Caboolture Hospital Paediatric Review

Summary of findings and recommendations

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The review found that Caboolture Hospital's care is clinically sound, however there are staffing, reporting, and cultural improvements to be made which would improve the experience and outcomes for children under 16 and their families.

The report identified that while there is an increasing number of children attending the emergency department, performance measures are not specific to children, and there does not seem to be adequate recognition of paediatrics as a speciality. It highlighted that the paediatric waiting area and outpatient area are not fit for purpose, that there needs to be better attention to and pathways for the escalation of serious illness or parental concerns, and that more dedicated paediatric clinicians and more training opportunities are needed, as well as a health service wide approach. It acknowledges the challenges in recruitment and retention, particularly of medical staff.

The reviewers recommend that Caboolture Hospital establish a paediatric consumer advisory group, and the planned paediatric outpatient building be co-designed with clinicians and community members, and there be more ways to access specialist care. More emphasis is needed on compassionate child-centred approaches, and safety and quality reporting and complaints handling.

Of broader impact, the reviewers found that child protection and disability services at the hospital are not meeting the needs of the community, and that there should be better integration of services and collaboration between paediatric centres. The reviewers also felt that more community education was required around accessing the Satellite Hospitals and about the good things happening at Caboolture Hospital.

The reviewers identified 18 priority areas: emergency department; outpatients; care pathways; escalation pathways; inpatient services configuration; support services for children; cultural safety and support for Aboriginal and Torres Strait Islander people; paediatrics as a subspeciality; the patient experience; partnering with consumers; safety and quality, including reporting and information sharing; reporting, including clinical incident and compliments and complaints handling; workforce recruitment and retention; workplace culture; reputational issues; innovation; disability, including diagnosis and access to support; and, child protection.

Recommendations

1. Develop a 24-hour paediatric triage within the internal waiting area supervised by nursing staff

2. Appointment of a specialist paediatric emergency physician as the Clinical Lead in paediatric emergency medicine for clinical work and leadership on the floor (0.5FTE) and leadership in education, policy/procedures, recruitment, academic functions, safety and quality assurance (0.5FTE)

3. Dedicated paediatric emergency medicine education for all staff incorporating team-based simulation and skills relevant to paediatric emergency medicine and a dedicated paediatric clinical nurse educator

4. An emergency consultant should be rostered to the paediatric ED for peak periods and should be considered in the future from approximately 8am to approximately 1130pm seven days a week

5. Acknowledgment of the potential for pain and distress experienced by children and their parents/carers through medical procedures

    a. Early pain scores at triage

    b. Enable rapid and safe administration of analgesia (this requires the weight of the patient)

    c. Avoid restraint where practical

    d. Utilise distraction (video, audio, printed) and/or child-life specialists for procedural distress

    e. Develop safe sedation practices including pharmacological agents such as:

- Nitrous oxide (preferably via a continuous flow device)
- Ketamine
- Propofol

6. Separate reporting of data pertaining to adults and children presenting to Caboolture Hospital ED

7. Identify meaningful performance metrics for Paediatric Emergency Medicine in Caboolture ED. Examples:

    a. time to antibiotics in children with a presumed diagnosis of sepsis [stratified by age]

    b. provision of an asthma management plan to discharged children with a diagnosis of asthma

    c. notification of an Indigenous Health Liaison Officer for families who identify as indigenous

8. Having done the above, create an evaluation framework to assess progress and implementation

9. Paediatrics and Child Health representation in Executive meetings to be expected and supported by adequate clinical support time

10. Development of a separate CKW Paediatrics and Child Health Service Line that encompasses all elements of the child and their healthcare journey. Examples include:

    a. Operations manager of Paediatrics and Child Health

    b. Medical and Nursing Directors of Paediatrics and Child Health (with management and paediatric clinical experience)

    c. Director of Paediatric Allied Health

    d. Consumer Advisory Group (CAG) sub-committee for Paediatric and Child Health

11. Integration of the Consumer Advisory Group into strategic planning partnerships building upon highly innovative consumer engagement initiatives and demonstrable gold standard examples showcasing the power of partnering with consumers

12. Equity in Allied Health recruitment so that developmental outcomes in all domains can be improved

13. Building on an innovative developmental screening clinic (First Contact Triage clinic), engaging with consumers on a suitable local model for expansion of this and integration with other high priority needs (e.g. behavioural assessments)

14. Redevelopment of the Child Protection Unit, bringing it into the Paediatric Service under the leadership of an acknowledged child protection specialist (paediatric medical or social work)

    a. Integration of child protection into the paediatric emergency department and children's ward

    b. Design of a functional and safe space for assessment of these vulnerable children and their families where confidentiality is maintained and culturally and age-appropriate forensic assessment can occur

15. Reconfigure office spaces of the Child Protection Unit to allow for private viewing and discussion of cases, ensuring confidentiality and focus.

16. Embed clinical supervision for staff working in Child Protection Unit (CPU).

17. Establish a formal debriefing program to facilitate structured and supportive discussions post-case handling

18. Explore opportunities for collaboration with other hospital services to create a network of support and learning.

19. Design a developmental service and implementation strategy, collaborating with other organisations to:

    a. develop an evidence-based service at Caboolture that provides clear pathways for screening, diagnosis, early intervention, parent training and support.

    b. Co-design processes to ensure the service meets the needs of all stakeholders. This includes:

        i. Consumers and persons with lived experience

        ii. Developmental disability experts

        iii. Developmental and General paediatricians

iv. Paediatric nurses including nurse navigators and advanced practice nurses

v. GPs

vi. Allied Health professionals

vii. Administrative staff

c. Initiate inter-agency discussions with Education, Human services and NDIS and create a memorandum of understanding between relevant stakeholders

d. Initiate inter-agency discussions with local disability support services to understand and enable referrals to local services.

20. Create a lived-experience advisory panel to co-design and develop:

a. inclusive communications campaigns and accessible feedback channels.

b. identification processes and training for the triage and admission process.

c. communication supports to prepare children with disabilities and their families for hospital visits (e.g. visual communication supports to explain common procedures)

d. a paediatric-specific Health Passport (Adapted version of Julian's Key)

e. a schedule of disability focused training with lived experience experts

f. trauma informed guidelines for working with children with disabilities

g. development of all new physical spaces in new outpatients and all future redevelopments

21. Create disability navigator roles (potential for lived-experience role).

a. Create criteria for identifying children and families with disabilities and procedure for accessing disability navigators. (See Aboriginal and Torres Strait Islander Traffic Light System)

b. Educate all staff on roles and procedures.

22. Create a co-design working group to adapt the Metro North Health Disability Services Action Plan to create site-specific, paediatric-specific actions and key performance indicators.

23. Publicise Caboolture's commitment to improving disability services and provide the community with updates on progress.

24. A purpose-built paediatric outpatient centre at Caboolture Hospital was welcomed by the review team. This needs consumer co-design collaboration from the beginning.

a. From a parent, "Take note of parents. They are the knowledge holders for their children. Trust they know their children and the needs. Listen to concerns and work together."

25. Development of modern clinic practices with roles for integration of allied health and nurse led clinics with the recognition of the potential for telehealth to be integrated.

26. Utilisation of appropriate referral systems so that GP referrals are efficiently identified and triaged

27. Approaching subspecialist services at Metro North HHS and Queensland Children's Hospital to discuss the potential of outreach clinics at Caboolture

28. Development of a coordinated approach to service provision across Metro North HHS and Queensland Children's Hospital. Consider the following:

a. Memoranda of understanding regarding transfer of children back to Caboolture Hospital if clinically appropriate from other centres, if they reside in the Caboolture Hospital catchment

b. Development of a unified referral system that includes developmental screening questions to better triage such referrals

c. Quarterly retrieval service reviews to determine and learn from the management of the sickest patients

29. Expand and develop educational collaborations between Metro North HHS campuses and Queensland Children's Hospital.

30. Develop research collaborations between Metro North HHS campuses, Queensland Children's Hospital and beyond. Research involving Allied Health, Indigenous Health, Nursing and/or Medical teams is possible.

31. Caboolture Hospital must engage in truth telling conversations to determine culturally appropriate methods for service reviews including the following:

a. Revisit the strategy described in the Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033 and the Metro North HHS Health Equity Strategy

b. Determine the next steps together

32. Develop analyses with IHLOs and SHWs that would allow an understanding of the proportion of those who identify as Aboriginal or Torres Strait Islander who receive cultural care

33. Explore advanced clinical practice roles for SHWs and/or IHLOs in the community, in outpatient clinics, in paediatric emergency and in Children's Ward.

a. Develop clinical governance and performance measurements

b. Take on additional clinical responsibility following best evidence pathways and collaborating with other nursing and medical teams

34. Prior to invoking Ryan's Rule, parents must be able to get rapid clinical care in the case of acute or severe deterioration, for example, via a parent-initiated escalation system (analogous to a MET call). A process that educates and empowers parents to initiate these calls should be strongly considered.

35. Develop systems that will mean that children arriving at triage will have their vital signs taken within 30 minutes of arrival

36. Roll out an education program to all the clinical teams on CW as part of mandatory MET and Paediatric Code Blue activation

37. Development of in-situ and translational simulation program that can expose latent threats and organisational issues affecting the response to critical illness in children across Caboolture Hospital, within the Satellite Hospital(s) and other existing and evolving services.

a. Implement change based on this program

b. Publicise this process in professional meetings and with the local community

38. Development of technological solutions to acute escalation in the ED. Telephones and photographs on a wall are not appropriate. Use simulation to facilitate development of a more responsive, robust and acceptable system.

39. Governance structures must provide visibility to the Board and to the Executive of the standard of paediatric service provision in near to real time.

a. Paediatric performance measures to be sourced from other centres, developed locally and trialled in the Caboolture environment

b. Explore the feasibility of a paediatrics and child health service line separate from Women's Health that includes medical and nursing leadership with paediatric skills and experience

40. Utilise local nursing expertise to develop paediatric skills in the Emergency Department

a. Children's ward paediatric nurses to be rostered into the Emergency Department (including resuscitation cubicles) with appropriate on-boarding, education and support

b. Expand the Paediatric Nurse Practitioner FTE in the ED

c. Development of a Graduate Nurse program in Paediatric Nursing utilising skills on Children's Ward, the Emergency

Department and Children's Outpatients.

i. Aim for a 70:30 ratio of experienced to junior nurses

ii. Regular clinical supervision for staff

41. Develop skills, through recruitment and training, in the management of mental health conditions such as eating disorders, anxiety and depression which are now the major diagnostic groups in children from as young as 8 years of age through into Adolescent medicine

    a. For many children these will be comorbidities

    b. Understand how they affect the child and their family during an acute hospital attendance or admission

42. Shift from blame to support and an educative mindset

43. Build capability in the workforce

    a. Compassion workshops for staff at all levels

44. Demonstrate how and where change has improved care frequently and through various channels

    a. Newsletters

    b. Local forums

    c. Social media (with great care)

    d. Network based symposia

    e. Formal research conferences

45. Invite patients to share their stories throughout all levels of the organisation, i.e. in-services, executive, performance and safety and quality meetings – ensuring they are acknowledged and first on the agenda.

46. Provide education to staff to minimise procedural trauma

47. Investigate the use of distraction therapies – music, therapy animals, digital art displays etc to minimise trauma, occupy children and families while waiting and reduce privacy issues.

48. Collaborate with the children of Caboolture to create designs and dedicated spaces that are child friendly and welcoming. Remember the “Child’s Voice”.

49. Metro North HHS develop a communication strategy to inform the public about Satellite Hospitals and when they should present there, including minimum age.

50. Public awareness of the role of the Caboolture Satellite Hospital will reduce delays to appropriate care, by preventing inappropriate attendances.

51. Mentoring and development of future paediatric medical and nursing leaders

    a. Includes a requirement for paediatric nursing experience as part of the selection process.

52. Development of paediatric Allied Health leadership under the larger Allied Health umbrella

53. No adult admissions to CW. This represents a risk to children in the ward and limits access for additional children who may require admission after acceptance of the adult patient(s).

54. Improve the balance of Performance Meetings to ensure appropriate representation of paediatrics.

55. Change the culture around RiskMan reporting.

    a. Set up every clinician in RiskMan to facilitate incident entry and incident review where relevant. **Incident entry is everybody’s responsibility.**

    b. Set expectations that near miss events must be entered into RiskMan. These will prevent the future SAC 1 or SAC 2 event.

    c. Use RiskMan incidents to inform abovementioned simulation program development

    d. Close the reporting loop on all clinical incidents by implementing structured procedures.

56. Perform an audit to correlate Riskman entries to the following:

    a. Clinical cases presented in M&M meetings

    b. Ryan’s Rule activation

    c. Audit and presentation of quality improvement actions taken because of Riskman entries

57. Paediatrics and Paediatric Emergency Medicine to hold joint M&M meetings

a. Standing invitations to all staff with an interest in paediatrics and child health

b. Other areas of Caboolture Hospital (e.g. ICU, mental health, pathology, radiology) or CKW Directorate (eg. Satellite Hospitals) can attend and must present if a paediatric case has occurred.

c. M&M meetings must have an agenda and minutes should be submitted to Metro North HHS Quality and Safety Committee

d. Strengthen and utilise patient's voice and stories as stimuli for M&M meetings

58. Allocate dedicated administrative time for Chairs to perform this task with their full attention during their working hours.

59. Perform Complaint classification audits regularly.

a. Was a Riskman clinical incident entry made?

b. If a Riskman entry was made, how was the complaint resolved through this process?

c. If no Riskman entry was made

i.Should one be made now?

ii.Why was it not made earlier?

d. Complaints that have been closed without a documented response.

60. Provide feedback to families about the service improvement activity or action taken in response to their complaint/compliment promptly (within 30 days).

61. Record all actions taken in Riskman

a. This includes, for example, escalation to Director, change or development of a Quality improvement process or change in policy/procedure.

62. Provide training for clinicians performing Open Disclosure including:

a. Trauma-informed care

b. Active listening

c. Compassion/empathy

63. Provide evidence and documentation of timely clinical debriefs with parents and children after an adverse or clinical incident has occurred.

64. Co-design and implement a recovery plan to regain the trust and build confidence of the community and clinicians.

65. Collaborate with other Caboolture departments, other Metro North campuses and Queensland Children's Hospital on education, clinical and research programs. Then publicise them using professional journals, conferences and community media.

a. The local community should be made aware through media opportunities of infrastructure developments and good news stories

66. Commence a Paediatric consumer advisory group from the commencement of design and development to completion and beyond of the new Paediatric Outpatients Department.

67. The Consumer Advisory Group (CAG) should review all compliments and complaints data and Patient Reported Experience Measures (PREMS).

68. Communicate to the CKW community regarding progress and implementation of recommendations made in this report.

69. Establish the Child's Voice methodology, a Children's and Adolescent's advisory council and family group to influence and inform models of paediatric care

a. Dedicated paediatric Consumer and Community Engagement Officer (1 FTE)

i. Suggest Metro North HHS-wide role

70. Continue to monitor, evaluate and maintain gains made in implementation of surgical services review.

71. Monitoring, evaluating, and maintaining gains achieved in WT Case recommendations.

72. Establish a multi-disciplinary working group, including consumers, to oversee the implementation of this report's recommendations. This, in turn, will be reported through Performance, Safety and Quality and Executive Meetings within Caboolture Hospital and Metro North HHS.

73. Provide a monthly progress report to the Chief Executive of MNHHS about implementation, monitoring and evaluation of recommendations.

74. The progress report to be tabled at the MNHHS Board meeting and MNHHS Board Safety and Quality Committee.

75. Provide updates regarding progress of implementation of recommendations to the paediatric community of Caboolture, Kilcoy and Woodford.

76. Engage a Review Team to complete an evaluation of implementation of recommendations in 18 months from this report's delivery. This should include invitations to the members of this Review Team.