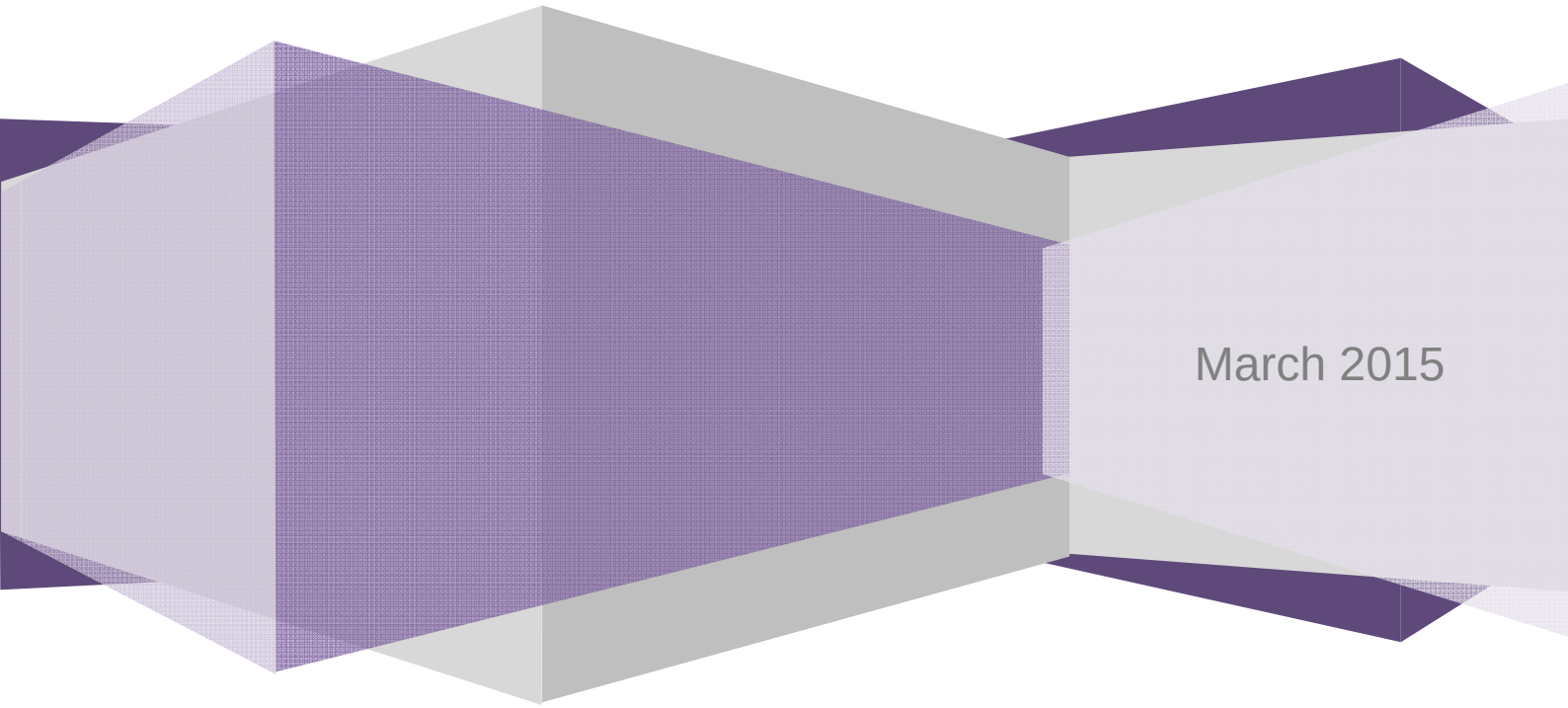
Lady Cilento Children's Hospital Clinical Review

Final Report



March 2015

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Executive Summary

The Lady Cilento Children's Hospital opened and commenced providing clinical services on Saturday 29 November 2014. In response to suggestions that clinical care had been compromised in the first two weeks of operation, the Children's Health Queensland Hospital and Health Service Board brought forward a planned assessment of the quality of care delivered to patients during this period. A Clinical Review was formally established and a team of independent reviewers appointed to undertake this assessment.

Over 5,000 parents and families who received care at the Lady Cilento Children's Hospital between 29 November 2014 and 12 December 2014 and more than 2,000 staff were invited to provide information to the Clinical Review Team. In addition to considering written information, the Clinical Review Team also met with staff and parents, and visited clinical areas across the hospital.

The scope of the Clinical Review included assessing the clinical care provided during the aforementioned period and identifying any patient incidents reported to have occurred during that period. The Clinical Review Team considered a significant volume of information provided through 96 submissions, 23 interviews and focus groups, 78 PRIME CI reports, 40 complaints as well as other relevant data and documents.

This Report presents the findings of the Clinical Review in alignment with the Children's Health Queensland goals for transition, that:

1. No patient is harmed
2. Patients and families feel (are) safe
3. Staff feel (are) safe.

The Clinical Review Team found that staff, patients and families were contending with this transition in the context of an unprecedented convergence of challenges and complexities. Two long-standing hospitals with different history, systems, governance and culture were closing and staff from each would be working together (most for the first time), new models of care and service configurations were being introduced, many staff had changed and/or had very recently negotiated new employment conditions, information systems were new for a number of staff, the physical environment was new to everyone and switchboard services had not previously been managed by either of the two former hospitals. Further, a large part of the service, facilities management, would be provided by a private provider new to Queensland public sector hospitals with a completely new workforce.

Planning for the opening included a period of time for staff familiarisation and orientation with the intention that the majority of staff would know the geographical layout of their new environment and be familiar with and able to use the new operating procedures and systems. A variety of factors delayed access to the building and the preparation of staff in their new environment. This included a delay in the practical completion of the building and other factors which were part of statewide reforms and external to one or both of the existing hospitals. Consequently, these orientation and transition processes could not occur to the extent required. To support staff during and after the move additional resources such as educators, safety clinical nurse consultants and *ie*MR support staff were made available.

The Clinical Review Team was not able to identify any quality and safety adverse events to have occurred on the day of move. In fact, move day was widely acknowledged to be a safe, precise, well managed and successful exercise. The most serious quality and safety events identified during the subsequent two weeks of the in-scope period were assessed as leading to minimal harm. There were no cases of death, permanent harm or temporary harm found. However, there were several cases

where the risk of a serious safety event was averted. There were many reports where interventions by staff, and parents and families mitigated minor risks to patient safety.

The reported experience for patients and families was mixed, with personal accounts of heartfelt appreciation by parents of the care staff provided to their children and excitement of the new facility through to frustration and angst.

It was evident that staff extended themselves in the lead-up to and after the opening of the new hospital. Many staff expressed and displayed a level of stress built up from the sustained and continuing level of challenges and frustrations experienced. Examples include incorrect or poorly located equipment, a multitude of new systems and processes to learn, new telephony processes and electronic communication systems. Following the move, the frustration of not knowing how design and space concerns raised would be resolved, particularly given the preclusions associated with the building Defects Liability Period, added to this stress.

The Clinical Review Team heard from a range of staff and families who have been, and continue to be, concerned about the adversities this complex set of circumstances has provided and the consequential impediments to their expectations of service delivery. At the same time, many staff, patients and families are excited by the opportunities presented by having such a state-of-the-art, purpose built tertiary paediatric facility and, for the first time, all paediatric specialties housed and working together.

Although a combination of factors generated an unparalleled level of complexity and risk, no serious adverse events causing long term harm occurred on the day of the move or during the first two weeks of operation of LCCH. The dedication, vigilance and inventiveness of staff in preventing potential risk causing actual harm is acknowledged. The consequential stress, fatigue and lowered morale requires some priority in the continuing development of the new facility. All clinicians, managers and families expressed their commitment to resolving differences, addressing residual obstacles and creating the outstanding clinical care environment they know the Lady Cilento Children's Hospital can deliver.

1 Introduction

Children's Health Queensland (CHQ) Hospital and Health Service is a specialist statewide Hospital and Health Service (HHS), one of 16 HHSs in Queensland. On 29 November 2014, the CHQ HHS opened the Lady Cilento Children's Hospital (LCCH) in South Brisbane, a 359 bed tertiary paediatric facility. This combined the staff and services of the previous Royal Children's Hospital (RCH) and Mater Children's Hospital (MCH). On this day, both previous children's hospitals closed, and services commenced operation at the LCCH. Children, young people and their families, along with staff were consulted during the planning of the hospital which was designed to provide a statewide service, as well as support regional and rural hospitals through telemedicine technology and outreach services[1].

The CHQ transition plan for the opening of the LCCH included an assessment of the quality of care delivered to patients both during, and immediately after patients were transferred from the MCH and RCH, and the LCCH was open. This assessment was to be undertaken after patients and staff had settled in.

As expected, media interest in the opening of the LCCH was high with a range of articles published in print and electronic publications, and opinions expressed on social media platforms reflecting positive and negative views. Some of these published views suggested clinical services at the LCCH may have been compromised or of an inadequate standard during the first two weeks of operation. In-line with their commitment to providing the highest standards of care, the CHQ Hospital and Health Board consequently brought this planned assessment forward.

A Clinical Review was established under the Hospital and Health Boards Act 2011 and a team of four independent reviewers from New South Wales and Victoria were appointed. This report presents the findings of the Clinical Review.

1.1 Scope of the review

The purpose of this Clinical Review was to assess the quality of patient care at the Lady Cilento Children's Hospital during the move of services on the 29 November 2014, and during the initial two weeks of operation.

Pursuant to section 125(2) of the Hospital and Health Boards Act 2011 (HHBA), the former Health Service Chief Executive appointed the following as members of the Clinical Review Team:

- Professor Les White AM – New South Wales Chief Paediatrician (Chair)
- Ms Cheryl McCullagh – Director of Clinical Integration, The Sydney Children's Hospitals Network
- Dr Sarah Dalton – Paediatric Emergency Physician at The Children's Hospital at Westmead, Clinical Director at the Clinical Excellence Commission (NSW) and President-elect of the Royal Australian College of Physicians – Division of Paediatrics
- Ms Jane Miller – Executive Director of Strategy and Organisational Improvement at The Royal Children's Hospital Melbourne.

The scope of the Clinical Review was to:

1. Assess the clinical care provided to patients of the LCCH during:
    a. The day of move – 29 November 2014
    b. The first two weeks of clinical operations at the LCCH – from Sunday 30 November to Friday 12 December 2014.

[1] Children's Health Queensland Hospital and Health Service. 2014. Annual Report 2013-14.

2. Identify any patient incidents reported to have occurred during the period outlined in (1). Comment on the nature of the incidents, how they were managed and any cases of preventable patient harm.
3. Comment on the standard of patient care reviewed in (1) with reference to the expected standard of care for an Australian tertiary paediatric hospital.
4. Assess the processes used to mitigate and manage risks to clinical care during the period outlined in (1). Comment on the effectiveness of these processes in minimising risks to patients.
5. As necessary, make recommendations for future actions to strengthen the reliability of clinical operations and minimise risks to patients.

This review did not include:

- A comprehensive assessment of HHS operations or an accreditation of health service delivery standards; it also did not test compliance with national standards
- Any assessment or opinion on performance
- An assessment of the readiness to open the LCCH.

The full Terms of Reference are provided at appendix 4.1.

1.2 Conduct of the review

This review was conducted over a 12 week period commencing Monday 22 December 2014 and concluded with submission of the final report on Friday 20 March 2015.

During this period, the Clinical Review Team considered and analysed information provided through:

- Submissions from families, staff and external stakeholders
- Interviews and focus groups with staff, and parents and families
- Visits to clinical areas
- Review of incidents reported to have occurred during the in-scope period
- Review of complaints received during the in-scope period
- Correspondence received by the Minister with respect to the LCCH during the in-scope period
- Matters raised in print media with respect to the LCCH during the in-scope period
- A range of data and documentation of relevance to the scope of the review.

This information was assessed in the context of the goals Children's Health Queensland had identified for a safe transition to the LCCH, namely, no patient is harmed; patients and families feel (are) safe; and staff feel (are) safe.

These goals were translated into respective domains which formed the basis of a purpose developed assessment tool (appendix 4.2) used by the Clinical Review Team to provide consistency when assessing submissions, interviews and focus groups, and reported incidents.

CHQ Goal	**Domain**
No patient is harmed	Quality of care (section 2.2)
Patients and families feel (are) safe	Patient and family experience (section 2.3)
Staff feel (are) safe	Staff experience (section 2.4).

Using the standardised ratings and definitions for clinical incident reporting adopted by CHQ, each in-scope submission, interview or focus group and reported incident was assigned a severity rating for the level of harm likely to have occurred (i.e. no harm, minimal harm, temporary harm, likely permanent harm or death) and assessed for the potential of a serious safety event. An additional assessment was also made regarding the likelihood that the event was related to the move. Medical records were reviewed where the assigned severity rating was temporary harm, likely permanent harm or death.

In order to enable analysis, individual matters raised or identified through submissions, interviews and focus groups, and incidents reported to have occurred were classified into six categories and respective sub-categories (and reflected in the assessment tool at appendix 4.2) as follows:

1. Physical environment:
    - access to meals for parents
    - air-conditioning
    - building design
    - equipment
    - facility access
    - furniture
    - laundry
    - parent accommodation
    - transport
    - way-finding / signage.
2. Support services:
    - administration
    - cleaning services
    - consumables
    - facilities management
    - linen services
    - patient food
    - porterage
    - security.
3. Hospital systems:
    - call / help desk
    - health information management / integrated electronic medical record
    - information communication and technology
    - outpatient department scheduling
    - patient flow
    - procurement
    - rostering
    - telecommunications / switchboard
    - theatre processes.
4. Workforce:
    - behaviour / attitude / conduct
    - individual performance
    - skill mix
    - team performance
    - training
    - workload / fatigue.
5. Clinical care:
    - clinical handover / communication
    - clinical incident
    - diagnostic testing
    - discharge planning
    - monitoring / care planning
    - patient assessment / diagnosis
    - safety event
    - treatment.
6. Change readiness :
    - communication to patients regarding the new facility
    - escalation
    - project / LCCH interface
    - staff awareness of issue status - non-clinical.

In each category, there was the option to add other items not coded above.

1.2.1 Submissions

Over five thousand parents and families, and more than two thousand staff were formally invited to provide information (a submission) to the Clinical Review Team. There were no prescribed requirements for a submission with authors having complete discretion over format and size.

A total of 100 submissions were received with four assessed as out-of-scope for the purpose of this Clincial Review as they related to events after the 12 December 2014.

Of the 96 submissions assessed as in-scope:

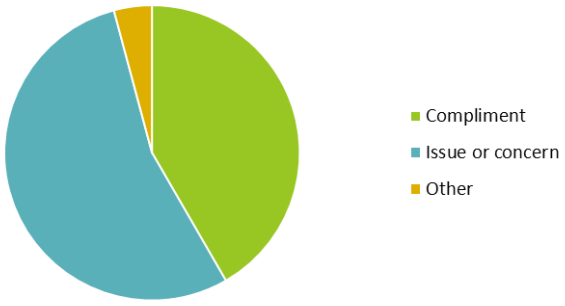
- 86 (90 per cent) were from parents and families
- 6 (6 per cent) were from staff of the Lady Cilento Children's Hospital
- 4 (4 per cent) were from external stakeholders including other health service providers and industrial bodies.

There were 7 submissions which were substantial in the breadth of the information they provided encompassing more than one of the three domains.

Where this information was in-scope for this Clinical Review, it is included in the analysis and detail provided in chapter 2, Findings. Information considered to be relevant and important, but not directly in-scope, is captured in section 3.3, Observations.

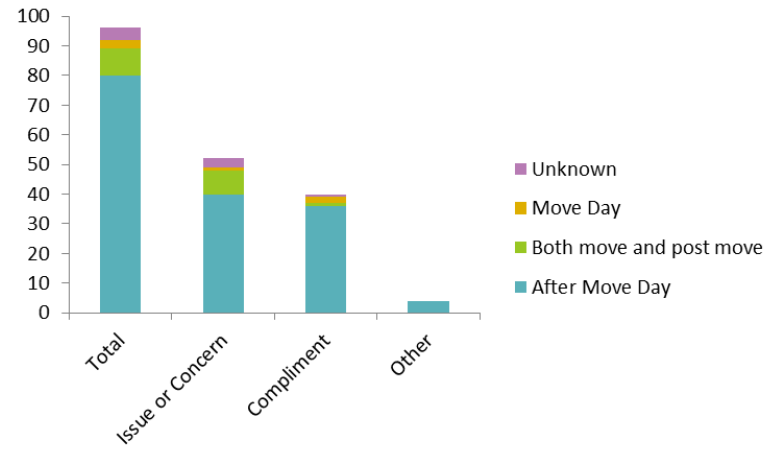
As illustrated in figure 1, the in-scope submissions contained a relatively even spread of compliments and issues or concerns. The 'Other' sub-category represents those submissions that focused on providing advice on matters to explore.

Figure 1: Focus of in-scope submissions



Clinical care was assessed for two time periods; the "day of move" (i.e. 29 November 2014) and the first two weeks of clinical operations at the LCCH (until 12 December 2014). As shown in figure 2, the majority (n=80) of in-scope submissions received related to the period post move day.

Figure 2: Period of time in-scope submissions related to



The majority (34 per cent) of parents and families who provided a submission previously received care through the Royal Children's Hospital, 27 per cent previously received care through both the Royal Children's and Mater Children's hospitals, and 19 per cent previously received care through the Mater Children's Hospital.

When examining the relationship between the facility at which patients had previously been cared for and the focus of in-scope parent and family submissions received, a higher proportion of issues or concerns were raised by those who had been patients of the Royal Children's Hospital (37 per cent) as compared to those who had been patients of the Mater Children's Hospital (21 per cent) (figure 3).

Figure 3: Where patients previously received care

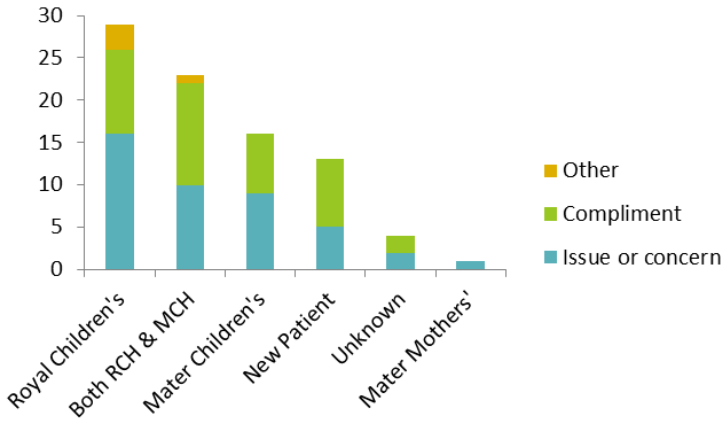
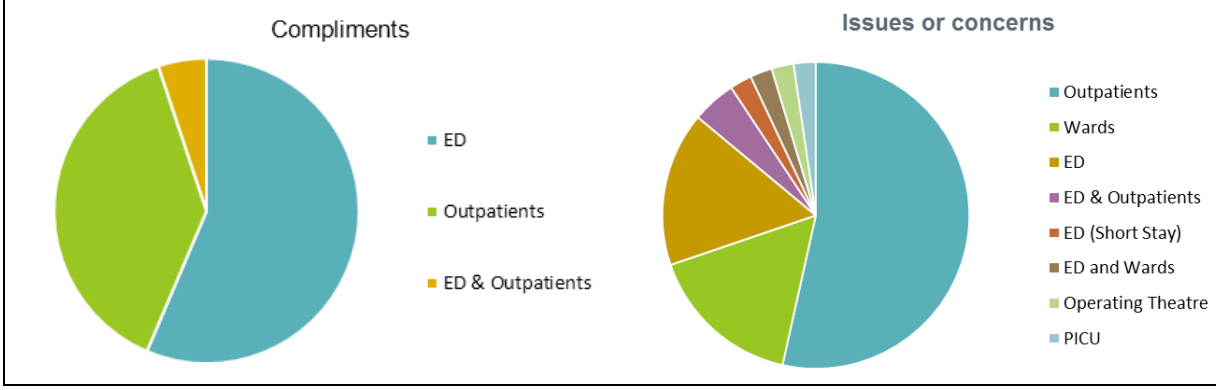


Figure 4 illustrates the clinical settings for the basis of the compliments made and issues or concerns raised through the in-scope submissions.

Figure 4: Setting of care for compliments and concerns raised through parent and family submissions



The majority of compliments received were for care provided through the emergency department (56 per cent), outpatients (39 per cent) or a combination of both the emergency and outpatient departments (5 per cent).

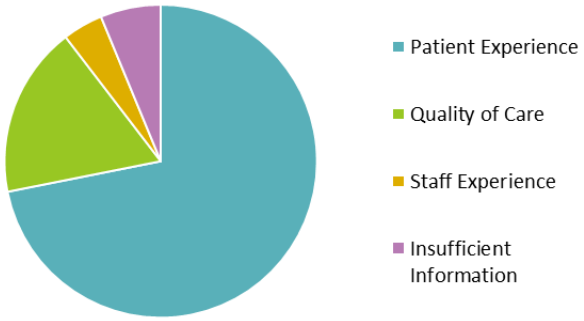
The majority of issues or concerns raised related to care provided through outpatients (54 per cent), the emergency department (16 per cent specific to the emergency department which increases to 26 per cent when combinations including the emergency department are included) and inpatient wards (16 per cent). The remaining issues or concerns related to care provided in the operating theatre (2 per cent) and paediatric intensive care unit (2 per cent).

As detailed on page six, each submission was assigned to one of three domains aligned with the CHQ goals for transition:

- Quality of care and associated sub-domains: safety, timeliness or effectiveness / appropriateness
- Patient and family experience
- Staff experience.

As illustrated in figure 5, the majority of submissions primarily related to patient and family experience (72 per cent or n=69), 18 per cent (n=17) to quality of care and 4 per cent (n=4) to staff experience. There were 4 submissions which had insufficient information for the assignment of a domain.

Figure 5: Distribution of domains for in-scope submissions



Detailed analysis of the content of submissions can be found within the section for each domain in chapter 2, Findings.

1.2.2 Interviews and focus groups

The Clinical Review Team convened 23 semi-structured interviews and focus groups with a total of 119 participants, which encompassed parents as well as clinical and non-clinical staff across all levels and streams, executive staff and contracted stakeholders from the following areas:

- Family Advisory Council
- Administration
- Catering services
- Cleaning services
- Clinical Support
- Critical Care
- ICT and Operational Services
- Health Information Management Service
- Mental Health
- Oncology
- Porterage
- Surgery
- Volunteers.

Patients were not interviewed by the Clinical Review Team. It is noted patients were named as co-authors in some submissions.

Clinician (and clinician manager) participation included:

- Medical staff (medical strategy group, medical directors, senior medical officers and resident medical officers)
- Nursing staff (nursing directors, clinical nurse consultants, nurse unit managers, clinical nurses, registered nurses, nurse educators, clinical facilitators, research nurses and enrolled nurses)
- Allied Health staff (directors and allied health assistants).

Attendees of the interviews and focus groups were encouraged to share their experiences through discussion guided by the following topics:

- Role of attendees
  - on the day of move
  - in their substantive position
- The process of physically transferring patients on the day of move
- Patient safety
  - incidents or concerns
  - quality of care
  - ability to undertake routine clinical activities
  - how patients were kept safe
- Reflections of the move and the first two weeks of operation.

A list of the interviews and focus groups convened is at appendix 4.3 and a copy of the questions used to guide the interviews and focus groups is at appendix 4.4.

The information provided through interviews and focus groups was mapped against the six categories listed on page 7. An illustrative copy of this mapping is provided at appendix 4.5. As illustrated in figure 6, a mixture of favourable information and issues or concerns was received with the majority of matters raised being issues or concerns. Most of the favourable comments related to the day of move.

Figure 6: Focus of information received during interviews and focus groups

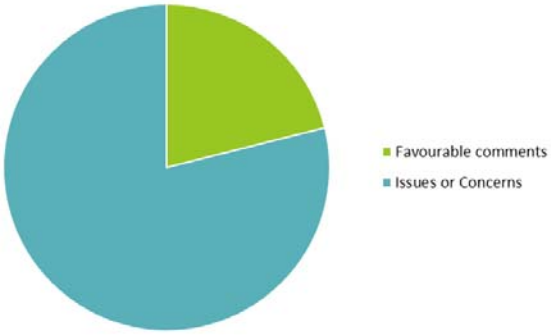
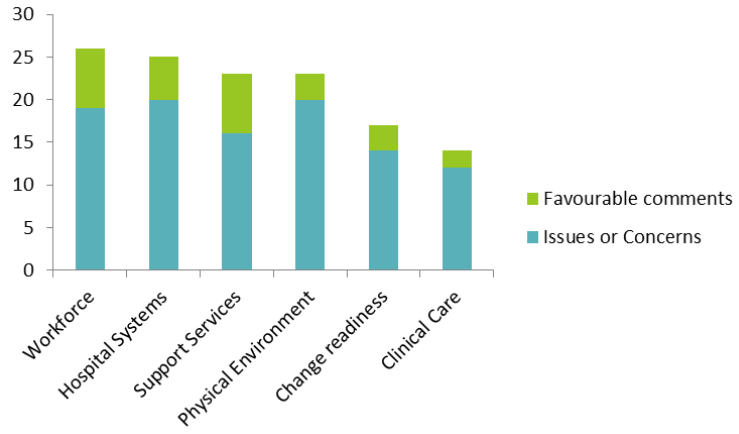


Figure 7 demonstrates the distribution of information received across the categories of physical environment, support services, hospitals systems, workforce, clinical care and change readiness.

Figure 7: Classification of information received through interviews and focus groups



Detail with respect to the information received through the interviews and focus groups can be found in the section for each domain within chapter 2, Findings.

To provide the Clinical Review Team with the contextual information required to undertake this Clinical Review, a number of preliminary meetings were held with Board, executive and senior management staff. These meetings were in addition to the formal interviews and focus groups and included:

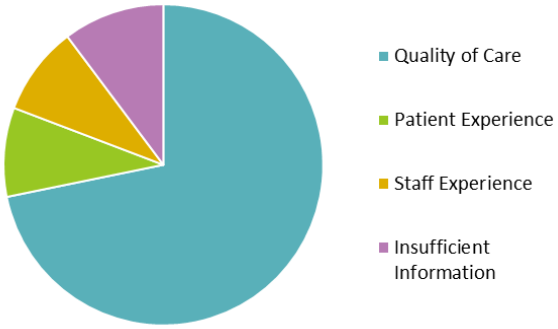
- Board Chair
- Acting Board Chair
- Acting Health Service Chief Executive / General Manager Operations
- Executive Director Development and Commissioning
- Executive Director Medical Services
- Executive Director Nursing Services
- Executive Director QCH / LCCH Project
- 'Order of March Leads' for Move Day
- Patient Safety and Quality Service
- Senior Director Facilities Management
- Senior Director Media and Communications.

1.2.3 Reported clinical incidents

The Clinical Review Team assessed a total of 78 clinical incidents reported, through PRIME CI, to have occurred during the in-scope period. There may have been underreporting as explained in section 2.2, Quality of care.

Almost three quarters (n=56) of these incidents were assigned to the quality of care domain with equal numbers assigned to patient and family experience (n=7) and staff experience (n=7) respectively (figure 8).

Figure 8: Domain assigned to reported clinical incidents



Detail with respect to these incidents can be found in section 2.2, Quality of Care.

1.2.4 Complaints made

There were 40 consumer complaints received by Children's Health Queensland for the in-scope period. The content of these complaints was reviewed and is included in the findings contained within section 2.3, Patient and family experience.

1.2.5 Letters to the Minister

The former Minister for Health received five separate letters from members of the community regarding the opening and the early weeks of operation of the Lady Cilento Children's Hospital. The matters raised through this correspondence were consistent with the submissions received and matters raised during the interviews and focus groups, and were not formally included for analysis.

1.2.6 Media coverage

There were approximately 150 media items during November and December 2014 related to the opening of the Lady Cilento Children's Hospital. Ranging from radio interviews, newspaper and other print media, the content reached audiences across Queensland and was consistent with the matters raised through submissions, interviews and focus groups, and was not formally included for analysis.

1.2.7 Other

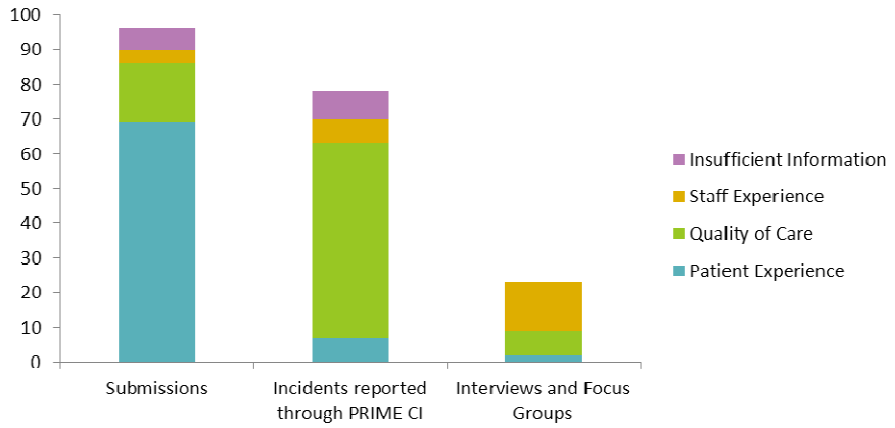
To better understand the environment in which people are working and the strategies in place to minimise the risk to patient safety, the Clinical Review Team visited a number of areas within the LCCH and observed one of the *Daily Operational Safety Briefing Meetings*. At these meetings, staff from the executive, patient safety, food services and each clinical area provide a status report of bed census and need (including predicted and known emergency admissions), staffing levels and need, patients of concern and other matters requiring urgent attention. Where relevant, issues raised during these visits were incorporated into the overall findings and have been included in the assessment and analysis of the respective domain.

Clinical areas visited included the emergency department, oncology, a surgical ward, a medical ward, paediatric intensive care, rehabilitation, allied health, child and adolescent mental health and several outpatient areas.

1.2.8 Summary of inputs

The Clinical Review Team formally invited over seven thousand stakeholders to make submissions and participate in interviews and focus groups. Many parents and families, staff and other stakeholder groups accepted the invitation. Additionally, reported clinical incidents and complaints, letters to the Minister for Health, media reports and on-site observations contributed to the Clinical Review Team's assessment. These inputs provided both front-line and higher level perspectives of the LCCH environment during the in-scope period. Figure 9 summarises the quantum of submissions, interviews and focus groups, and PRIME CI incidents assessed during the review, by their assigned domain.

Figure 9: Summary of inputs assessed



1.3 Limitations

The assessment and analysis conducted for this Clinical Review was limited to the time, information and data that was available. Reports were accepted as provided. Time did not permit an independent investigation to validate all information or data provided.

1.4 Acknowledgements

The Clinical Review Team would like to thank parents and families, Children's Health Queensland staff and management, Medirest and external stakeholders for sharing their experiences and the information they provided. The Clinical Review would not have been possible without the level of disclosure that was afforded. There was an overwhelming sense of commitment to learning from adversity, to addressing ongoing challenges and to working towards a hospital which provides outstanding services for children and their families.

1.5 Report structure

This report comprises four chapters:

1. ***Introduction*** providing the context for the review, the methodology used and a profile of the mechanisms through which information was received during the review.
2. ***Findings*** detailing the assessment and analysis of the information received in the context of the scope of this review using three domains based on the CHQ goals for transition:
    a. Quality of care
    b. Patient and family experience
    c. Staff experience.
3. ***Commentary and observations*** providing commentary on the standard of patient care reviewed and management of risks. It also includes information not specifically in-scope for this review but considered important for the future operations of the LCCH including the reliability and productivity of services as well as ongoing risks to patients.
4. ***Appendices***.

2 Findings

2.1 Setting the scene

The opening of the LCCH saw the emergence of an entirely new service. While two historic paediatric hospitals were closing, it was not simply a matter of "doing the same job in a different place". Every aspect associated with the delivery of paediatric services was different including:

- New roles for staff
- New co-workers and teams
- New environment
- New equipment
- New managers and leaders
- New models of care
- New models of service delivery
- New service configurations and structures
- New systems for ICT and communications.

Planning for this new service commenced in 2008. An intensive program of work was subsequently conducted to design and build the building, and design and develop the new models of care and service delivery, and prepare for the transition. This included work to meet the challenges associated with the effective merging of two cultures with proud but distinct traditions of service and practice in a newly designed and constructed facility.

In addition to the inherent challenges of a totally new organisation, there were a number of factors in the lead-up to the opening which substantially impacted on the preparation for, and transition of, services to the new single-site tertiary paediatric facility. Of particular note:

- The positions required at the LCCH were not an exact match to those of the previous Royal Children's and Mater Children's hospitals. To provide all staff with an equal opportunity to assume a role at the LCCH, a closed merit process was used to recruit the first cohort of staff. A staged approach, conducted in accordance with prescribed recruitment processes, was used to fill the positions across all streams and levels. This exercise was conducted over an 11 month period and concluded in close proximity to opening for some groups.

  In most circumstances, staff received verbal notification of their successful appointment in advance of receiving their formal letter of appointment. There were reports that some staff received written confirmation the day prior to opening.

- Services at the Royal Children's Hospital and the Mater Children's Hospital needed to continue until the LCCH was operational. Business continuity at these two sites while also commissioning the LCCH became increasingly challenging particularly in the second half of 2014. Difficulties in securing the release of staff from the Mater Children's Hospital provided challenges in orienting them to the IT, and the operational systems and processes they would need to use on the opening of the LCCH. Additionally, the uncertainty of employment prospects at the LCCH resulted in some staff pursuing alternative employment opportunities.
- Three quite different organisational cultures were being brought together being those of the Royal Children's and Mater Children's hospitals and the new third party service provider, Medirest.
- The process to open a newly built hospital includes a defined stage for *Project Commissioning and Finalisation,* the purpose of which is to facilitate the effective transition of an infrastructure project from the design and construction stage to the service delivery stage.

While significant planning for this stage was undertaken, the practical completion of the LCCH (handover from the builders to the Department) was significantly delayed compressing the time available to operationally commission and allow staff to access the facility.

- Neither the RCH nor MCH had previously been responsible for managing their switchboard service; this service had been managed and provided by the Royal Brisbane and Women's Hospital (RBWH) and the Mater Health Services (MHS) respectively. Therefore a new service was required to be established. This compounded the inherent challenges of switchboard as a key resource operating in a totally new environment. In recognition of these challenges, CHQ employed staff with experience in switchboard operations and commenced their positions prior to opening.
- MCH records and other patient information such as outpatient appointments needed to be transferred to the Queensland Health systems used to support the integration of patient care into one site. This included the systems for recording and viewing medical records and clinical investigation results, the scheduling of outpatient appointments and communication to families. Scanning of MCH records commenced well before transition however, the process had not been completed and technical challenges migrating the outpatient data required the use of resource intensive manual processes (using multiple versions of data in spreadsheets which were manually transcribed) to transfer patient appointment information.

Some factors were part of Queensland Government statewide reforms and external to this process, but created further complexity and workload required of CHQ:

- The introduction of individual contracts of employment for senior and visiting medical officers saw the attention of medical staff diverted away from their involvement in planning for the transition to the LCCH while the protracted contract negotiations took place. This also had a significant impact on the recruitment process with medical staff recruitment concluding only three weeks prior to opening.
- With a commitment to improving the efficiency and effectiveness, and value for money of public sector services, the previous Queensland Government embarked on a program of contestability, reviewing all services to ensure the best possible services at the best possible price. Through this program, all hard and soft facilities management services at the LCCH were contracted to a third party provider, Medirest (a list of services provided through this arrangement is provided at appendix 4.6). Medirest was required to recruit and orientate a completely new workforce specifically for LCCH due to industrial agreements precluding the recruitment of previous RCH employees for a period of three months following their cessation with CHQ.
- The structure and governance of the LCCH Project where the Department of Health was the responsible owner and key decision maker for a facility which was to be operated and managed by CHQ added further complexity. This compounded the challenges in communication across multiple stakeholders and ensuring clinician and other front-line staff were heard and appropriate feedback provided. Further, there had been several changes in lead roles and transitions during the planning years.

The combination of these factors created an unprecedented level of complexity and change as well as potential for risk. Notwithstanding the risks associated with these events had been identified and mitigating strategies put in place, the impact of these inter-related factors and/or activities on the initial operations of services at the LCCH cannot be underestimated and largely underpins the findings of this Clinical Review. The findings on the following pages are detailed by the three domains described on page six.

2.2 Quality of care

Submissions, interviews and focus groups, and incidents reported through PRIME CI were all reviewed and each report assigned both to a primary domain, for example quality of care, and assessed for the presence of a quality and safety event. Significant quality and safety events were defined as those demonstrating temporary patient harm (where full recovery is expected over a period of time, including physical and psychological harm) or the potential for a serious safety event (2.2.1 refers). All cases were also assessed to determine the likely contribution of the move.

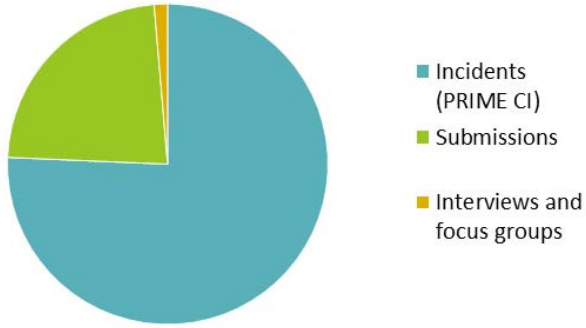
Of relevance when considering the number of incidents reported through PRIME CI, is the advice provided through submissions, and interviews and focus groups suggesting that under-reporting was more common during the in-scope period because:

- Time to log reports was limited
- Access to computers was limited
- Staff new to Queensland Health systems were unfamiliar with the use of PRIME CI.

There were a total of 74 reports assigned to the quality of care domain for this Clinical Review (figure 10):

- 56 incidents reported through PRIME CI
- 17 through submissions
- 1 through interviews and focus groups.

Figure 10: Sources of quality and safety reports

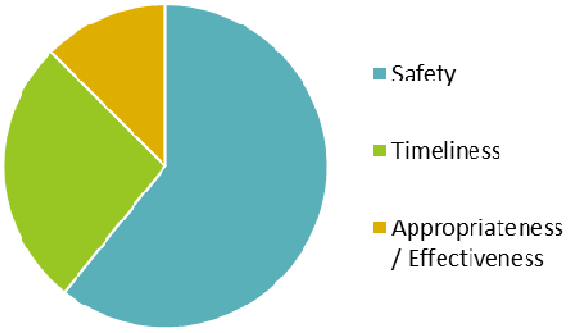


Each quality and safety report was classified with respect to its impact on care, into one of three groups or sub-domains:

- Safety
- Timeliness
- Appropriateness or Effectiveness.

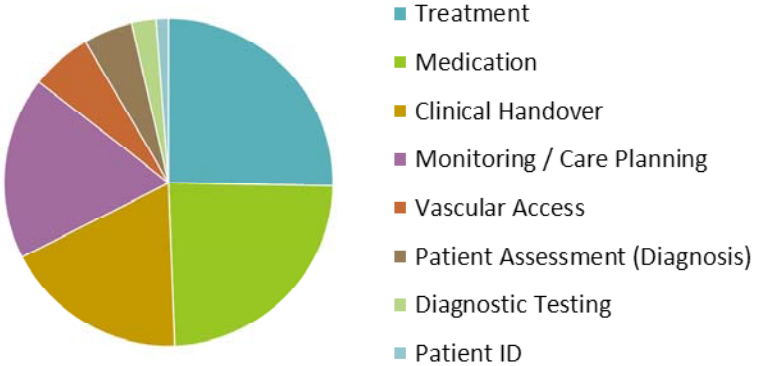
The majority of these reports related to patient safety (61 per cent) with timeliness and appropriateness or effectiveness of care comprising 27 per cent and 12 per cent respectively (figure 11).

Figure 11: Subdomain of quality and safety reports



As illustrated in figure 12, the most common type of quality and safety report related to treatment and medication, followed by clinical handover and monitoring or care planning.

Figure 12: Type of quality and safety reports



It was noted that a significant number of quality and safety reports related to high acuity patients such as those from oncology (n=4), neurology (n=6) and mental health services (n=5). Issues such as central line management, access to emergency management plans and previous medical records for complex patients were common themes.

2.2.1 Quality and safety events

As described on page seven, the standardised ratings and definitions for clinical incident reporting adopted by CHQ, were used to assign a severity rating for the level of harm likely to have occurred (i.e. no harm, minimal harm, temporary harm, likely permanent harm or death) and assessed for the potential of a serious safety event, defined by CHQ as "a variation from expected practice followed by death, severe permanent harm, moderate permanent harm or significant temporary harm"[2].

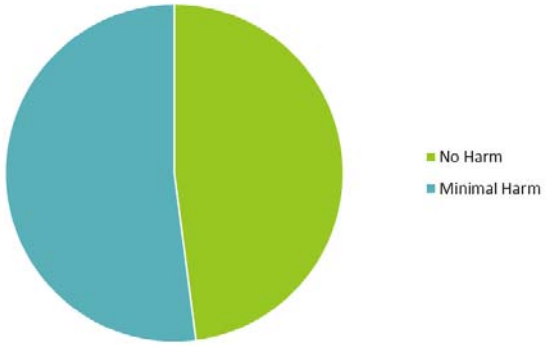
Reports assessed as including potential serious safety events were reviewed by a minimum of two reviewers and all were reviewed by the Clinical Review Chair for consensus and confirmation.

There were no cases of death, permanent harm or temporary harm identified within the scope of the Clinical Review. There were no quality and safety adverse events reported to have occurred on move day.

Quality and safety categorised reports (n=74) relating to events occurring during the two weeks after the move were assessed as leading to minimal or no harm (figure 13). These reports were reviewed for the potential for a serious safety event.

[2] Children's Health Queensland. 2013. Patient Safety and Quality Improvement Strategy 2013-2015.

Figure 13: Assessed level of harm (severity) of quality and safety reports



The Clinical Review Team did not identify any serious safety events for the period in review. There were 18 quality and safety reports assessed as move related where the actions of staff averted the potential for a serious safety event. Issues regarding equipment availability, use and function featured in several reports relating to quality of care. Delays in treatment and difficulties with clinical communication were noted. These cases are grouped as follows:

- Clinical care (n=5)
- Equipment (n=5)
- Support services (n=4)
- Hospital systems (n=2)
- Physical environment (n=2).

2.2.2 Quality and safety data

Available quality and safety data was reviewed for the time period in question and where possible compared to historical data for the RCH. The routine use of trended data for quality and safety by staff and management appeared limited. This, combined with a nascent organisation and historical data being only available from the RCH, makes the identification of emerging quality and safety issues and the monitoring of performance over time challenging.

December, and January where complete, data for readmissions, representations, unplanned return to theatre and staph aureus infections all had a reported incidence rate similar to previous data from 2014.

Although there was a known issue with false alarms, total true Medical Emergency Team (MET) calls were reduced compared to the same time period in 2013.

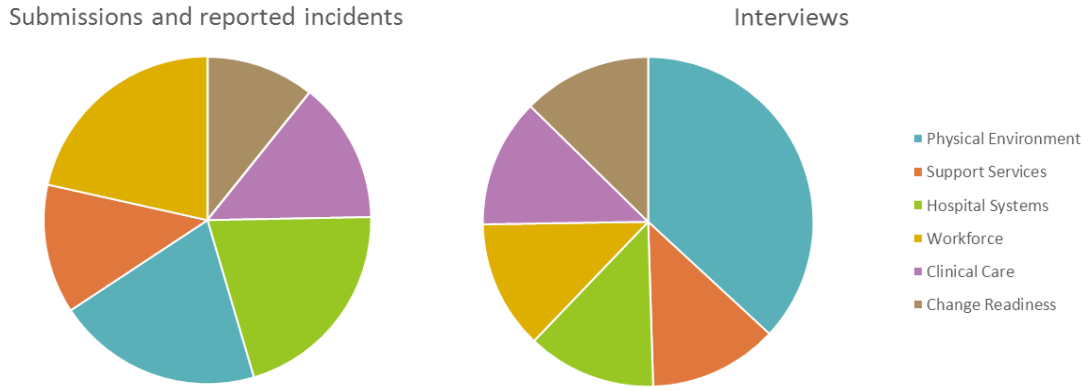
The Executive Director Medical Services Patient Safety and Quality Monthly Board Report for December 2014 showed all key performance indicators except for the National Emergency Access Target (NEAT) were met. The Health Round Table data are not yet available for this period.

2.3 Patient and family experience

Submissions (n=69) and incidents (n=8) were reviewed and interviews (n=2) with parents and a volunteer representative were conducted to facilitate an understanding of whether patients and families had felt safe during the in-scope period. Submissions varied in length considerably ranging from short statements through to several pages.

The reported issues, both positive and negative, were identified and grouped into the six main categories for submissions, interviews and reported incidents (figure 14).

Figure 14: Patient experience - issues classification



All submissions identified as reporting on patient and family experience were analysed according to the timing of occurrence:

- Move day – 3 per cent
- Both move day and post move – 6 per cent
- After move day – 87 per cent
- Unknown – 4 per cent.

Analysis was undertaken to determine whether the reported experiences were related to the move and/or the stand-up of operations in the new hospital. The majority of submissions and reported incidents (86 per cent), together with the information provided at interviews, were considered to be directly associated with the move and/or stand-up of operations in the two weeks subsequent to the move. The remainder of the submissions and reported incidents (12 per cent) were assessed as being possibly related and 3 per cent of submissions and reported incidents, whilst in-scope, were not considered to be directly related and were thought to be consistent with routine feedback or activity of a paediatric hospital.

There were no family submissions that dealt specifically with the transfer of inpatients from RCH or MCH as part of the physical move on 29 November 2015.

Of the 69 submissions assessed, more than half (52 per cent) were categorised as compliments and provided positive statements about the new hospital's facilities, the professionalism of staff and the delivery of patient and family centred care:

> *[My son's] admission was efficient. The staff were outstanding, caring and prompt. [My son] was fed excellent food and refreshment. The doctor and nurse(s) was thorough, pleasant and professional. I do not have any complaint about process … Queenslanders are most fortunate to have such an outstanding public health facility and such hardworking, dedicated health workers.*
>
> *Overall I think our son was managed well in light of this issue and we got excellent service. His privacy was respected. He was spoken to directly and respected as a young person of 14 with his own views and identity.*
>
> *...my family is fully satisfied with patient care provided during our appointment. The hospital surrounding is child friendly and the volunteers are very helpful to guide us to various departments.*

We were very impressed with the caring, helpfulness and knowledge of the staff of Lady Cilento. They went through all possible issues and were able to find the source of his pain quickly while also calming my son and making us all comfortable. The hospital itself was clean, sparkly and beautiful. We were very impressed with our whole experience.

My experience at LCCH was nothing but positive. We found it easy to locate where we needed to be for my daughter's appointment. All staff were friendly and helpful.

Thank you. We were seen quickly by caring and knowledgeable staff. Great facilities.

Families did demonstrate an appreciation that working in a new environment would be challenging for staff. In many instances families reported that staff demonstrated extra effort to provide a positive experience and deliver timely treatment and care.

The only observations would be that some of the medical staff seemed to be a little disoriented with the new building still becoming familiar with the location of equipment and overall layout of the hospital however I believe that this would be normal in any similar situation.

We were in the hospital on day three and even though I could see there were some 'teething' issues and some confusion about where equipment was stored, they took it all in their stride, it never compromised their care or professionalism.

… our NUM did an excellent job sorting out certain confusion in policies and inconsistencies in care which are bound to happen when two different entities merge.

One staff member went out of her way to direct us and everyone who we approached for direction were friendly and helpful. It was a surprise as everyone would have been under stress and pressure.

Assessment of the submissions and reported incidents for evidence of harm, as defined by CHQ, revealed that 78 per cent did not experience harm. However, 22 per cent reported a less-than-positive experience resulting in minor harm, which was predominantly short-term distress.

… surgery took longer than I expected I later asked if this was because the surgery was complicated but it was actually due to set-up issues with the laser, perhaps in this circumstance have someone call the parents so they aren't worried that something has gone wrong.

The phone system did not work and we were unable to contact the unit. This resulted in a quite a bit of hardship for [my daughter] coming to Brisbane tired in the heat.

We drove around to the main entrance but could not easily see how to gain access, the main entrance was poorly signposted and eventually we discovered that we need to press a communication button further up the street and then turn 90 degrees to our left to access the building. I am assuming that during the day that these issues could not occur, but with a half unconscious infant at 3am this was a stressful and difficult exercise at the time.

For each submission, issues were identified within the six broad categories and assigned appropriate sub-categories. For each, there was an assessment whether the issue delivered either a positive or a negative experience. The underlying assumption when completing this analysis was that a poor patient experience could be associated with families not feeling safe. In some instances, there was evidence that family concerns about hospital systems and processes did adversely affect their overall confidence in the hospital even though they may have reported receiving good clinical care. This

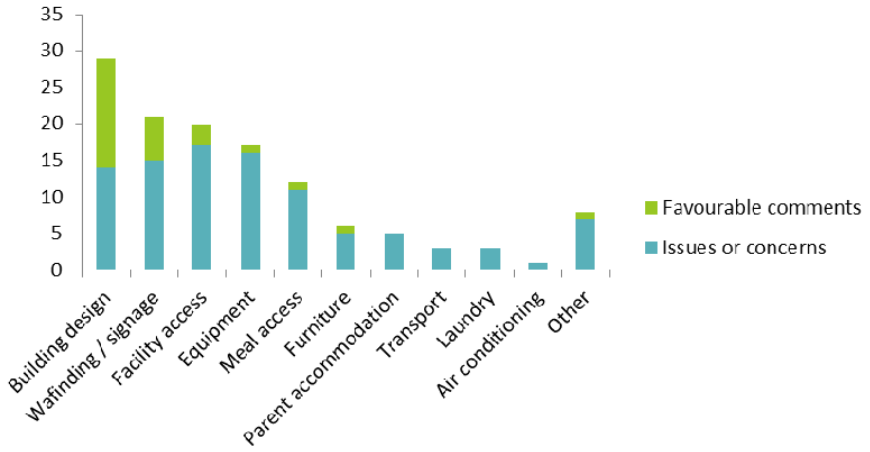
analysis provides more detailed feedback about the factors contributing to the patient and family experience as well as opportunities for improvement.

2.3.1 Physical Environment

There were 125 issues associated with the physical environment (figure 15) with many of these being negative. Consistent with information in the public domain, families reported that there were limited parent amenities at the time the hospital opened. This included a lack of access to a retail food outlet on-site, and limitations in the laundry, kitchen and respite facilities.

The 'Other' sub-category included references to bathrooms, child-friendliness, décor, fire alarm volume, MET call buttons, parking, patient entertainment systems, patient privacy, play spaces (in wards), the Starlight Room, ward orientation and outpatient waiting spaces.

Figure 15: Physical environment issues



It was reported that access to the facility, particularly from the car park, could be problematic and general issues with way-finding and use of appropriate lifts were described. Insufficient signage to support way-finding was identified although there were numerous positive comments about the advice provided by staff and volunteers when families sought directions. Access to the Emergency Department, especially after hours to seek treatment for a sick child, was reported to be problematic.

> *… when arriving after hours there was little signage from the car parking station to the Children's emergency unit.*
>
> *The main problem with the visit was the lack of signage. There were temporary signs (pieces of paper) attached to the counters instead of easy to read large permanent signage. This led to uncertainty about where we were supposed to be.*
>
> *It was also confusing working out the lifts in the hospital. Signage could have been better.*
>
> *One thing that was an issue was when we came to leave. We had parked in the basement car park and had come up to emergency through the lifts in the main building. Since emergency is located on the outside of the main building, when we went to leave, as it was quite late (around 11.45pm), the doors to the main building were locked and there was no obvious way to access the lifts and/or the car park. I returned to emergency and one of the staff was able to come and let me into the main foyer and to the lifts, but I wonder how I would have returned to my car if they couldn't do this.*

Signage for the Emergency Department when walking on street level is poor (the word 'Emergency' is so large you actually do not recognise it from street level).

As parents, we also had some basic problems during the hospital visit. Road signage to the entrance of Emergency on approach was unclear, seeming to direct you to the rear of the hospital, rather than the fastest route.

Families identified issues with waiting areas, particularly in outpatient areas. These were often described as busy with insufficient or inadequate furniture to accommodate families while they waited to be seen.

When we arrived at the new hospital operating theatre area there were no seats or areas for parents to sit and we stood in a hall.

In both areas the waiting rooms are small and at times children are sitting on the floor! The furniture is not very practical and not enough seating is provided.

There were also issues with access to the right equipment to support clinical care and provide a positive experience.

Blood pressure machines were so high most staff had difficulty reaching them. In order to take my child's blood pressure the cot had to be manoeuvred right into the corner, as the cord was not long enough.

At a practical level, while the décor of the new hospital was impressive, some basic supplies and facilities were sadly lacking. For example, the toilet pans we were given were a green plastic container, which we could not fit in the toilet bowl.

…back in the ward, he was in bed and the TV above him was in such a place that he couldn't actually view the screen. It was too close and at the wrong angle so all he could see was a black screen.

There were many positive comments about the building design, particularly the child-friendly environment. However, issues with child access to the emergency call buttons were identified and it was recommended that a process for orientating families to the ward environment would be beneficial.

2.3.2 Support Services

There were 36 issues associated with support services (figure 16). There were negative (and some positive) experiences associated with patient meals, which included meals not being provided or inadequate meal sizes, accessing supplies and consumables, and the cleanliness of the facility.

By around 7:30pm [my son] was becoming peckish after being nil by mouth all day. I asked could he have some food. I was told he was able to, but the nurse on duty was unable to access any food or drink whatsoever for my son. So after about an hour of trying to access food to no avail I found myself out on Stanley Street looking for food, luckily Subway was open.

Over the stay, no meals were provided other than breakfast. Some nurses and admin staff also assumed that they would be provided to the room. No prepared baby food or formula was provided even though formula was requested.

We waited for hours for the medication to be released.

On our first visit to the pharmacy, it took over 90 minutes for a script to be filled. Very hard on [the] parent to entertain two kids when no canteen is available. On each of our visits to pharmacy, you pay for [the] script at one window, the items are taken away and [the] pharmacist comes out to give you the script [dispensed]. This did not happen at the Mater or our local pharmacy unless it was new medicine which is understandable. I visited the pharmacy in the last few days, and was frustrated when asked questions, this is a waste of time considering [my child] had been taking these medicines for the last 3-4 years. If I could get the scripts filled at our local pharmacy, I would do that, the visiting of the hospital pharmacy is time-consuming and frustrating.

[My husband] was told that the LCCH did not have any of the tubes we use to connect [my daughter] to the feeding machine and [my husband] was informed that he should have brought our own from home. (We didn't know that she would be admitted, because not every time she has a flare she is admitted). We were always supplied these tubes when admitted to the Royal Children's Hospital.

What was striking about our trip to the Emergency was the difficulties that staff were having in accessing basic supplies. For example – we were trying to collect a urine specimen from [my daughter] and when the urine pot needed replacing, there were difficulties finding more. There also wasn't ready access to "blueys" (plastic-backed absorbent mats) to put under her, which resulted in quite a lot of mess while we were trying to collect the urine specimen.

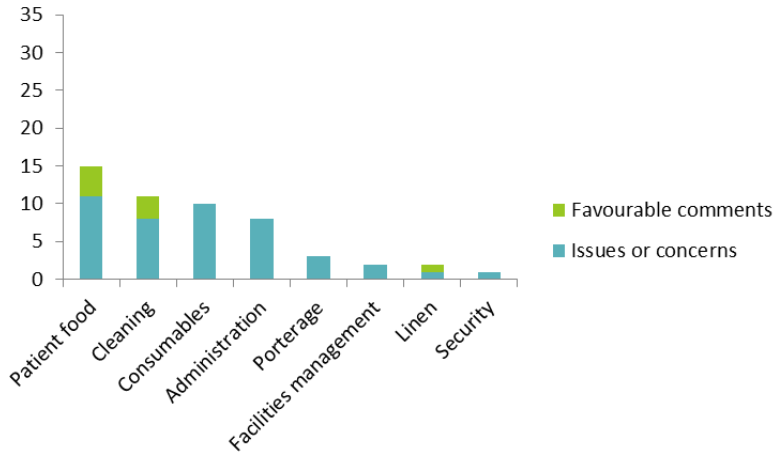
The cubicles/room which [my child and I] were in was not clean – the floor was visibly dirty and the cleaning staff kept walking past.

Toilets in the fracture clinic (females) obviously hadn't been cleaned all day.

The contracted cleaning staff were not briefed on cleaning requirements and the importance of keeping a sterile environment for [complex] patients. The floors in patient rooms and kitchen/share areas were not cleaned regularly enough. The shared kitchenette was constantly filthy. …

There were absolutely no bins for rubbish in bathrooms and the bins in patient rooms were not cleared regularly enough causing overflow – not good in a [specialty] ward.

Figure 16: Support services issues



2.3.3 Hospital Systems

There were 100 issues associated with hospital systems (figure 17). The 'Other' sub-category included references to duplication of processes, infectious diseases management, mail management, pharmacy dispensing, rostering and Wi-Fi usability.

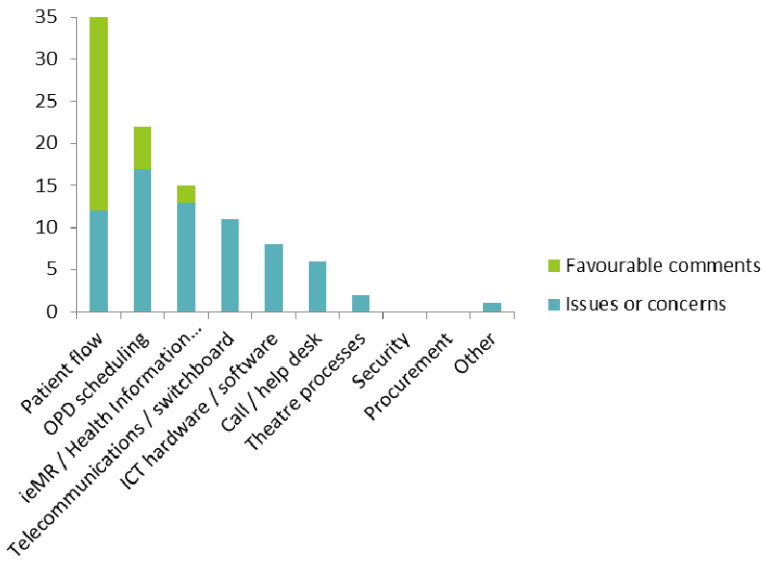
There was considerable comment about patient flow, either as an outpatient or inpatient. Many (n=23) were positive describing an efficient experience that was well-coordinated with minimal waiting time.

> *The new hospital was impressive. In 1.5 hours, we were assessed, records made, saw a doctor, went to x-ray and revisited the doctor for dressing. With so many steps it could not have done any quicker.*

> *Though the reception staff stated they were unfamiliar with a few new processes, network systems were slow and disruptive and it seemed staff did not know each other very well our appointment was … run efficiently and close to our appointment time.*

> *Everyone performed to the high standard I expected and the procedure on leaving was efficient.*

Figure 17: Hospital systems issues



There were, however, a number of long-waits reported for outpatient appointments. Furthermore, outpatient scheduling was identified as a source of stress, which was often exacerbated by challenges associated with contacting staff to reschedule appointments or alert them to issues impacting about their attendance. Short notice of outpatient appointments was highlighted as an issue.

> *Was not a very well organised appointment. I received a phone call two days prior to our appointment; luckily I didn't have other appointments to attend that day.*

> *I did have an appointment for my daughter with [the medical team] although I tried phoning for three days without getting through to anyone or even to leave a message. I was either 12th or 13th in line or more and the waiting was more than two hours at a time, without getting to speak or leave a message.*

> *We have a three hour drive to get there and we tried to call ahead to explain we had been caught in heavy traffic. We were placed on a waiting system and we were number 19, we finally got through after 25 minutes on hold.*

It was over a week before our letter arrived in the mail and I would like to have received notification of our appointment a lot sooner to be sure you had received our referral. Also, on arrival at the hospital for our appointment we had to wait over an hour to be seen even though the appointment was scheduled for 9am.
I had a missed call on my mobile for this appointment which I called back to confirm this appointment. The day came and when we got to clinic there was no clinic. But the ladies at the counter could see there was an appointment. So for us it was not a great first impression of experience.

Issues associated with accessing or managing health information (n=13) using the computer systems (n=8) or accessing switchboard services (n= 11) were identified as contributing to a negative experience.

None of the children's records had been transferred to the new system, which made it very difficult for our doctor…

Witnessed a lot of confusion over computer systems.

The computers were down when we were trying to check the referral from my paediatrician.

Medical staff and switchboard staff had difficulty contacting [specialty] surgical staff as no one knew any numbers, which prolonged our stay.

2.3.4 Workforce

Of the 96 issues identified as being related to the workforce (figure 18), there was an overwhelming number of positive comments regarding the attitude and behaviour of staff members and the performance of individuals and teams. This is something to celebrate as there is strong evidence that the workforce is committed to the delivery of patient and family centred care even though working in the new environment was challenging and, at times, stressful.

The doctors talked to me about the incident and were empathetic and complementary of my response to the accident. Their assurances, lack of judgement and encouragement went a long way towards helping me through that day. The medical expertise, efficiency and professionalism were something I expected, the kindness was not, and it made such a lasting impact.

The Medirest Ancillary Staff are to be congratulated too. Their contribution to patient care is not to be underestimated. [Three staff members] certainly did everything in their power to ensure the children were well looked after…

Your staff were very friendly and well organised. [My daughter's] doctor was wonderful as he always is. You should be very proud of what you have achieved.

Timeliness and quality of service was high from reception, nurse and treating doctor.

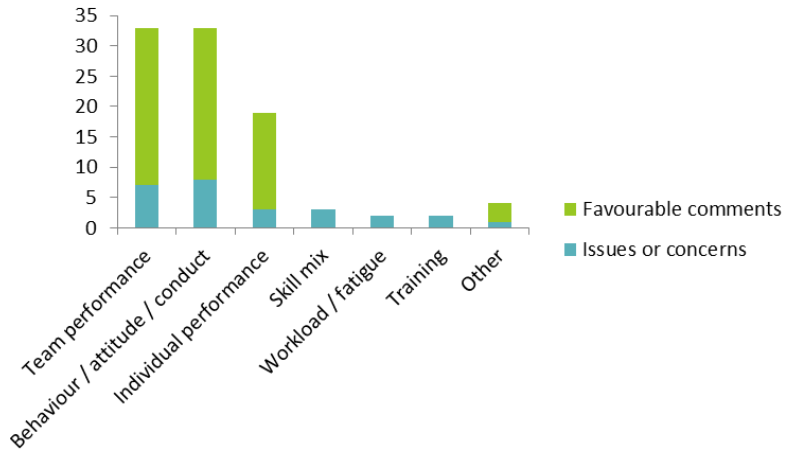
Staff are amazing – efficient, fast, friendly and supportive.

What works: the friendliness of staff and their positive attitude even when they themselves are still trying to find their way around the hospital.

I, as a concerned father, found the staff exemplary and the facilities were absolutely magnificent.

The staff were very professional and thorough, and treated us and more importantly our son with kindness and support. As it was a very emotional time for us, we would like to say thank you to all the nurses, and doctors involved in his treatment. He has recovered perfectly, and we are forever grateful. The process in the new hospital was both smooth and efficient.

Figure 18: Workforce issues



The 'Other' sub-category included references to ability to locate staff, culture, interpreter services, junior staff, recruitment, staff support, switchboard, TMS Consulting or the Employee Assistance Program and volunteers.

There were some opportunities for improvement identified in relation to general customer service.

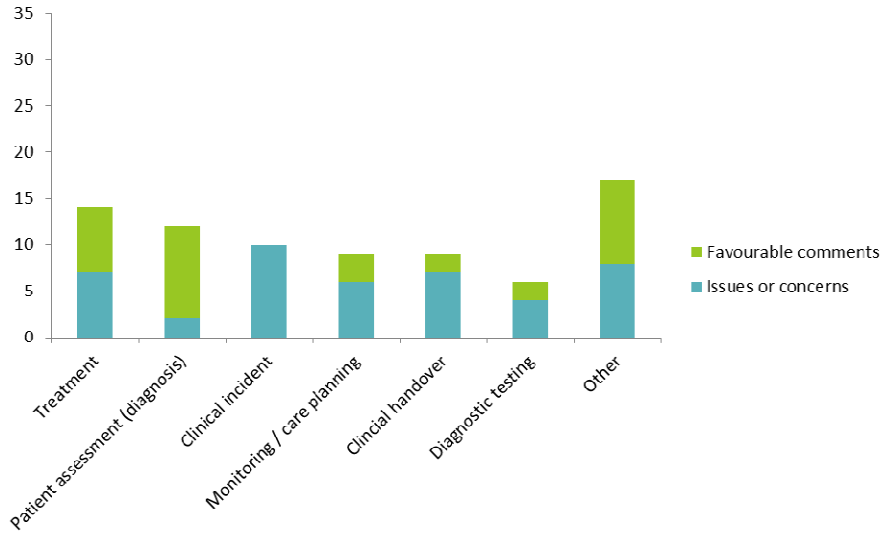
I stood at the counter in the [specialty] section on arrival for five minutes and was not acknowledged by any of the staff. … While waiting to be acknowledged various staff could be heard complaining about how many patients they were expected to see in the clinic and how they themselves still didn't know where things were yet.

All this said, at no point was anyone rude to me and I do believe that most people I had dealings with did genuinely want to help me, but they just weren't sure how to.

2.3.5 Clinical Care

There were 77 issues associated with the delivery of clinical care (figure 19), 43 per cent were positive and 57 per cent were negative. The 'Other' sub-category included references to clinical communication with families, equipment, nutrition, patient and family-centred care, and privacy.

Figure 19: Clinical care issues



The clinical incidents (n=10) which have been considered in section 2.2, Quality of care were all classified as SAC 3, which were minimal harm, no harm or near miss. This included potential for harm associated with inappropriate diet and compromised access to health information. It was reported that some parents may have assisted in averting clinical incidents as a result of facilitating handover or remaining with their child throughout their inpatient admission.

> *… the paediatrician could not access the relevant information to compete this. Fortunately, I had brought copies of these blood results with me (which I always have to go out of my way to get), so the paperwork, appointment and review could proceed*.

> *… was unable to get anyone to provide thickened fluids asked kitchen, asked nurse, asked to see dietician.*

> *The element I have found most exhausting is that I have had to be constantly advocating for the ongoing clinical coordination of [my son's] care.*

> *The responsibility falls on the parent to keep across all details and frequently fill in the gaps as there is never one key accountability. Therefore the parent seeks out understanding of all processes to anticipate potential errors.*

In relation to handover, there were positive experiences about the support provided to deliver care at home.

> *[My son] was seen without delay and we were discharged fairly quickly with a follow-up plan.*

> *Every visit I was sent home with dressing supplies and information sheets, as well I was told to call at any time if I was concerned, which I did on one occasion. I was able to speak to one of the nurses immediately and was able to follow her medical advice.*

However, there were issues reported regarding the transfer of information to the general practitioner. Families interviewed reported that a discharge summary had not been received and similar information was provided in the submissions.

> *The follow up letter to the GP omitted relevant clinical information and inaccurately indicated that [my daughter] had a UTI a week previous. My concern is the doctor did not have a full*

understanding of the [reason] why we presented at the ED either because he dismissed or forgot relevant information prior to updating [my daughter's] patient record.

[It has been] over 10 days post operation, and still no notification from LCCH to [my child's] GP as to all the procedures that were undertaken including pre- and post-op complications. Why has this not been done as it has [also] been a week since speaking to the Nursing Manager…

There was considerable positive commentary about clinical care processes and many teams were identified as providing high quality treatment and care. In particular, the Emergency Department received considerable praise for the manner in which assessment was performed and treatment provided.

She was seen by a triage nurse in emergency who was very efficient and welcoming… My daughter was looked after very well, we saw the doctor not long after her arrival at emergency. He reviewed her thoroughly, he explained her condition to us and arranged for pharmacy to come…

I have not complaints only compliments for the care of my daughter. We got seen straight away in A and E. All staff were kind and considerate. We experienced great care and attention. Thank you.

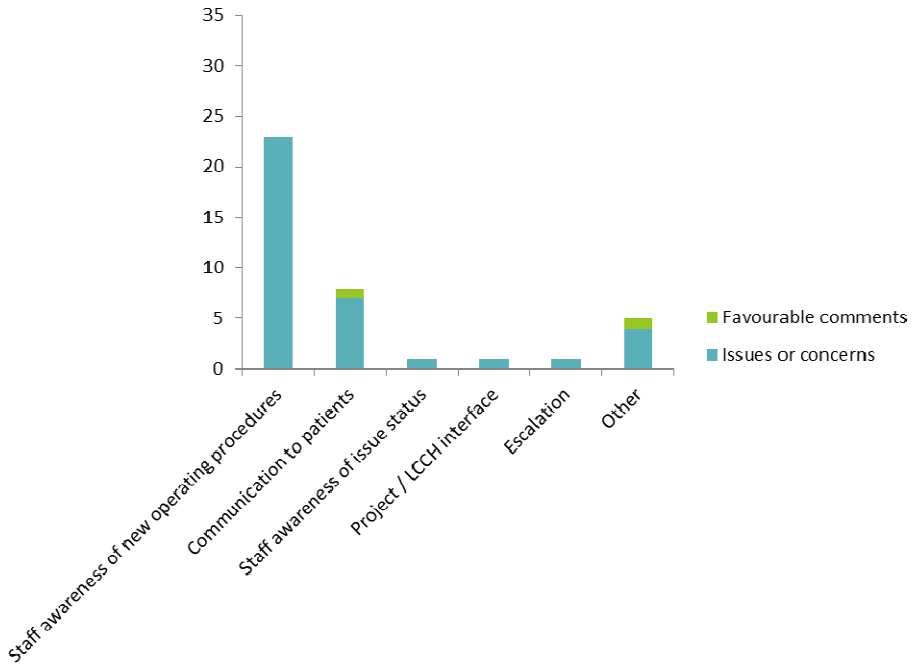
Our daughter attended Emergency at LCCH on the afternoon of 4th December. We have only compliments for the fantastic medical and nursing staff who were involved in her care. We were particularly impressed with the efficiency of her review in triage, then transfer into the red and purple zones. The medical and nursing staff were helpful and attentive in her care. They were also very helpful to and supportive of us as parents.

From the moment the triage receptionist dealt with my frantic concerns and questions and calmly gave me answers and looked after my son, through to the triage nurse assessing him to the actual nurse and doctor, I felt he was being looked after brilliantly by people who were knowledgeable, well equipped and confident in their facilities. The doctor, in particular deserves special praise for her excellent and timely work.

2.3.6 Change Readiness

In total, 39 issues relating to change readiness were identified (figure 20) with a particular focus on the implementation of new operating procedures, change communication to families and complaints management. The 'Other' sub-category included references to complaints management, culture, move timelines, operating theatre preparedness and patient transfers.

Figure 20: Change readiness issues



Issues (n=23) were highlighted in relation to staff awareness of new operating procedures, which was often described as staff not being sufficiently familiar with the new environment.

> *I wouldn't leave [my son] at the hospital and go home and rest as there was the feeling of disorganisation and nobody knew where things were or what they were doing.*

> *I found the staff were great with my daughter's care. They just didn't seem to know where anything was. I don't know if there was orientation done.*

> *Staff unable to locate many items (which I guess is understandable as the hospital had only been open for two days).*

> *Nurses seemed to be struggling with some of the equipment and haven't had the opportunity to familiarise themselves with the hospital, equipment and processes to ensure they felt confident when the hospital opened.*

Issues (n=8) were identified with communication to families regarding the relocation of services to the LCCH and the new facility. There was only one reported event where a family presented to the former Royal Children's Hospital for treatment.

> *We then arrived at The Royal Children's Hospital, which is where [my son] has had all of his [procedures] and appointments for the last five years. At this point in time we were 10 minutes late, we quickly parked and paid and ran to the hospital. As we arrived we found it empty with an evacuation drill being done. Confused and uncertain and clearly lost, we found a group of ladies who explained the hospital had moved to Southbank.*

Issues with complaints management, which were both positive and negative, were captured in the 'Other' sub-category.

> *Although the initial error was incredibly distressing, I understand that due to switching hospitals this would cause some issues, however the response time and resolution they offered has been*

incredibly satisfactory and that is the true mark of efficiency. Everyone will make mistakes, but how those mistakes are rectified is what matters.

Once home, I made a formal complaint through the patient liaison office that has seen the issues dealt with though I am not aware how all the issues were resolved.

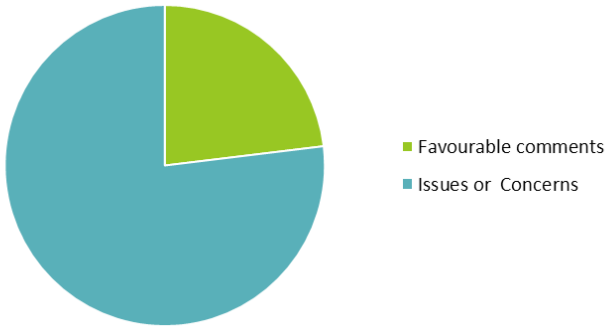
2.4 Staff experience

Staff experience data was collected through submissions, interviews and focus groups, and reported incidents. PRIME CI reports and submissions were analysed and categorised using the assessment tool in appendix 4.2. The interviews are collated separately in appendix 4.5 in a heat map from information provided, notes and quotes taken during the discussions.

2.4.1 Interviews overview

The overview of discussions is shown in figure 21 with 74 per cent of the collective discussions reporting negative experiences of the move and the period in review, and 24 per cent of the conversations commenting on positive aspects.

Figure 21: Types of matters raised by staff



Overwhelmingly the positive commentary related to the following:

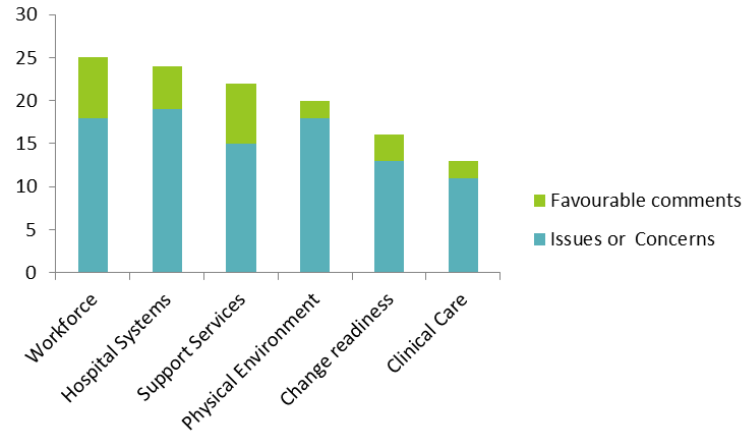
1. Staff reported that the move day was well coordinated, responsibly supported and smoothly executed, with a laser-like focus on patient assessment and safety for the transition to the new location. All patients were moved without incident.
2. All discussions commended the tenacious efforts of all staff to go beyond the usual work day roles to solve problems, avert clinical risks or prevent and manage poor patient experiences.
3. That having all services finally in one place was of benefit to teams and families, and that staff would be able to work productively for a better care environment.
4. Excellent support from ICT and security was worthy of special mention by many groups.

There was conversational acknowledgement that staff performed well in difficult circumstances. This included reports of Medirest staff needing to learn on the run and trying hard to quickly get up to speed, that nurses overcame barriers of different backgrounds to come together around the patients' needs and to fill gaps left by rostering shortfalls, and efforts of the dietetics staff to work with the catering staff to address dietary needs. There were reported multiple efforts of staff who came in on days-off in the lead up to opening to prepare the patient areas. A few groups had complimentary comments about the facility; that parts of the new building were really beautiful, and that it was an improvement on older facilities.

It was apparent during interviews that some staff remained stressed or even distressed about the additional burdens endured during transition and continuing now. There was a sense of isolation and staff expressed a need to pursue their own workarounds to solve issues. It was clear that during the two weeks in-scope for this review, staff were working longer hours and outside of the scope of their usual role to maintain a functional work environment. Staff reported little or no feedback on defects reported and felt there was no visibility or transparency on the progress of their issues, leading to further anxiety and frustration.

Individual matters raised or identified through interviews and focus groups were classified into six categories (figure 22). The majority of concerns related to hospital systems followed by physical environment and workforce. The clinical care concerns mainly related to averted events; any actual patient safety events are referred to in section 2.2, Quality of care.

Figure 22: Categorisation of matters raised by staff



2.4.2 Physical environment

In most reports the physical environment provided staff with some unexpected difficulties, most of which created practical concerns or extra work for staff rather than safety issues. For example,

- Staff work stations were reported as crowded and noisy, with too few workplaces for transient team members
- Patient rooms varied in space around the bed
- In some wards the pan rooms and medication rooms were too small
- Corridors created difficult sight lines and some 'black spots' in terms of visibility of patients
- Some of the furniture fixtures did not seem to be fit-for-purpose, for example seating in circulation spaces and small family facilities
- Door noise, safety and access to some areas
- Some phones were not operational or available
- Placement of MET call buttons, power points and fridges.

There were 27 per cent of reports related to equipment. Most of the equipment was either new to staff, not located where expected, or not set up for use on opening day. Many staff reported difficulties with the set-up of outpatients and that nothing was really ready for them to see patients, for example computers and workstations not were set up, and basic assessment equipment needed to be sourced on the first day. Staff reports included:

One PICU wing was physically unfinished on move day (pendants barely completed, missing suction devices).

There were no bins whatsoever… In my first clinic there was no soap in the dispensers… no…examination equipment on the walls.

I spent the first day in clinic setting up computers, printers, faxes.

EEGs systems have not been set up for remote monitoring.

Administrative staff reported no paper or forms in their work areas as well as needing to sort out directions and scheduling mix-ups on the first days.

There were numerous mentions of the lack of adequate staff space to eat or share time-out. There were defects being resolved by building crews after moving in which staff found disruptive and compromised the use of some spaces.

Lack of access to the environment prior to the move meant only some staff had exposure to the space and actually knew how the facilities worked and how to find their tools.

The unresolved issues of parking and food facilities did not create grief with staff in interviews but was mentioned as adding to their daily irritations and concerns.

2.4.3 Support services

The perception of a number of staff interviewed was that there were fewer administrative staff than they had expected, that many administrative staff had increased workloads and that they often were the front-line in handling parents' concerns, enquiries and confusion.

Cleaning staff were considered under-trained for the speed or standards in the acute hospital environment. In interview one staff member reported:

I had to teach the cleaner how to clean a room for the [immuno-compromised] patient.

Many of the stock consumables were difficult to find or source in the first few weeks and this created delays to care and extra work for staff to seek them out.

There was a mismatch between linen utilisation and disposal capacity in the first weeks.

Linen bags were so small they were filled and left lying around in the corridors for hours.

Staff reported feeling clumsy with new tools and new equipment, and were concerned that parents saw this as potential incompetence.

Porterage was difficult in the first few weeks, with 38 per cent of reports of related issues in this area.

It seemed that the concept of 'urgent' requests meant different things to clinical versus Medirest staff. It was difficult to determine how many of these 'urgent' requests were delayed by the telecommunications system problems which further complicated responses. Many clinical staff reported transferring patients themselves because the porterage delays were too long, or the porter did not arrive.

The contract with Medirest was not reviewed by the Clinical Review Team and therefore it is not clear whether the cleaning and porterage responses were reasonable according to their agreement.

Variable food issues arose, usually when patients needed something outside of the usual meal times, or usual meal content, and this affected staff in the time required to source alternatives.

2.4.4 Hospital systems

Two key system areas combined to raise problems and increase the stress for staff:

1. Reports of difficulties with telecommunications were frequent among all groups, and reported in submissions from staff.

   It became clear from the first day…that the majority of staff were inexperienced in switchboard operations.

   The main problems reported were:

   - Staff were unfamiliar with the online system so it was difficult them to use it quickly; many of the destination numbers were incorrect
   - Local departments did not understand how their phones were set up or should work and therefore some calls were not acknowledged in an appropriate timeframe, including those to pathology and blood bank
   - Switchboard staff did not understand acute hospital support systems, for example on-call rosters and paging requests or the sense of urgency of concerns. They did not often understand the request being made and put calls through to incorrect locations
   - There were long waits for any call to switchboard, sometimes up to 45 minutes.

   Junior medical staff, in particular, felt particularly at risk at this time, often working on their own and feeling quite lost in the new spaces.

   A Telecommunications Taskforce was established on 2 December 2014 to address these concerns. The Clinical Review Team noted most of the issues have since been rectified or improved.

2. ICT support was considered very good by all, but the systems themselves were often described as highly challenging by staff. The additional support provided during the transition period included formal training, floor walkers and support drop-in centre and hotlines.

   Computer access was reported to be an issue for all staff and it was noted that for staff new to Queensland Health, including those from MCH, there were a large number of new systems which required multiple log-ins.

   Some staff reported difficulties with finding their way around the integrated electronic medical record; this led to some information not being found, or being found after lengthy searches. They noted causes related to poor preparation for users, particularly MCH staff, who were not easily able to be freed up to attend training. Equipment set-up again was reported to create problems in many areas.

   Although there was very good circulated and printed information to all employees for accessing records, not all staff seemed to be aware of support resources, and some did not call for help when they could not find a record. In addition some had received information about charges to be applied to record requests at the MCH which led to further reluctance to seek records.

Patient flow issues in the main related to porterage as reported in 2.4.3, but some references were made to information regarding incoming patients and transport procedures not being well documented, but no further explanations came out in discussions.

The integration of outpatient department scheduling was disrupted due to the late transfer of information from MHS and the need to manually transcribe data from old systems to new. The resolution of these issues was not clear to staff and seemed to be of continuing concern.

The new patient self-help and check-in systems were not consistently working adding to stress for administrative staff as queuing became an issue and waiting rooms filled.

Many staff reported they were not sure of the processes to report issues or how to get feedback on their progress which added to their concerns.

2.4.5 Workforce

Rostering was raised as an issue specifically in nursing. Many rosters were reported to not be covered as expected due to resignations and the subsequent gap before the new appointees commenced. In cleaning and porterage, the services were reported to be initially under-resourced to meet demands being placed on the services. This seems to have improved but was difficult in the first two weeks.

Most of the comments around attitude or conduct had surrounding circumstances leading to some frustrations, for example not being able to find appointments or records leading to some comments reflected to families. There were a few reports of unhelpful responses from requests to Medirest and there seemed to be confusion between the work that had been contracted and the expectation of LCCH staff for these services, for example response times or flexibility. These particular communication breakdowns at least partly reflect inexperience rather than a lack of willingness to meet expectations. Clarity around what the Medirest team was contracted to do was not transparent to clinical staff. There appeared to be some confusion with respect to where responsibility lay for repairing faults or defects. There was also discord between timeframes and the expectations of staff, particularly when it came to clinical equipment.
The largest area of concern was training. Most groups reported an issue with preparedness in the new systems or environment. While some simulation opportunities were set up, it was not possible to conduct them for all areas and not all staff could be released to attend. Where units had dedicated off-line managers to support the transition in preceding months, for example the Emergency Department and Paediatric Intensive Care Unit, areas were better prepared.

After the effort of the move day and its lead up, workload fatigue seemed to further compromise the ability of staff to meet their work expectations.

2.4.6 Clinical care

There were very few concerns over direct clinical care with matters raised in interviews and focus groups related to averted problems rather than actual events. Anything specific to an actual event that was raised appears in section 2.2, Quality of care. The biggest ongoing concern was around having enough staff to meet the increased demands and larger hospital requirements, and not losing information through the transition of information systems. It is understood that CHQ follows the Queensland Health Business Planning Framework to determine and allocate nursing resources.

Clinical care was also felt to be affected by staff not familiar with the specialty or environment where they had been allocated. The late allocation of nurses to their respective locations was concerning for both them and their colleagues, and some incidents reported by staff related to the inexperience of the team relative to the specific conditions of patients in their care.

The inexperience of Medirest staff affected the ability to provide timely clinical care on some occasions, but other professions filled the gaps so although patient care may have been late in some cases it was not compromised.

2.4.7 Change readiness

The communication to staff about the new building was well received up to move day, but unfortunately many staff either did not, or could not, take up the training opportunities on offer to prepare them for the new environment.

Almost half (46 per cent) of the responses in this category related to staff familiarity with new operating procedures. In escalating new issues, staff had little understanding of the division of responsibility between Medirest and LCCH staff, or reporting and feedback processes for issues of the building versus the project versus internal repairs.

The next biggest area of concern for staff was the LCCH Project and CHQ interface where issues staff had believed were addressed and agreed through project consultation did not become reality in the building and therefore created a sense of disappointment and confusion.

One nurse described a shift as being a series of relatively minor irritations, inconveniences and problems to overcome,

> *We could provide the care required, but nothing came easily.*
>
> *Each shift was a struggle just to get through*.

An overall observation of staff experience is that the layering of issues over many repeated days has caused stress and concern; this would seem to have the most potential to affect ongoing care.

2.4.8 General comments

Staff cited a need to restore trust between management and clinical delivery staff, and build relationships with service providers (Medirest) to ensure a cohesive operational team. Clarity of the timeline to address any outstanding building issues will provide some certainty for staff. Some commitment to working towards longer term improvements to the environment was also requested at interviews. Although not specific to any category of the analysis, there were several groups that raised concern about barriers to communications and relationships between the MCH and LCCH and that this needed some attention.

3 Commentary and observations

3.1 Standard of care

(Appendix 4.1: Terms of Reference - Scope, item 3)

Objective standards for comparable scenarios, as described at 2.1, were not available to the Clinical Review Team. However, members of the Clinical Review Team applied their considerable experience and expertise in comparable organisations and settings. The findings and observations were interpreted in this context. It should be emphasised that no events leading to permanent harm or death were identified to have occurred during the in-scope period.

While it is not possible to benchmark, the number of quality and safety reports, the level of risk ascertained and the role of staff in mitigating the realisation of such risks were considered higher than during a similar period of regular operations of a children's hospital. These were also considered to be higher than had been experienced in prior scenarios of major organisational change, such as unification without relocation (Sydney Children's Hospitals Network) or single organisational relocation (The Royal Children's Hospital, Melbourne). However, no prior scenario or circumstance known to the Clinical Review Team had been anywhere near the convergence of complexity described at LCCH.

The observations provided in this section reflect and acknowledge those challenges. Some risks and challenges were anticipated but not fully mitigated while others were of a statewide nature and beyond the direct control of the organisation.

3.2 Risk mitigation

(Appendix 4.1: Terms of Reference - Scope, item 4)

3.2.1 Move day

Staff, and parents and families were universally complimentary of how the transfer of patients was managed on 29 November 2014. The planning and execution was described to be an exercise of collaboration and military precision with risks well identified and mitigated through, for example:

- Development and use of clinical safety and transfer checklists
- Scenario testing and mock trials of the move
- Involvement of the Queensland Police Service to manage traffic flow
- Establishment of a central command centre with control centres based in each facility, i.e. MCH, RCH and LCCH
- Medical review / assessment of patients prior to leaving the RCH or MCH
- Medical review / assessment of patients on arrival at the LCCH
- Development and use of Standard Operating Procedures comprising a 24/7 safety team, clinical practice guidelines and communication, for patient flow and management, and clinical care during the transition period
- Provision of food packages for snacks and lunch.

This exercise was comprehensively planned, appropriately implemented and highly successful.

3.2.2 Post move day

Examples of mitigating strategies which were highly effective included the introduction of safety nurses, use of standard operating procedures, convening of daily operational briefings, and leader and clinical roundings.

The findings contained with sections 2.2, 2.3 and 2.4 identify and describe a number of examples where mitigating strategies were incomplete or insufficiently effective.

3.3 Observations pertinent to future operations of LCCH

(Appendix 4.1: Terms of Reference - Scope, item 5)

A wide range of information was received during the course of this Clinical Review, not all of which was directly in-scope but which was important to better understand the context in which care was provided during the in-scope period and the concerns raised through submissions, and interviews and focus groups. Beyond the findings in respective sections describing the matters directly in-scope of the Clinical Review, it was neither possible nor intended to capture all the concerns raised by clinicians, support staff and families. Many of these concerns were already part of various internal processes or communications and staff were further encouraged to engage in such opportunities.

While the issues may not all be new, those considered to have a substantive and continued impact on the operations of the LCCH and which remain unresolved and/or require noting have been themed and summarised. Some themes are highlighted to reflect and acknowledge the continuing distress expressed by a number of staff as well as some parents and families. Staff emphasised their perceived need to continue a level of hyper-vigilance and the impact this is having on increased fatigue and workplace stress.

3.3.1 Complexity, time constraints and challenges relating to preparation for the move

The extraordinary complexity of the challenges and the combination of external factors contributing to the process have been highlighted. It is understood that the delay in practical completion, the proximity of finalising the recruitment process to the opening of the LCCH and/or late resignations, the coincidental industrial or contractual factors disrupting staff continuity and the challenges associated with the release of MCH staff significantly influenced familiarity of staff with the geographic layout and operational environment of the LCCH.

3.3.2 Workforce and culture

Staff throughout the LCCH and at all levels of seniority demonstrated extraordinary dedication and effort in mitigating risk, avoiding serious harm to patients and finding innovative solutions ("work-arounds") in very challenging circumstances. These efforts were noted by parents and families, and were largely successful in the short term but, as explained to the Clinical Review Team, delivered at considerable personal sacrifice and associated with substantial longer term risks.

Staff who participated in interviews and focus groups commended all their colleagues in this regard and particularly acknowledged some specific groups and individuals such as the Divisional Director of Critical Care, ICT staff, security staff, the Patient Experience Improvement Officer and Safety Nurses.

To support staff during this time, additional employee assistance support was made available on-site at the RCH prior to the move, the RCH, MCH and LCCH on the day of move, and continued at the LCCH during the transition period.

The previously described difficulties in access to orientation, familiarisation and simulation opportunities continues to be identified by staff as requiring further redress. For example, there are some previous MCH staff who, along with some other groups, have still not received a full orientation.

3.3.2.1 Mater Health Services

It is understood that MHS was supportive in the development of the new single tertiary paediatric facility and a partner throughout the journey of planning, constructing and commissioning the LCCH. Positive aspects of the partnership between CHQ and MHS includes the permission granted to delay

the transition of the Queensland Paediatric Cardiac Service by two weeks and the continued provision of associated support services.

The impact on MCH staff in particular has been acknowledged and was raised through a number of submissions as well as interviews and focus groups. A broad range of staff reported that MCH staff in particular were considered to be disadvantaged with respect to preparedness for working at the LCCH. Access to orientation, familiarisation, commissioning and socialisation activities was limited, reportedly due to MHS prioritising their commitment to service delivery.

3.3.2.2 Staff recruitment, numbers, distribution, skill-sets and service continuity

Staffing the LCCH was managed through a dedicated recruitment process which, for a number of largely external reasons, was finalised very close to the opening of the LCCH. It was reported that the delayed outcome of recruitment impacted on service planning and individual staff morale. In some cases it was reported that staff found out they had been appointed just prior to the move.

Examples were provided to suggest there may be a maldistribution of staff streams and skill mix with reports that individuals were placed in areas without having sufficient knowledge or experience in the respective specialty. These challenges impacted on staff as well as parent and family confidence with staff expressing feelings of inadequacy and incompetence, and families not wanting to leave their children. It is noted that an internal review of nursing staffing levels and distribution was underway at the time of this Clinical Review.

There were reports that administrative staff are insufficient in number and under considerable pressure. The role of administrative staff in resolving scheduling issues as well as often being the first contact for distressed families, particularly in outpatient departments, has added considerably to their workload and stress.

3.3.3 Organisational culture, trust, collaboration and change management

The integration of multiple and distinct organisational cultures with respective traditions and histories has been acknowledged to be highly challenging in other clinical settings both in Australia and internationally. The previously described additional, external and cumulative factors substantially increased the challenge.

Further, the differences in professional culture between front-line clinicians and senior management has been well documented in the literature and health service reviews or reports. In New South Wales, Commissioner Peter Garling SC, in reporting his findings in 2008, emphasised this divide as "the schism" confronting health services culture. It is understood that at times of substantive change and pressure such differences become enhanced and accentuated. A number of the submissions received and interviews experienced by the Clinical Review Team addressed such concerns and pointed to opportunities to "*press the reset button*" or "*restore the trust*", to quote some of the voices heard.

Partnership with patients and families, using formal and informal mechanisms, is well documented as an essential activity for creating a health service culture committed to the delivery of high quality and safe care. The submissions provided by parents and families provided evidence of the workforce's commitment to the delivery of patient and family centred care at LCCH but also highlighted that opportunities in quality improvement activities exist. Families described the use of patient stories and other experience information as well as mechanisms for consultation with patients and parents or carers.

3.3.4 Staff amenities (including food and cafeteria)

Staff identified the lack of amenities, including a cafeteria, as important. They are keen to understand the obstacles and the proposed timeframes for their resolution.

3.3.5 Staff engagement, feedback and timely updated communications

A theme related to internal communications permeated submissions, and interviews and focus groups. Staff expressed a high level of frustration with not knowing where their reported issues or concerns were in terms of priority, and the process and timeframe for their resolution. Staff do not expect everything will be resolved immediately but they are wanting feedback on what can or will be, or is being, done and the anticipated timelines. Both personal and system-wide updates and feedback were considered important.

3.3.6 Access to technology, equipment / computers and key platforms / programs

Continuing difficulties associated with accessing computers were reported, particularly for junior medical staff. This could be related to distribution of available computers and/or insufficient space in the ward staff stations. Clinicians also expressed continued frustration with the ongoing challenges associated with access to, and the interface between, information systems; it is noted these primarily relate to the age and functionality of statewide systems in use. There is a continued lack of confidence in the referral management process and outpatient scheduling system as well as concerns over the inability of information systems to support contemporary clinical care models. Examples include a lack of video storage capability within the picture archiving and communication system (PACS), inability to access the RBWH PACS and inability to remotely monitor electroencephalograms (EEGs).

3.3.7 Switchboard, telephony and paging systems

The issues reported on the impact of the switchboard operations, telephony and paging during the first two weeks were numerous and are described in previous sections. However, many of these challenges continue, albeit to a progressively decreasing extent.

3.3.8 Medical records access / integration and referrals / appointments

Clinicians reported a lack of confidence that the information held in electronic medical records was complete and/or that patient information is always available. A number of factors contributing to this remain unresolved including a continued lack of familiarity with using the *ie*MR, the inability to read all correspondence contained in a scanned MCH record due to a black banner appearing over parts of letters and the time delays in retrieving paper records for those which have not been scanned.

3.3.9 Medirest

Medirest is a new provider in Queensland. Furthermore, Queensland public sector health services are not experienced with partnering with third party providers for facilities management services. Numerous submissions, and interviews and focus groups highlighted the challenges to be overcome while establishing the facilities management services within the LCCH. Services receiving particular mention included cleaning, linen, food and porterage.

While acknowledging not all issues have been addressed, it is important to note staff as well as parents and families commented on the improvements made to date. Ongoing issues of concern are reported to be related to the lack of understanding, knowledge and experience by Medirest staff of a hospital's (and particularly children's hospital's) functions and requirements. Examples provided included doors being left open in the mental health unit, delays in the transfer of patients to the operating theatre, wards or imaging services and delays in cleaning beds for patients requiring admission. There are opportunities for strengthening the communication between CHQ and Medirest staff with the shared goal of providing high quality services to LCCH patients and their families.

3.3.10 External partners and referral pathways

While CHQ has a statewide role and in essence partners with all HHSs in fulfilling this role, interdependencies exist with two service partners in particular namely the MHS and Metro North HHS. It is understood there is a collaborative working relationship and negotiations are taking place.

However, there are no formal arrangements reported to be in place at the time of this report to provide clarity and certainty with respect to the level of service that will be provided and/or received.

3.3.11 Family amenities, supports and services (include signage)

A number of issues relating to family amenities were identified and addressed soon after the move. Some concerns, as exemplified by way-finding, family accommodation and car parking issues, remain and require continued vigilance by LCCH staff and management.

3.3.12 Design issues and defects

While there was a sense of excitement with the opportunity to work in a new and purpose-built facility, there were a number of concerns raised with respect to design impacting on service provision.

Staff and families provided a range of location-specific examples, such as outpatient departments (consult rooms and waiting areas), the bone marrow transplant rooms and the operating theatres, where further work and/or remediation may be helpful.

Issues related to the difficulty in rectifying functional flaws during the Defects Liability Period were reported. In addition there are multiple partners to work with including Medirest, Honeywell, Lend Lease and the LCCH Project Team.

Recommendation

The Clinical Review Team wishes to acknowledge that CHQ Board, executive and managers have already made considerable progress in solving many of the problems encountered during the first two weeks of operations. The Clinical Review Team provides these Observations in a constructive context and recommends that they, along with the Findings, be incorporated by the Board and Executive of CHQ in the continuing governance, planning and management of the organisation.

4 Appendices

4.1 Terms of reference

1. Purpose

The purpose of this Clinical Review is to assess the standard of patient care at the Lady Cilento Children's Hospital during the move of services on the 29th November 2014, and during the initial two weeks of clinical operations.

The Review has been requested by the Chair, Children's Health Queensland Board, in response to concerns raised in the media. The CHQ HHS Chief Executive (HSCE) is formally commissioning the review.

2. Appointment

Pursuant to sections 125(2) of the *Hospital and Health Boards Act 2011* (HHBA), the Health Service Chief Executive – Children's Health Queensland, has appointed the following members of the Review Team:

Professor Les White – NSW Chief Paediatrician (Chair)

Ms Cheryl McCullagh – Director of Clinical Integration, Sydney Children's Hospitals Network

Dr Sarah Dalton –Paediatric Emergency Physician, The Children's Hospital at Westmead

Ms Jane Miller – Executive Director of Strategy and Organisational Improvement, Royal Children's Hospital, Melbourne.

All members of the Review Team have the necessary expertise and experience to conduct the Review.

The Review Team is to prepare a report containing expert clinical advice in accordance with section 135 of the HHBA to me.

The Terms and Conditions of the indemnity provided to members of the Review Team are detailed in the Instrument of Indemnity as provided to each Review Team Member.

3. Scope of the Clinical Review

1. Assess the clinical care provided to patients of the LCCH during:
    a. The day of move – 29th November 2014
    b. The first two weeks of clinical operations at the LCCH – From Sunday 30th November to Friday 12th December 2014
2. Identify any patient incidents reported to have occurred during the period outlined in (1). Comment on the nature of the incidents, how they were managed, and any cases of preventable patient harm.
3. Comment on the standard of patient/family care reviewed in (1) with reference to expected standard of care for an Australian tertiary paediatric hospital.
4. Assess the processes used to mitigate and manage risks to clinical care during the period outlined in (1). Comment on the effectiveness of these processes in minimising risks to patients.
5. As necessary, make recommendations for future actions to strengthen the reliability of clinical operations, and minimise risks to patients.

4. Powers of the Clinical Review Team

The Clinical Review Team has the authority under section 129 of the HHBA to enter a public sector health service and to access, copy or take extracts from any document (including documents that contain confidential information) that is relevant to the Clinical Review Team's functions and is in the possession or control of the public sector health services.

The Clinical Review Team should make every reasonable effort to obtain any other material or documentation that is relevant to these terms of reference.

5. Conduct of the Clinical Review

5.1. The Clinical Review Team is to make clear to any person who provides information to the Clinical Review Team that they have been appointed as an independent Clinical Reviewer, having no conflict or perceived conflict in respect of the matters under review.

5.2. The Clinical Review Team is to be aware of and comply at all times with the provisions of Part 6 Division 3 of the HHBA which govern the undertaking of this Clinical Review, including (but not limited to) the duty of confidentiality, requirements regarding stopping of a Clinical Review and the protection for Clinical Review reports.

5.3. With the prior notification to and facilitation by the CHQ HHS Chief Executive, the Clinical Review Team has the authority to:

a) interview any person who may be able to provide information which directly assists in the Clinical Review. The Clinical Review Team may seek to interview persons who are not employees of Queensland Health who may be able to directly assist in the Clinical Review. The Clinical Review Team needs only interview persons who can provide information that they believe is credible, relevant and significant to the matters under review; and

b) give any appropriate lawful directions which may be required during the review. For example, to provide a lawful direction to an employee to maintain confidentiality, to attend an interview, or to provide copies of documents maintained by the CHQ HHS. The Chair of the Clinical Review Team will inform the Chair, Children's Health Queensland Hospital and Health Service Board, of any failure to comply with a direction and the Chair, Children's Health Queensland Hospital and Health Service Board, will advise regarding the approach that will be taken.

5.4. The Chair of the Clinical Review Team may co-opt specialist clinical, clinical governance, legal or human resource management expertise or opinion where it is deemed appropriate. The Chair of the Clinical Review Team must obtain Chair's, Children's Health Queensland Hospital and Health Service Board, prior approval, before incurring any expenses in this regard.

5.5. The Chair of the Clinical Review Team must provide persons who may be able to provide information

5.6. which directly assists in the matters set out in '3 Scope of the Clinical Review', and likely to be credible, relevant and significant to the matters under review, with the opportunity to respond verbally and/or in writing to the specific matters under review.

5.7. The report prepared in accordance with section 135(2) of the HHBA should specifically address the matters outlined above. The Clinical Review Team is to provide in the body of their report their assessment and reasons for these conclusions. Any inferences, which are derived from hearsay, should also be clearly identified.

5.8. A summary of evidence relied upon by the Clinical Review Team in order to make a recommendation is to be referred to in the report.

5.9. The names of persons providing information to the Clinical Review Team and any patient or staff names must be kept confidential and referred to in a de-identified form in the body of the report (with a legend confirming the identity of those persons to be provided by way of attachment as appropriate), unless the identification of the person is essential to ensure that natural justice is afforded to any particular person.

5.10. The Chair of the Clinical Review Team is to provide, by close of business 9 January 2015, (or as otherwise agreed) of receiving the appointment and these terms of reference:

a) Clinical Review plan; and

b) Confirmation in writing of an ability to meet the timeframes for the conduct of the Clinical Review, including the due date for the report.

5.11. The Chair of the Clinical Review Team is to notify the Chair, Children's Health Queensland Hospital and Health Service Board, about the progress of the review at regular intervals, as will be agreed following the submission of the Clinical Review plan.

5.12. Any request for an extension of the due date for the Clinical Review report being provided under section 135(2) of the HHBA is to be in writing at least 7 days before the due date, with supporting reasons.

5.13. The Chair of the Clinical Review Team is to submit a draft Clinical Review report to Chair, Children's Health Queensland Hospital and Health Service Board, no later than 7 days prior to the due date for the report.

5.14. The Clinical Reviewers' professional rate for this Clinical Review will be as per the letter of appointment for each member of the Review Team.

5.15. Out of pocket expenses incurred in the undertaking of the Clinical Review will be reimbursed by CHQ HHS in accordance with Public Service Directive 9/11 Domestic Travelling and Relieving Expenses (or any replacement Directive as in force from time to time).

5.16. If necessary, the Chair of the Clinical Review Team should report back to the Chair, Children's Health Queensland Hospital and Health Service Board (or other person nominated by the Chair, Children's Health Queensland Hospital and Health Service Board) for further instructions during the course of the Clinical Review.

6. Methodology

The Review methodology will include the following steps:

1. Sign off Terms of Reference and appointment of Reviewers under Hospital and Health Boards Act (2011) – 18th December 2014.
2. Identification of key documents/reports.
3. Written submissions/ interviews with staff and families.
4. On-site visit #1 – interviews/document review/scheduled meetings.
5. Analysis of data.
6. On-site visit #2 – interviews/document review/scheduled meetings.
7. Preparation of draft report.

8. Submission of draft report.
9. Meeting with Board Chair/any outstanding issues.
10. Submission of final report.
11. On-site visit #3 to report back to Board/staff/Department etc.

The Chair of the Clinical Review Team must immediately escalate to the Chair, Children's Health Queensland Hospital and Health Service Board any issues identified in the Review, which pose an unacceptable risk to patients and/or staff.

Review Panel Members are expected to comply with legislative obligations with respect to reporting professional conduct matters.

7. Secretariat

The Team will be provided with secretariat support that will include the following:

- Logistics – planning travel, accommodation, meeting scheduling etc.
- Communications – staff and family communications; Media management, Board, Department and Ministerial communications.
- Document management – accessing relevant documents, filing, compiling etc.
- Meeting secretariat support – documentation of interviews/meetings etc.
- Report writing – high level writing skills; synthesis of information and preparation of summary briefing documents for the Review Team.

DR PETER STEER
HEALTH SERVICE CHIEF EXECUTIVE
CHILDREN'S HEALTH QUEENSLAND HOSPITAL AND HEALTH SERVICE

19/12/2014

4.2 LCCH clinical review assessment tool

Is this event related to Move? ☐ Yes ☐ No ☐ Maybe (click on / check the box applicable)

Is the primary issue: (click on the box that is applicable)

☐ Quality of Care ☐ Patient Experience ☐ Staff Experience ☐ Insufficient Information

- ☐ Safety
- ☐ Timeliness
- ☐ Appropriateness / Effectiveness

Domain Items (click on / check those applicable; use - / + to indicate if positive or negative)

PHYSICAL ENVIRONMENT	SUPPORT SERVICES	HOSPITAL SYSTEMS
☐ Access to Meals (for parents/visitors)	☐ Administration	☐ Call / Help Desk
☐ Air Conditioning	☐ Cleaning Services	☐ Health Information Management / eMR
☐ Building Design Features	☐ Consumables (supply/storage)	☐ ICT Hardware / Software
☐ Equipment	☐ Facilities Management/Maintenance	☐ OPD Scheduling
☐ Facility Access	☐ Linen Services	☐ Patient Flow
☐ Furniture	☐ Patient Food	☐ Procurement
☐ Laundry	☐ Porterage	☐ Rostering
☐ Parent Accommodation	☐ Security	☐ Telecommunications / switchboard
☐ Transport	☐ Other (specify below)	☐ Theatre Processes
☐ Way-finding/Signage	Click here to enter text.	☐ Other (specify below)
☐ Other (specify below)		Click here to enter text.
Click here to enter text.		

WORKFORCE	CLINICAL CARE	CHANGE READINESS
☐ Behaviour/Attitude/Conduct	☐ Clinical Handover / communication	☐ Communication to Patients (re new facility)
☐ Individual Performance	☐ Clinical Incident	☐ Escalation
☐ Skill Mix	☐ Diagnostic testing	☐ Project/LCCH Interface
☐ Team Performance	☐ Discharge Planning	☐ Staff Awareness of New Operating Procedures (clinical and non-clinical)
☐ Training	☐ Monitoring / Care Planning	☐ Staff Awareness of issue status (non-clinical)
☐ Workload/Fatigue	☐ Patient Assessment (diagnosis)	☐ Other (specify below)
☐ Other (specify below)	☐ Safety Event	Click here to enter text.
Click here to enter text.	☐ Treatment	
	☐ Other (specify below)	
	Click here to enter text.	

Severity Rating (actual) (click on the boxes that are applicable)

☐ Death / Likely permanent harm	*Where full recovery is not expected, includes physical and psychological harm.*
☐ Temporary harm	*Full recovery is expected over a period of time, this includes physical and psychological harm.*
☐ Minimal harm	*No long term physical effect to patient. First aid provided. Short term pain, distress.*
☐ No harm	

Was there potential for a serious safety event? ☐ Yes ☐ No

A variation from expected practice followed by death, moderate permanent harm or significant temporary harm.

4.3 Interview and focus group cohorts

Group	No. of participants
Children's Hospital Foundation	1
Division of Clinical Support	6
Nursing Directors	3
Division of Critical Care – nursing	10
Division of Surgery – nursing	6
Junior Medical Workforce	6
CHQ Executive (two interviews conducted)	3
ICT and Operational Services, Finance	3
Nurse Educators and Clinical Facilitators	10
Medical Strategy Group	6
Allied Health Heads of Department (two interviews / focus groups conducted)	9
Division of Child and Youth Mental Health – inpatient nursing	3
Health Information Management Service	1
Medical Directors Forum	12
Family Advisory Council	4
Medirest Heads of Department	2
Medirest Catering Staff	5
Medirest Cleaning and Porterage Staff	8
Oncology	8
Outpatient Nursing and Administration Staff	13

4.4 Questions used to guide interviews and focus groups

The following questions were used to guide the interviews and focus groups:

1. Tell us about your usual role.
2. What was your role on move day.
3. How did the move go.
4. Were there any surprises / things that you did not expect.
5. Are you aware of any concerns or incidents that occurred on move day or in the first 2 weeks of the hospital being open.
6. Are you aware of any concerns about the quality of care provided on move day or in the first 2 weeks of the hospital being open.
7. Was there any clinical activity that you usually perform that was either enhanced/improved after the move or made harder after the move
   a. Improvements
   b. Impediments.
8. What did you do to keep the patients safe, and how was this managed
   a. During the move
   b. During the following two weeks.
9. Do you have any current concerns about safety.
10. What did you discover on the days that followed the move.
11. On reflection, do you think anything could have been done differently.
12. How are things now.

4.5 Categorised interview and focus group information

Individual matters raised or identified through interviews and focus groups were classified into the six categories and respective sub-categories listed on page 7. The following seven heat maps illustrate the distribution of the matters raised in relationship to these categories and respective sub-categories.

Map 1 provides a high level overview of the matters raised at the category level. Maps 2 to 7 provide the detail at the sub-category level; there is one map for each category.

- ● = favourable or complimentary
- ● = issues or concerns.

4.5.1 Map 1: Matters raised during interviews by category

ID	1. Physical Environment		2. Support Services		3. Hospital Systems		4. Workforce		5. Clinical Care		6. Change Readiness	
	+	-	+	-	+	-	+	-	+	-	+	-
A		●		●		●		●		●		●
B		●	●	●		●		●		●		●
C		●				●	●	●		●		
D		●	●	●	●	●		●				
E		●		●		●	●	●		●		●
F		●	●	●		●		●				●
G		●					●	●				
H						●						
I		●				●		●		●	●	●
J		●		●		●		●		●		●
K	●	●										
L	●		●		●	●	●	●	●	●		●
M		●	●	●		●		●				●
N	●	●		●		●		●	●	●	●	●
O		●		●		●		●		●		●
P		●		●		●	●	●		●	●	●
Q		●	●	●	●	●		●		●		
R		●	●	●		●		●				●
S*												
T		●		●		●		●		●		
U		●		●	●	●		●		●		●
V	●	●		●		●	●	●				●
W		●		●	●	●	●	●			●	●

* There were no participants for interview / focus group 'S'. This has been removed from maps 4.5.2 to 4.5.7.

4.5.2 Map 2: Physical Environment

ID	Access to Meals		Air Con		Building Design		Equipment		Facility Access		Furniture		Laundry		Parent Accomm		Transport		Way-finding / Signage	
	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-
A		●																		
B		●				●		●				●				●				
C						●		●		●										●
D		●		●		●		●		●										
E		●						●										●		●
F						●		●		●		●								
G		●				●														
H																				
I		●			●	●		●		●								●		●
J		●				●		●		●										●
K		●			●	●		●						●						●
L					●				●											
M										●										
N					●			●												
O		●				●		●		●										●
P								●												●
Q						●														
R						●		●												
T		●		●		●		●		●		●		●		●		●		●
U						●		●		●		●								●
V					●	●		●												
W						●		●												

4.5.3 Map 3: Support Services

ID	Admin		Cleaning Services		Consumables (supply / storage)		Facilities Management /Maintenance		Linen Services		Patient Food		Porterage		Security	
	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-
A						●						●		●		
B				●		●				●	●	●		●		
C																
D	●			●		●						●		●		
E						●		●								
F	●							●								
G																
H																
I																
J		●		●						●		●		●		
K																
L															●	
M			●					●							●	
N						●				●						
O		●		●		●		●				●				
P		●														
Q	●											●				
R								●							●	
T				●		●		●		●		●		●		
U						●		●								
V						●		●								
W				●		●										

4.5.4 Map 4: Hospital Systems

ID	Call/ Help Desk		Health Info Management		ICT Hard / Software		OPD Schedule		Patient Flow		Procurement		Rostering		Telecomm / Switchboard		Theatre Processes	
	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-
A				●		●				●								
B				●		●		●								●		●
C						●						●				●		
D	●			●	●	●		●								●		
E				●		●		●								●		
F						●												
G																		
H				●		●		●										
I								●								●		
J								●								●		
K																		
L								●	●					●		●		
M																		
N								●										
O				●		●										●		●
P				●		●							●			●		
Q	●			●		●		●								●		
R						●										●		
T		●		●		●		●		●		●		●		●		●
U			●			●		●		●						●		
V						●												
W												●	●					

4.5.5 Map 5: Workforce

ID	Behaviour/ Attitude/Conduct		Individual Performance		Skill Mix		Team Performance		Training		Workload /Fatigue		Other	
	+	-	+	-	+	-	+	-	+	-	+	-	+	-
A						●				●				
B												●		
C				●	●	●		●		●		●		
D						●								
E	●			●				●		●		●		
F						●		●		●				
G												●	●	
H														
I						●				●		●		
J		●												
K														
L			●			●				●		●		
M		●				●				●		●		
N						●				●				
O		●				●		●		●				
P	●						●							●
Q										●				
R										●				
T						●				●		●		
U						●				●		●		
V									●			●		
W									●	●				

4.5.6 Map 6: Clinical Care

ID	Clinical Handover		Clinical Incident		Diagnostic Testing		Discharge Planning		Monitoring/ Care Planning		Patient Assessment (diagnosis)		Safety Event		Treatment		Other	
	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-
A										●						●		●
B																		
C						●						●						
D																		
E																		●
F																		
G																		
H																		
I																		●
J		●						●		●								●
K																		
L		●							●	●								
M																		
N	●							●										
O								●										
P						●												
Q												●				●		
R																		
T						●												●
U								●										
V																		
W																		

4.5.7 Map 7: Change Readiness

ID	Communication to patients (re new facility)		Escalation		Project / LCCH Interface		Staff Awareness of new operating procedures (clinical and non-clinical)		Staff Awareness of issue status (non-clinical)	
	+	-	+	-	+	-	+	-	+	-
A		●		●				●		●
B								●		
C										
D										
E								●		●
F								●		
G										
H										
I		●					●	●		
J		●								
K										
L								●		●
M				●		●		●		●
N	●		●				●	●		●
O								●		●
P	●							●		
Q										
R								●		
T										
U		●						●		
V								●		
W							●	●		

4.6 Facilities management services contracted to Medirest

Medirest has been contracted to provide the following services:

- Building and engineering maintenance (sub-contracted to Honeywell)
- Central Energy Plant operations
- Cleaning
- Facilities management helpdesk
- Grounds and garden maintenance
- Linen and laundry
- Materials distribution
- Patient food
- Pest control
- Porterage and patient support
- Security.

4.7 Documents reviewed

Category	Title
LCCH / CHQ Project	CHQ Project Benefits Management Strategy
	Fault Management Status Report 191114
	Fault Management Status Report 8 December 2014 - v12
	LCCH PD Report Nov current Draft
	LCCH Post PC Governance
	LCCH Program Fault Reporting Procedure
	LCCH Program Governance
	LCCH Program Governance Diagram
	LCCH Program Governance Diagram
	LCCH Project Governance
	LCCHP Defects and Faults
	PRME Key Risk Review
	PRME Updated Summary Report
	Schematic Design Report
Move and Transition of Services	Accessing MCH Medical Record at LCCH
	Board S&Q Committee - Designing a safe transition to LCCH
	Issues Register - Cardiac ICU (final review)
	LCCH Daily Operational Briefing Note Template
	LCCH Issues Register - EMT Rolled up version 12.12.14
	LCCH Issues Register - Full version 24.11-29.11.14
	LCCH Theatre Consumables Action Plan
	LCCH Theatre Consumables Issue Register
	LCCH Theatre/ORS Issues Register 30.12.14
	LCCH Theatre/ORS summary of critical issues 03.01.15
	Mater Cardiac Transition Issues Register - final
	Medirest Service Escalation Protocol
	Minister Briefing - Designing a safe transition to LCCH
	Move Day Tracking Flow - LCCH
	Move Day Tracking Flow - Mater Children's Hospital
	Move Day Tracking Flow - Royal Children's Hospital
	Nursing staff forum presentation
	Paediatric Cardiac Services Project – Governance Structure
	PICU Issues Register
	Standard Operating Procedure
	Work Instruction - Medirest Complaints

Category	Title
Quality and Safety	CHQ Clinical Incident Management Procedure
	CHQ Clinical Incident Triage Tool
	CHQ SAC 1 Analysis Decision Making Tool
	HRT Report Jan 13 to Jun 13
	HRT Report Oct 13 to Sept 14
	MET Call Data 29/11/14 - 17/01/15
	PRIME CF dictionary
	PRIME CI dictionary
	PSQ Improvement Framework
	PSQ Improvement Strategy
	Readmissions; Returns to OT; Re-presentations to ED & Staph Infections
	SBAR Response
Risk Management	CHQ HHS Risk Matrix
	CHQ HHS Risk Policy
	CHQ Strategic Risk Report ARC_Nov_DM edits
	CHQ Strategic Risk Report PSQ_Dec_14
	Clinical Risks
	Q&S LCCH Clinical Safety Assurance - Special S&Q Meeting
	Quarterly QSC Top Line Risk Report July 2014
	Risk Appetite Statement
	Strategic Risk Profile Report Coversheet_ QSC Dec
	Topline Risk Review Coversheet
Workforce	Workforce Data I: resignations; sick leave; EAP access
	Positions advertised
	Workforce Data II by stream: resignations; sick leave; EAP access
	TMS Quarterly Report December 2014
	TMS Quarterly Report December 2014 Att 1 - progress
	TMS Quarterly Report December 2014 - dashboard

4.8 Terms used

Term	Definition
Building commissioning	Completion for occupation by the contractor from a physical point of view such as the successful running of all plant and equipment.
Culture clash	A conflict arising from the interaction of people with different values.
Likely permanent harm	Where full recovery is not expected, includes physical and psychological harm.
Minimal harm	No long term physical effect to the patient. First aid provided. Short term pain, distress.
Operational commissioning	The preparation of a facility and its staff for commencement of operation such as equipping and familiarising of staff with facility operation.
Practical completion	When the construction work has been completed and the building is suitable for occupation. At this stage, the control of the building passes from the contractor to the department.
PRIME CF	The clinical Incident application used for reporting consumer feedback.
PRIME CI	The clinical Incident application used for reporting clinical incidents.
Serious Safety Event	A variation from expected practice followed by death, severe permanent harm, moderate permanent harm or significant temporary harm.
Temporary harm	Full recovery is expected over a period of time, this includes physical and psychological harm.

4.9 Acronyms used

Acronym	Full form
CHQ	Children's Health Queensland
EEG	Electroencephalogram
HSCE	Health Service Chief Executive
HHS	Hospital and Health Service
***ie*MR**	Integrated Electronic Medical Record
ICT	Information Communication and Technology
EAP	Employee Assistance Program
EDMS	Executive Director Medical Services
LCCH	Lady Cilento Children's Hospital
MCH	Mater Children's Hospital
MCPB	Mater Children's Private Brisbane
MET	Medical Emergency Team
MHS	Mater Health Services
MMH	Mater Mothers' Hospital
NCCU	Neonatal Critical Care Unit
NEAT	National Emergency Access Target
PACS	Picture Archiving and Communication System
PICU	Paediatric Intensive Care Unit
RBWH	Royal Brisbane and Women's Hospital
RCH	Royal Children's Hospital
TMS	TMS Consulting

4.10 References

Children's Health Queensland. 2014. *Annual Report: 2013-14*. Queensland Government.

Children's Health Queensland. 2013. *Patient Safety and Quality Improvement Strategy 2013-2015*.

Garling, Peter SC. 2008. *Final Report of the Special Commission of Inquiry: acute care services in NSW public hospitals*. State of NSW.