at all within the Emergency Department presentations.

The complaint was recorded in the Queensland Health incident management system, 'Riskman'. In accordance with the timeframes defined within the *Consumer Feedback* procedure, the due date was recorded as 19 January 2023. The complaint was severity rated as 'minor'. Mother was advised that she could expect to receive a response to her complaint from Caboolture Hospital on or prior to 19 January 2023.

The complaint was sent, through the incident reporting system, to the Emergency Department for their review of the care provided and development of a formal response. The complaint was first viewed by the Emergency Department on 15 December 2022, the date the complaint was received. It was then viewed again on 12 January 2023. There are no journal entries recorded within the incident management system from the Emergency Department, nor after 15 December 2022 by any other department.

There is no evidence that the lack of a response to the complaint from the Emergency Department was escalated for attention, nor that the overdue status of the complaint was monitored and/or actioned by the Safety and Quality Unit at Caboolture.

The complaint was recorded in the incident reporting system as 'closed' on 15 February 2023, with a comment recorded 'refer to OHO case'. This is likely a reference to a subsequent complaint made by Mother to the Office of the Health Ombudsman relating to the same matter.

There is no record within the incident reporting system that Mother was advised that the complaint was being closed, nor of any formal response to her.

Throughout the timeframe examined in this review, there was a short-term acting Consumer Liaison Officer in place. She assumed the role from another short-term acting Consumer Liaison Officer. She reported that her handover was brief, from one acting Consumer Liaison Officer to another, regarding processes for managing consumer feedback, particularly complaints. The process for mentoring, supporting, and supervising the work undertaken by this officer is unclear. This complaint was closed inappropriately, without review and response from the Emergency Department, and without any response to Mother. The decision to close the complaint was made by the acting Consumer Liaison Officer who incorrectly believed that the submission of a complaint to the Office of the Health Ombudsman negated the complaint made to Caboolture Hospital.

It is also unclear if complaints were being monitored within performance meetings, both at Caboolture Hospital Emergency Department level and Caboolture Hospital Safety & Quality Committee.

Identified issue 1

The complaint made by Mother was rated as 'minor' against the severity assessment scale. The complaint should have been rated as 'major' as the complaint related to quality of care and had the potential to cause lasting detriment.

Identified issue 2

The complaint was not monitored for compliance with the timeframes required for resolution and feedback to complainants.

Identified issue 3

The complaint was inappropriately recorded as closed, despite their being no review recorded and no response to Mother developed or provided.

Identified issue 4

The training, mentoring, monitoring and supervision of acting Consumer Liaison Officers has been inadequate.

Identified issue 5

The monitoring of complaints from the time they are lodged until they are appropriately closed has been inadequate.

Identified issue 6

The monitoring of complaints in performance review meetings has been inadequate. Routine and regular monitoring of overdue complaints should occur and be reported, with defined remedial actions recorded and monitored.

Recommendations

1. A comprehensive training manual be developed, along with a defined program of 'on-boarding' for all Caboolture Consumer Liaison Officers.
2. Caboolture Consumer Liaison Officers be provided routine and regular supervision and mentoring.
3. Caboolture consumer complaints be routinely monitored by the Director, Safety & Quality regarding:
   a. The severity rating attached to complaints.
   b. The progress of complaint investigation against defined time periods for investigation and response.
   c. Feedback being provided to the complainant within defined timeframes, including when there has not yet been resolution of the complaint.
   d. Recording of all actions taken within the clinical incident reporting system.
   e. Complaints that are still active at 28 days from the date of receipt to ensure that appropriate progress has been made.
   f. Complaints that are overdue for resolution.
   g. Complaints that have been closed without a documented response to the complainant.
4. The Caboolture, Kilcoy & Woodford Safety & Quality Committee receive routine reporting from the Director, Safety & Quality regarding:
   a. The percentage of complaints that are overdue for resolution.
   b. Each individual complaint that is overdue for resolution and the reason(s) why, and the plan for finalising the complaint.
5. The Caboolture, Kilcoy & Woodford Performance Meeting routinely report:
   a. The percentage of complaints that are overdue for resolution.
   b. The number of complaints that have been closed without feedback to the complainant.

The complaint to the Office of the Health Ombudsman

On 24 January 2023, Mother made a complaint to the Office of the Health Ombudsman about the care provided to her son in the Emergency Department at Caboolture Hospital. At a family meeting between WT's grandfather, the Chief Executive of Metro North Health, and the Acting Executive Director – Clinical Governance for Metro North Health, Grandfather advised that Mother had made the complaint to the Office of the Health Ombudsman because she had not received a response to her complaint to Caboolture Hospital by the date she was advised.

The Office of the Health Ombudsman wrote to Metro North Health providing them with the complaint and requested a response. Caboolture Hospital, through Metro North Health, provided:

- Medical imaging and reports
- Medical records
- A written submission in response to the complaint made to the Office of the Health Ombudsman
- A copy of a letter from the Chief Executive, Metro North Health to Mother, dated 22 February 2023, including an apology for the distress experienced relating to WT's care.

On 2 March 2023, the Office of the Health Ombudsman wrote to Metro North Health to advise that no further action was to be taken on their part, and the complaint to them was now finalised.

In that written submission, Caboolture Hospital advised they would contact Mother to offer a family meeting. This offer was accepted, and a family meeting was held on 29 March 2023.

The meeting was attended by WT's Mother, Grandfather, the Acting Director of Medical Services for Caboolture Hospital, the Director of Paediatrics for Caboolture Hospital, the Co-Deputy Director and Staff Specialist of the Caboolture Hospital Emergency Department, the Nursing Director of the Caboolture Hospital, and the Clinical Nurse Consultant/Consumer Liaison Office, Caboolture Hospital. The purpose of the meeting was to provide feedback arising from a 'full clinical investigation' of the care provided to WT in the Caboolture Hospital Emergency Department and Paediatric Unit.

Cultural Support

At the meeting between WT's Grandfather and the Chief Executive held on 26 June 2023, Grandfather expressed his concerns about the absence until the third day of WT's in-patient care of cultural support through the services of the Indigenous Hospital Liaison Officers. WT's Mother also recorded this aspect of her experience in her complaint made to Caboolture Hospital on 15 December 2022. This contact on that date was 'accidental', with the Indigenous Hospital Liaison Officer visiting the Paediatric Unit and noticing that Mother and WT were present, rather than by any referral process.

There was no record of a referral being made for Indigenous Hospital Liaison support for Mother, Father or baby WT.

Identified issue 7

No evidence of the offer of cultural support was identified in the health record until Day 4 of WT's hospital admission, nor was a record of referral for such support found.

Recommendation

6. All patients and their families who identify as Aboriginal and/or Torres Strait Islander are to be offered support by Indigenous Hospital Liaison Officers (IHLO) in the Emergency Department during IHLO service operating hours.
7. Every admitted patient who identifies as Aboriginal and/or Torres Strait Islander is to receive a visit by an IHLO within 24-hours of admission. Where the patient is away from their bed, a 'pillow postcard' advising IHLO services available and contact details is to be left.
8. Every complaint raised by a patient / family who identifies as Aboriginal and/or Torres Strait Islander is to be offered support to navigate the complaint process by the Indigenous Hospital Liaison Officers (IHLO).