169

QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF JENNIFER KIRBY

1. I, **JENNIFER KIRBY,** Manager, District Quality and Decision Support Unit (DQDSU), of c/- Bundaberg Base Hospital, Bourbong Street, Bundaberg, acknowledge that this written statement by me dated 17 June 2005 is true to the best of my knowledge and belief.

2. This statement is made without prior knowledge of any evidence or information held by the Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me.

Qualifications and Experience

3. I obtained my Certificate of Nursing from the Townsville Hospital in 1986.

4. I have been employed at the Bundaberg Base Hospital (Hospital) as a registered nurse since 1988. From 1995 to October 1999, I held a range of level 3 nursing positions including Elective Surgery Coordinator, Infection Control Coordinator and Pre-admission Clinic Coordinator.

Clinical benchmarking

5. In October 1999, I was appointed as Project Manager to implement the Transition II Clinical Benchmarking Information System by Peter Leck, District Manager, and Dr John Wakefield, Director of Medical Services. This was a project that was being implemented across the state by Queensland Health (QH).

6. The project had an external vendor who came on site as an implementation specialist to train myself and Alan Lawrie on how to use and implement the system. The implementation phase of the project was completed around May 2000.

7. By that stage it had been identified that the Hospital would need to recruit two staff permanently into the clinical benchmarking unit. The Hospital advertised the position of Manager – Clinical Benchmarking. I applied and was successfully appointed to that position around October 2000. Attached and marked **JK1** is a copy of my position description.

Position responsibilities

8. Up until approximately mid-2001 it was my responsibility to manage the clinical benchmarking information system, which is essentially a repository of data. This is used to collect electronic data from a number of information systems. The data is inputted into the Transition II database to enable us to measure performance within the District and against other QH hospitals.

9. Transition II is the link between financial and patient activity, case by case. The intent of the database is to draw information from different applications such as radiology, emergency and operating theatre and effectively have them 'talk to each other'. The database enables us to examine clinical activity, patient costing and financial data collection. For example, a clinician may wish to examine a particular diagnosis related group (DRG) and extrapolate that information down further to examine in detail, the nature of the care provided to a particular patient. This information is then able to be benchmarked against performance in other QH hospitals in respect of the same DRG. This in turn enables us to assess where we sit as against other hospitals in terms of performance. The information is intended to add value to performance, monitoring and planning.

District Quality and Decision Support Unit

10. In mid-2001, there was a merger of three units, resulting in the formation of the District Quality and Decision Support Unit (DQDSU). These units included clinical benchmarking, finance and quality management. Following the merger of these units, I was appointed Manager of the DQDSU. Attached and marked **JK2** is a copy of my position description.

11. Whilst I held the title of Manager, I did not have line-management responsibility for Leonie Raven, Quality Coordinator. The Quality Coordinator reported directly to the District Manager however, we worked in partnership. I continued to have responsibility for the clinical benchmarking support officer and assumed responsibility for the finance team. In turn, my line-management changed and I reported to Peter Heath, Director of Corporate Services.

12. As Manager of the DQDSU my responsibilities were largely unchanged from my previous position in Clinical Benchmarking. However, from an HR perspective, I had responsibility for the finance team. I also became responsible for a patient revenue officer, a position which was established in 2003.

13. In or about December 2004, the finance team were relocated out of the DQDSU as part of the Shared Services Initiative.

14. The purpose of the merger, was to provide the District with a 'one stop shop' for clinical, financial and quality management information. As such, Leonie and I worked collaboratively.

15. The District Manager had identified that there was some confusion for staff regarding accessing and sourcing information. Establishment of the unit was intended to meet the information needs of the District.

Reporting functions

16. In my role as Manager, DQDSU, I provide routine casemix and activity reports on a monthly basis. The casemix data looks at the acuity or complexity of care for inpatients. The data tells us how complex the patient care is that we are delivering. These reports are provided to the executive team and also to the clinical heads of department. I also provide ad hoc reports on request by any person requiring information ranging from medical, nursing, allied health, administrative or operational staff.

17. The DQDSU also prepares activity and utilisation reports, outpatient activity and any specific reports that various clinical units may request. These reports are collated from data held at the DQDSU and distributed monthly.

18. As part of clinical benchmarking, I was responsible for facilitating benchmarking in collaboration with other QH hospitals. The Central Zone Regional Benchmarking Forum was established and included Rockhampton, Gladstone and Fraser Coast. The purpose of these activities, was to support clinical improvement and the advancement of the use of information to support decisions. An annual report was produced and distributed to the participating districts. Essentially this enabled the four participating districts to measure their performance, against each other.

19. In addition to these reports, I produce clinical indicator reports, which are for submission to the Australian Council for Healthcare Standards (ACHS) as part of our accreditation process. The clinical indicators are collected from various sources and reported to ACHS every six months.

20. I am also responsible for co-ordinating the collection of data and reviewing of data quality for the measured quality reports. The report is provided by the Measured Quality team at QH. These reports measure the Hospital's performance against a range of indicators to identify potential areas for improvement across the District.

21. The measured quality report is produced annually and provided to the District Manager. The Measured Quality team then attends the District to meet with staff to discuss their findings. The Measured Quality team provide the District with a technical supplement which details the source of the information obtained and data specifications. Both the report and the technical supplement are provided to me and I undertake further data analysis, on an ongoing basis, at a patient level to enable the District to look at issues arising out of clinical performance.

22. I am also involved in monitoring the District's elective surgery activity. The District is provided with a target by the Central Zone Management Unit at the beginning of each financial year. The yearly target is calculated on the number of weighted separations to be achieved for the year. In conjunction with the District Manager and the Director of Medical Services, a monthly target is identified. This figure takes into account seasonal adjustments such as vacation periods and greater bed occupancy during winter months. I provide monthly reports to the

District Manager and Director of Medical Services on the Hospital's progress towards achieving that target.

23. In addition to the Hospital's elective surgery target, I also monitor the additional elective surgery 'election commitment' activity. This is the additional elective surgery component the District agrees to undertake following an election promise. This reporting was undertaken by me on a fortnightly basis during 2004.

24. The DQDSU is able to provide a range of clinical audit reports, at the request of clinicians. On 18 June 2003, a presentation was delivered by QH about the clinical audit process. The focus of this presentation was to educate staff on how to undertake a clinical audit. Attached and marked **JK3** is a copy of the flyer and the handout provided at that presentation.

Additional responsibilities

25. I spend a significant amount of time providing information to the District executives on an ad hoc basis. For example, I provide data for Ministerial Responses and requests for data from the Central Zone Management Unit for specific service planning, including activities such as cataract and gastroenterology services.

26. I was also asked by the District Manager to establish the patient revenue position in or about March 2003. This position was developed in response to an internal audit investigation which identified a need on the part of the district to establish processes for managing private practice and patient revenue.

27. I was also involved in providing information to the District executives regarding activity in various areas that were undergoing services review. In particular, there were two reviews at the Hospital being the Administrative Services Review and the Operational Services Review. I spent a significant amount of time collating data for each of these reviews.

Project involvement

28. In addition to my substantive position, I am also involved in the Integrating Strategy and Performance (ISAP) project. This project was developed by QH and commenced in Bundaberg in May 2004. The ISAP project is aimed at identifying key strategic objectives for the District through the development of a strategy map. Attached and marked **JK4** is a copy of that map.

29. I was assigned by the District Manager as Project Officer for this project and, in conjunction with a core team of people, identified the key issues facing the District that needed to be addressed in order for the District to align themselves with the QH strategy map and community needs. For example, some of the key issues identified by the leadership team included issues arising from an ageing population and population growth in the District. Health determinants data which identified the major causes of death and illness in older people was also identified. We then determined the strategic objectives the District required to ensure service

provision to the community based upon their identified needs and alignment with QH strategic goals and objectives.

30. The strategy map was developed with identified objectives and measures across four perspectives. These perspectives included:
    - consumer;
    - paying for health;
    - internal processes; and
    - shaping the workforce.

    The strategy map forms the Balanced Scorecard for measuring performance and strategy.

31. This project ran for six months from May to November in 2004. Following completion of the project, I assumed responsibility for administering the Balanced Scorecard.

Involvement with Committees

32. I sit on a number of committees, of which the major committees include Information Management; Improving Performance (which includes the District strategy meetings); Executive Council; Clinical Services Forum; and Finance.

33. My involvement in these committees is to represent the information management function of the DQDSU. We also provide a resource to staff attending those committee's for information management and requests for data relevant to those committee's.

34. The only Clinical Services Forum I am no longer involved in is the Medical Clinical Service Forum. I recall that sometime in 2002, I was informed by Dr Peter Miach, Director of Medicine, that Leonie and I were no longer required to attend that meeting as he did not require the services of the DQDSU.

Dealings with Dr Jayant Patel

35. I became aware that around June 2004 the issue of wound dehiscence was raised by Di Jenkin, Nurse Unit Manager, Surgical Ward, at the Anaesthetic Surgical Pre-Admission Intensive Care (ASPIC) Clinical Services Forum. DQDSU was asked to provide information about patients identified by Di Jenkin that had experienced wound dehiscence. In response to this request, DQDSU provided a report. Attached and marked **JK5** is a copy of the initial report requested.

36. At this time, I believe Dr Patel was on leave. On his return from leave, Dr Patel was made aware of the issue of wound dehiscence by some of the staff involved in the ASPIC Clinical Services Forum. Dr Patel approached me and requested further information regarding wound dehiscence in order to compare the rates against the total number of procedures.

37. In collaboration with the clinical benchmarking support officer, Dr Patel identified the procedure codes that identify wound dehiscence and the types of surgical

procedures conducted. Subsequently, a report was developed comparing wound dehiscence rates over 2 years. Attached and marked **JK6** is a copy of that report.

38. During this time, the discussion regarding wound dehiscence had remained on the agenda of the ASPIC Clinical Services Forum. At a meeting held on 13 October 2004 the minutes note the issue had been closed and that further wound dehiscence would continue to be reported by clinical staff as an adverse event. Attached and marked **JK7** is a copy of those minutes.

39. Dr Patel accessed the DQDSU on numerous occasions. On one of those occasions Dr Patel requested a report regarding laparoscopic cholecystectomy as the Department of Surgery and Day Surgery Unit were considering undertaking this procedure as a day case. Attached and marked **JK8** is a copy of that report.

40. Other information provided to Dr Patel included progress towards achieving the elective surgery target. Dr Patel was involved with the Theatre Management Group who were responsible for management of theatre activity.

41. I formed the view from my dealings with Dr Patel that he seemed interested in the data that could be obtained from the DQDSU. He was one of few clinical directors who accessed the unit.

Adverse events

42. The responsibility for management of the adverse event register rests with the Quality Co-Ordinator. However, I have had some involvement in adverse events monitoring.

43. In April 2004, I was involved in supporting the Project Officer in the DQDSU to establish data definitions and develop an electronic data collection system. The adverse events register is essentially an Excel spreadsheet where all adverse events are inputted from April 2004. I was involved in establishing the data collection register for adverse events.

44. This project coincided with the new Hospital policy on adverse event monitoring which was rolled out in March-April 2004. During this time, Leonie Raven, Quality Co-Ordinator, was on extended sick leave for approximately six months (from February to August 2004). Accordingly, I assumed responsibility for delivery of adverse events monitoring training to all staff across the District in or about March-April 2004 at the request of the District Manager. This training was delivered by me in conjunction with the Director of Medical Services, Dr Darren Keating. That training was rolled out over a 6 to 8 week period. Attached and marked **JK9** is a copy of the powerpoint presentation.

45. Initially the DQDSU proposed to provide a response to the person who had reported an adverse event, acknowledging receipt of the report. After the training was rolled out, there was a peak of reporting that was undertaken by staff. Due to Leonie's absence, it became somewhat untenable for us to acknowledge all the incident reports that were coming in to the unit.

46. Discussions were held at this time with executive and some of the nurse unit managers about the types of reports that they required from the adverse events register. Unfortunately, the project officer involved in this resigned and resources within the DQDSU did not allow further development of this in a detailed manner. Reports were established at a summary level, on a quarterly basis for executive and heads of department and specific key areas namely, falls prevention and pressure ulcers were provided with more detailed reports. Detailed reports were available upon request for any other area.

47. I continued to be involved in risk assessing all of the adverse event reports in accordance with the Hospital policy. Anything that I regarded as a medium to high risk, I would consult with a member of the executive and have them review the adverse event with me to ensure it had an appropriate risk rating. This was because at this stage, the whole process was relatively new to us and had been developed by Leonie who was on sick leave during this time.

48. In or about May to June 2004, Jane Truscott, Registered Nurse, was seconded into the position of Acting Quality Co-Ordinator. Her main focus was to continue co-ordination of the ACHS self assessment documentation for accreditation, which was due in July 2004. Jane took over responsibility for risk rating adverse events sometime in June.

49. In accordance with the Hospital policy any events rated high to very high would be forwarded to the relevant Executive Director for their action. Anything rated below a high risk was registered in the adverse events register and trended for reporting purposes. The data could then be examined to ascertain whether a trend was emerging, for example, whether there was an increasing number of patient falls. Feedback from executive directors about incidents that had been rated high or above, would be entered into the register when the file was returned.

50. My perception of the function of the DQDSU across parts of the organisation was that we were seen to be obtaining data that could examine individual's performance. However, this was not the case. Rather, the focus of the unit was data collection for the purpose of improving clinical performance. This perception was difficult to overcome. For this reason both Leonie and I were requested by Peter Leck to participate in a number of committee's in order to provide a resource to staff as to functions of the DQDSU.

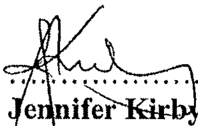
51. The DQDSU also published two brochures which provided information to staff about the functions of the unit and how they could access meaningful data and reports to assist their practice. These brochures were also provided to new staff on commencement during their orientation. Attached and marked **JK10** are copies of those brochures.

52. My opinion of the staff's perception of the unit was confirmed by Linda Mulligan, Director of Nursing who informed me within a few weeks of her arrival, that nursing staff regarded the DQDSU to be 'policing' their performance. This was a misunderstanding on the part of some staff as to the functions of the unit.

53. In my dealings with Mr Leck and Dr Keating, I always found them to supportive of the function of the DQDSU and approachable. In my opinion, they were managers who were focussed on obtaining objective evidence in responding to issues raised with them and therefore, accessed the unit for data and information frequently.

54. I am aware that both Mr Leck and Dr Keating would encourage staff who raised issues with them, to access data from DQDSU in order to further assist in the analysis and investigation of the issue.

Signed at **Bundaberg** on **17 June 2005.**



....

Jennifer Kirby
Manager
District Quality and Decision Support Unit
Bundaberg Base Hospital