Townsville Hospital and Health Service

Media statement

Queensland Government

Please attribute to Mrs Julia Squire, Townsville Hospital and Health Service Chief Executive

Response to Questions about THHS Aged Care Facilities

Townsville Hospital and Health Service delivers aged care services in two facilities, Parklands in Townsville and Eventide in Charters Towers. These services are based on the needs of aged care users and they are residential homes not hospitals. They are regulated by the Department of Health and Aging. Both homes are accredited.

There are now two open SAC 2 cases at Eventide. All other cases have been closed. Incidents are only closed when we are satisfied that a full analysis has been completed and any recommendations put in place.

On the reported incident relating to aggression, the incident was between two patients.

All residents of our residential aged care facilities are risk assessed for the development of pressure injuries on admission, every three months thereafter and if there is a change in their physical condition. All residents have a standard pressure-reducing mattress. If a resident's risk is high additional actions and or equipment are used for the purpose of prevention. Pressure injuries are a particular risk in aged care facilities where many residents are frail and/or have reduced mobility. Residents in our facilities exercise their own judgement and wishes. On one of these occasions, a resident declined the use of further pressure-relieving aids.

A non-compliance notice at Parklands followed a routine audit by the Department of Health and Ageing. This did not relate to patient care, a full response was provided to DoHA and the facility has recently been fully accredited for three years.

Response to questions about SAC 1 events at Townsville Teaching Hospital

At the Townsville Hospital and Health service we actively encourage reporting of possible clinical incidents in order that they are investigated and any necessary changes made to our services.

The leadership for patient safety rests with our Executive Director of Medical Services. In 2012-13 we provided nearly 280,000 occasions of service to our communities. In that 12 months, 25 patients sustained permanent harm or death, suspected to be related to their care. That is approximately 0.01 per cent of the occasions of care we provided. In other words 99.99 per cent did not result in such concerns. Whenever such concerns are found they are reported.

Across the State only 0.5 per cent of incidents relate to permanent harm or death and this pattern is reflected at Townsville Hospital and Health Service.

The Executive Director of Medical Services then reviews each case and initiates investigations into them. Each of these reported cases is taken very seriously. Fifteen of those cases in 2012-

13 sadly involved the death of a patient. None of these cases were related to instrumentation retention or wrong-site surgeries.

Under the leadership of the Executive Director of Medical Services, the THHS patient safety team conducts a rigorous review of each case of potential permanent injury or harm, involving a multidisciplinary team to establish what happened, why it happened and what if anything may be done to prevent it from happening again. We involve families in discussions to ensure that we understand any questions that they may have, and show them what we have found. On occasions, we do find things that we could have done better, and in those situations, we are open with the families, explain to them what we are doing to address the things that we have found and take their views on board as well. Actions can include reviewing the performance of individual staff but most commonly involve improving protocols and systems in the light of new evidence.

In some cases, we seek to understand the specific circumstances of a common problem; falls for example. In a hospital setting patients can fall as a result of their illness or when beginning their rehabilitation. We constantly strive to learn how and why they occur so that we can either reduce the risk of falls, or reduce the consequences when patients do fall. Three of the 25 cases related to falls, in each of the cases the patients were elderly and had underlying conditions which made them more likely to fall and sustain injury if they did fall.

In our maternity services, we have begun significant work to ensure that we identify mothers who may need extra care in childbirth following investigations into two cases of stillbirth. Stillbirths are not routinely reported as adverse clinical events everywhere in Australia. This year, our health service has decided to investigate these cases more fully to establish if there is more that we can do to prevent this tragic outcome. THHS now reports these events where we did not in the past. This means that our reported number of adverse events of this type seems higher this year because of this change.

Ends…

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