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LMM1-13

PO Box 6081
Broome
WA 6725

12July 2005

The Bundaberg Hospital Commission of Inquiry
PO Box 1317
George Street
Brisbane QLD 4003

To Whom It May Concern,

I am writing this letter in support of Mrs. Linda Mulligan, the District Director of Nursing Services, Bundaberg Health Service.

My association with Mrs. Mulligan has been in a professional capacity as her colleague while I was employed as the Medical Superintendent of Dalby Health Service. During the 3 years that I was employed by Northern Downs Health Service District, I was able to observe Mrs. Mulligan's professional and leadership behaviours, and it is on this basis that I feel compelled to write to the Commission.

For a period of approximately 10 months, Mrs. Mulligan was also my immediate supervisor when she acted in the District Manager role. I believe that Mrs. Mulligan performed these roles with integrity and professionalism. Her management style was always underpinned by strong values that reflected her commitment to her staff and to her patients about whom she cared a great deal.

Mrs. Mulligan acted as my informal mentor in many ways. I learned a great deal from her in relation to the principles of natural justice and performance management. The principle of confidentiality was an absolute value for her and I am aware that her nursing staff respected her for being able to manage their concerns fairly and conscientiously. I am aware that she provided support to her nursing teams and indeed, she was always supportive of my needs when I faced challenges in my own work environment. I never found her to be distant or inaccessible. On the contrary, Mrs. Mulligan was immediately accessible whenever I required her advice or assistance.

Most importantly, Mrs. Mulligan and I worked as a team in caring for patients in our community. While not always directly involved in patient care, as this was not her role, Mrs. Mulligan nevertheless demonstrated her interest in quality patient care by her actions in managing the health service. Mrs. Mulligan walked through the clinical areas on an ad hoc basis during which she would often stop to chat to patients in the areas who knew her.

I am aware that Mrs. Mulligan held regular meetings with senior nursing staff who she trusted to manage the different areas of the health service. In addition, the close

working relationship between Mrs. Mulligan and myself permitted the sharing of information about individual patient care issues on a regular basis.

During our time working as a management team at Dalby Health Service, the Director General of Health, Dr. Rob Stable, was highly complimentary about the work being done to provide quality medical care to the community of Dalby.

Yours sincerely,

Dr. Sue Phillips

LMMI

17 June 2005

The Bundaberg Hospital Commission of Inquiry
Po Box 13147
George Street
Brisbane, Qld 4003

To Whom it may Concern

I am writing this letter in support of Mrs. Linda Mulligan, the Director of Nursing, Bundaberg Hospital.

I am currently the District Nurse Educator of the Northern Downs Health Service District. I was appointed to this position in 2001. I am located at Dalby Health Services and answer to the Dalby Health Services Director of Nursing. Prior to that I was the Nurse Practice Coordinator for Karingal Nursing Home, the 80 bed Aged Care Facility located at Dalby Health Services. Both these positions are at Nursing Officer 3 level. I was employed as a NO 3 (level 3s) at the Aged Care Facility when Mrs. Mulligan was appointed as Director of Nursing of Dalby Health Services, so I answered to Mrs. Mulligan for the whole 9 years of her appointment.

When Mrs. Mulligan first commenced her appointment at Dalby Health Services few clinical governance systems were in place. Mrs. Mulligan introduced these systems and trained her 'Level 3s' in the process. There was resistance at first, and I was one of those who received a directive from Mrs Mulligan. The incident was over the rostering system that was in place, which from my point of view was working nicely. However, it did not comply with the Nurses Award.

Mrs. Mulligan quickly brought the Level 3s up to date with the Queensland Health complaints management system. She coached us in the correct process, including writing 'File Notes' so that a record could be maintained should further action be required at a later date. These File Notes were also to be forwarded to Mrs. Mulligan when the issue was classified greater than minor. Mrs. Mulligan insisted on complete confidentiality to ensure that all parties received natural justice. Every party would be given an opportunity to put their point of view, either verbally, or in writing, depending on the level of seriousness of the complaint.

Features of Mrs. Mulligan's administration was that she was very professional, followed the correct processes, expected professional documentation, was fair and equitable and reasonable with her staff. She expected her level 3's to manage their units and refer to her when they needed advice.

Mrs. Mulligan delegated the management of her calendar to the Executive Support Officer, which included appointments for interviews with her. However, whenever an issue was urgent she was always immediately available. I experienced no difficulty in contacting her in these circumstances. Mrs. Mulligan answered her emails and would

promptly respond to any red letter icons on the email. (Red letter icons attached to emails are an indication of urgency)

The Employee Assistance Service was available to all staff, and they could contact the psychologist at any time without reference to their supervisors. Mrs. Mulligan insisted that all staff be made aware of this during the orientation process, and notices were up in all departments.

Mrs. Mulligan made rounds of the hospital on an ad hoc basis, ensuring that she visited at different times of the day so that she got a picture of the activity throughout the day. She had no need to visit on a regular basis as her Level 3s would apprise her of any problems as they arose. She also instituted a system of 'Nursing Alerts' which the shift coordinators completed at the end of each shift. This form indicated the level of activity, number of staff on the shift and any issues that arose. These forms were placed on her desk first thing each morning. With this system Mrs. Mulligan was aware of the incidents and activity that occurred in the previous 24 hours.

There were regular formal meetings that Mrs. Mulligan had with staff. With the Level 3s, she held 2nd weekly 'Taskforce Meetings'. They were cancelled on occasions but they were held at least monthly. She had monthly General Nursing Staff Meetings on the first day of the month. If Mrs. Mulligan was unable to attend one of the Level 3s would be delegated to chair the meeting.

In conclusion, I found Mrs. Mulligan to be very professional, and to have high ethical standards. She expected the Queensland Health policies and procedures to be followed with appropriate documentation of issues as they arose. She managed her staff in a reasonable, fair and equitable manner. Staff who came out of her office had their dignity intact, and yet were very clear of what was expected of them.

Yours Faithfully,

Mrs. Mary Gilbert
District Nurse Educator
Northern Downs Health Service District

23 June 2005

The Bundaberg Hospital Commission of Inquiry
PO Box 13147
George Street,
Brisbane Qld 4003

To Whom it may Concern,

I am writing this letter in support of Mrs. Linda Mulligan, District Director of Nursing, Bundaberg Hospital.

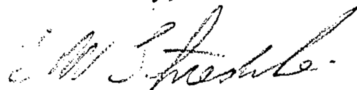
I have worked at Dalby Health Services for 15 years in various positions. I am currently employed by Dalby Health Services as a Resident Care Assistant at Karingal Aged Care Facility.

During the 9 years that Mrs. Mulligan was the Director of Nursing at Dalby Health Services I have found her to be fair and reasonable with all staff although she expected a high standard of professionalism and performance. This was acknowledged generally at Karingal Aged Care Facility.

At the time of Mrs. Mulligan's employment at Dalby Health Services I was the Australian Workers Union (AWU) representative. As a union representative, on two occasions I supported staff members who were called to see Mrs. Mulligan regarding performance issues. I was impressed with how she managed the interview. She gave the staff member every opportunity to explain the circumstances; she was sensitive to the personal difficulties of the person; strategies were worked out together to address the concern. The staff member invariably left the meeting with a clear understanding of Mrs. Mulligan's expectations and was very pleased with the outcome.

I was also a member of the Local Consultative Forum as the AWU representative. During the meetings I found Mrs. Mulligan approachable and listened to explanations. The outcomes of the negotiations were satisfactory to all parties.

Yours Sincerely,



Thomas Thiedeke

22 June 2005

The Bundaberg Hospital Commission of Inquiry
PO Box 13147
George Street
Brisbane, Qld 4003

To Whom it may Concern

I am writing this letter in support of Mrs. Linda Mulligan, the Director of Nursing, Bundaberg Hospital.

I commenced work at Dalby Health Service as a registered nurse in July 1995. Mrs. Linda Mulligan was the Director of Nursing here at Dalby at this time. My present position at Dalby Health Service is as a Nurse Manager (NO 3). I have held this position since December 2002. Prior to this I had also spent seven months in the role of Acting Nurse Unit Manager in Acute here at Dalby Health Service. In both these roles Mrs. Mulligan was my immediate supervisor.

In both of these roles I was an inexperienced NO 3. In my experience with Mrs. Mulligan as my supervisor she conducted her management role in a professional manner and set a high standard of what she wanted her NO 3's to achieve and how they were to perform in their own management roles. Although, she set this standard for me to achieve as a NO3 she was there to coach and to provide direction and support.

Mrs. Mulligan did encourage the practice of making appointments when staff requested to discuss matters with her. In my role as a NO3 I would make an appointment when I wanted to discuss a matter with her. However, if I had a concern that was urgent and required actioning immediately I was always able to see her promptly. I never experienced a time of her not dealing with the important issue that I brought to her.

Mrs. Mulligan viewed the complaints process as a very important part of her management. She coached her NO3's in this process and always ensured that the correct procedure was followed and completed within the correct time frame. She once told a staff member in my presence that "everyone has the right to make a complaint no matter who they are". Mrs. Mulligan also coached her NO 3's in ensuring "file notes" were written on any issues that had arisen and which could be reviewed at a later date if further action would be required.

Within the "complaints process" if a complaint was made about a staff member they were provided with the written complaint and a letter informing them of the opportunity to provide a counteraction of the complaint levelled against them. This process was completely confidential but staff were able to access the Employee Assistance Service if they required support and consult with their union delegate if they chose to do so. I was unaware of any staff who went through this process

complain that they were not supported and I witnessed it as a fair and equitable system.
Whilst still new in my role as a nurse manager I would consult with Mrs. Mulligan if I felt unsure about the best plan of action to take when I had to deal with a staff issue. I would make an appointment to see the staff member and if I was unable to achieve an outcome I would not hesitate to refer that staff member to Mrs. Mulligan. I always found that Mrs. Mulligan dealt with staff issues firmly but ensured that a fair and equitable outcome was achieved.

Mrs. Mulligan did not undertake daily ward rounds opting to attend ward rounds at varying times. However, in my role as the Nurse Manager I always present myself to the wards every morning to ascertain if there is adequate staffing for the acuity of the ward and to enquire if staff have any concerns. If there were concerns that I was unable to deal with or that I felt required input from a higher level of management I would consult with Mrs. Mulligan who would action my concerns. I always found that Mrs. Mulligan was aware of any patient or staff concerns owing to the system that she introduced of "Daily Alerts". Night staff would provide her with a "bed report record" which contained patient's personal particulars and provisional diagnosis (PD), the number of staff for the previous 24 hours and any concerns that had arisen.

Mrs. Mulligan conducted regular Nursing Task force meetings with her No3's. During these formal meeting previous minutes, new business and any concerns were discussed. Mrs. Mulligan would also use this time to coach and educate us. I always felt comfortable in being able to discuss any concerns and always knew that an outcome would be achieved. She also chaired monthly General Staff Meetings and General Nursing Meetings.

My professional opinion of Mrs. Mulligan is that she conducts herself in a professional manner, she possesses high ethical standards and integrity.

Yours sincerely,

Mrs. Vivienne Jones
Nurse Manager
Dalby Health Service
Northern Downs Health Service District

23 June 2005

The Bundaberg Hospital Commission of Inquiry
PO Box 13147
George Street,
Brisbane Qld 4003

To Whom it may Concern,

I am writing this letter in support of Mrs. Linda Mulligan, District Director of Nursing, Bundaberg Hospital.

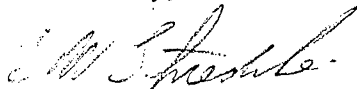
I have worked at Dalby Health Services for 15 years in various positions. I am currently employed by Dalby Health Services as a Resident Care Assistant at Karingal Aged Care Facility.

During the 9 years that Mrs. Mulligan was the Director of Nursing at Dalby Health Services I have found her to be fair and reasonable with all staff although she expected a high standard of professionalism and performance. This was acknowledged generally at Karingal Aged Care Facility.

At the time of Mrs. Mulligan's employment at Dalby Health Services I was the Australian Workers Union (AWU) representative. As a union representative, on two occasions I supported staff members who were called to see Mrs. Mulligan regarding performance issues. I was impressed with how she managed the interview. She gave the staff member every opportunity to explain the circumstances; she was sensitive to the personal difficulties of the person; strategies were worked out together to address the concern. The staff member invariably left the meeting with a clear understanding of Mrs. Mulligan's expectations and was very pleased with the outcome.

I was also a member of the Local Consultative Forum as the AWU representative. During the meetings I found Mrs. Mulligan approachable and listened to explanations. The outcomes of the negotiations were satisfactory to all parties.

Yours Sincerely,



Thomas Thiedeke

24th June 2004

The Bundaberg Hospital Commission of Inquiry
PO Bo 13147
George Street
Brisbane, QLD 4003

To Whom it may Concern

I am writing this letter in support of Mrs. Linda Mulligan, the Director of Nursing, Bundaberg Hospital.

I am employed at Dalby Health Service as a Clinical Nurse (NO2). I have held this position since 2002. At times during my employment I have been required to act in the position as Nurse Unit Manager of the acute ward. During my employment Mrs Mulligan as well as being my Director of Nursing was at times my immediate supervisor.

In my acting role as Nurse Unit Manger of a busy acute ward I was in contact with Mrs Mulligan on almost a daily basis. In my experience with Mrs Mulligan as my supervisor I found her to be extremely supportive. I was able to take my concerns to her knowing I would be listened to and my position would be understood.

On such occasions Mrs Mulligan would encourage discussion with a view to a suitable resolution. Mrs Mulligan would support and direct me in the follow through of any actions required. Her guidance in some extremely delicate matters relating to staff was appreciated as I was not experienced in management issues.

In my acting role, it was necessary for me to deal with complaints from various sources. From Mrs Mulligan I was able to learn the process for responding to these issues and I was expected to proceed and provide feedback. She did encourage me to document using 'file notes' and the importance of such behaviour in the complaints process.

On one occasion I found myself in an unsafe situation with an abusive patient. The situation was diffused at the time and afterwards when debriefing with Mrs Mulligan she offered guidance and support. She then went on to offer her time for an in-service on the ward for staff with regards to safety and dealing with difficult patients. At all times I found her to be interested and supportive of her staff and concerned for their well being.

I was at all times aware of the expectations of my position and included as a integral part of the management team. As an Acting NO3 I was part of 'Taskforce' meetings that were conducted in a professional manner by Mrs Mulligan. During these meetings we were able to refer to any matter that was concerning us in an atmosphere

of confidentiality with the knowledge that we would be supported and our opinions considered.

In conclusion I have found Mrs Mulligan to be a person of integrity and honesty. She conducts herself in a professional manner and has high ethical standards.

Yours sincerely

Diane Henning
Clinical Nurse
Dalby Health Service
Northern Downs District

24 June 2005

The Bundaberg Hospital Commission of Inquiry
PO Box 13147
George Street
Brisbane Qld 4003

To Whom it may Concern

May name is Colleen Rasmussen and I am the Current Director of Nursing/Service Manager at Dalby Health Services. I commenced this position on 12 July 2004. Linda Mulligan was the previous Director of Nursing at Dalby Health Services.

When I commenced at Dalby Health Services, this position had been filled by acting directors of nursing over a large period of time due to Linda acting in District Manager roles. I was surprised at how well this health service functioned and by the capabilities of the NO 3s. They were obviously well trained and possessed an excellent work ethic. I did state at the time that the NO 3s were well trained and they all stated that Linda had trained them well.

The complaints process at Dalby was well set up and followed by all managers. This system continues today, as I have not needed to revamp a system that works well. I believe that Linda set up this system.

My management style is such that I perform ward rounds daily, and have an open door policy. I believe that this was not the case with Linda. However, staff complaints/issues appeared to have been dealt with adequately and with excellent documentation. Staff have informed me that Linda was fair and equitable in her dealings with them.

Yours sincerely,

Colleen Rasmussen
Director of Nursing/Service Manager
Dalby Health Services
Northern Downs Health Service District

LMM2

From: Beryl Callanan
To: Peter Leck.Bundaberg-District.WBAY-BURNETT
Date: 12/12/03 4:47pm
Subject: ADON responsibilities

Peter,
Carolyn has managed to not be working today when I asked her to ahve the info to me on her role. I have put together a list of the types of jobs that I think that the ADON can do in this organisation. As the position does not have line manag responsibility I think it is important to review the committees on which that role sits and definately have double up of the DONS and ADON on many of the committees ..some of the meetings are wasting time for at least one of the positions. Patrick is planning on reviewing the meetings that nursing has as some of them appear to be rehashing other committee issues.
I think that in this organisation the ADON should be the right hand of the DONS and undertake some specific portfolio work as noted but aslo be available to undertake change projects and develop business cases as required by the DONS.
See attached for further info.
Beryl

Suggested ADON (NO5) responsibilities, Bundaberg Base Hospital

- Manage **project** as directed by DONS and DM
- Manage permanent portfolios of
  - **Incident** reporting and add action plan to decrease incidents
  - **Risk management** in nursing
  - Conduct **root cause analysis** as directed
  - Sick leave tracking and assisting NUMs by providing data and staff sick leave councelling

- Coordinate **Enrolled Nurse** advanced practice rollout and be resource person.
- Coordinate **pastoral care** issues
- In consultation with DONS organise **student placements and graduate placements** for Universities
- Debrief staff when **critical incident** occurs
- Patient/visitor/family **complaints** in consultation with DON. investigate and prepares response
- Available to assist with **recruitment and selection**
- **Career counselling** for nurses
- Coordination of corporate issues eg **uniforms**
- **Nursing admin roster** and budget reporting for Nr admin
- **Nursing accommodation** planning
- **Exec policy updates** eg disaster planning
- Develop **Business Plans** re changes for DCF under direction of DONS

Does not need to attend as the DON does and these things are line responsibilities

- Staffing meeting
- Should not attend all the meetings attended by the DON as this can be duplication…need to review meeting attendance eh Nr Educator and Nr manage meeting
- If no line responsibility should not do on call
- Does not need to be on product review committee
- Negotiate and coordinate placement of nurses from other org eg Rotary New Guinea or Private Hosp

LMM3

from TOM HOFFMAN

ADON RESPONSIBLTIES:

ROUNDS
MEETINGS RESPONSIBLE OR REPORTS TO:
DON/ADON.
NURSE EDUCATORS
STAFFING MEETING
LEVEL 3/4/5
NURSING SERVICES
HODS
SPE
INFECTION CONTROL
DON/ ADON/ NURSE MANAGERS.
PRODUCT REVIEW

TROUBLE SHOOTING: HELP ANY NUMS THAT NEED ASSISSTANCE.
INTERVIEWS AND INTERVIEW PANELS,
SUPPORT TO STAFF
VARIANCE REPORTS.
FALLS REGISTER.
INCIDENT REPORTS;
INVESTIGATIONS AND QUALITY IMPROVEMENT ACTIVITIES.
NAAS/ MEDICATION PACKAGES/LIASING WITH ED CENTRE.
WORK WITH DON ON ANY ISSUES AS REQUIRED. WORK WITH DON ON ANYTHING REQUIRED.
ACTION AND REPORT BACK TO ANY MEETINGS
REVIEW OF POLICIES AS REQUIRED.
NURSING ADMIN BUDGET REPORT
NURSING ADMIN ROSTER.
COORDINATE INTERNAL DISASTER PLAN (WILL BE SHORT TERM PROJECT HOPEFULLY).
THERE ARE MANY OTHER THINGS YOU DO ON A DAILY BASIS , THAT CROP UP AND YOU DEAL WITH AT THE TIME. CAROLYN WILL HAVE A LOT MORE THAT SHE DOES THAT I HAVENT DONE , I HAVENT DONE ANY VARIANCE REPORTS ETC.
ON CALL/SHARING OF ON CALL
ACTING UP INTO DON POSITION.
WORKING WITH ED CENTRE AND STUDENT PLACEMENTS , NEGITOTATING WITH THE UNIS THE STUDENTS ETC.

LMM4

ADON RESPONSIBILITIES & JOBS

The ADON role supports the DDONS role. There are things that the ADON does independently also and these are mostly listed below.

AUDITS - examples of audits:

CARE PATH VARIANCES

This year the ADON took over the role of auditing care paths for completion and for recording of variances. Time permitting, one Care Path is audited every 2 months and approx 20 patient charts are audited each time. Reports were presented at the Nursing Services meeting (now Nursing HOD) but as a Clinical Pathways Committee has now been formed the reports are channelled in that direction.

MEDICATION SHEETS

New medication sheets were introduced in 2004. Before their introduction, the ADON conducted an audit on existing medication charts and a comparative audit on the new charts will be conducted in September/October 2004.

PRESSURE AREA AUDIT

The ADON coordinated and participated in a recent 2 day pressure area audit as requested by the District Manager.

OTHER AUDITS

The ADON, as requested, assists the Nursing Informatics Nurse Manager to audit patient charts for completeness, content etc.

INCIDENTS

Until February 2004, all patient incidents came to the ADONs office for review and action as required. From February, the ADON has only been required to review and investigate certain incidents as requested by the District Quality & Decision Support Unit or a Director.

MENTORING PROGRAM

In 2002, the current ADON was part of Queensland Health's inaugural Mentoring Program. This program ran for just over 12 months during which time the ADON gained skills by attending workshops in the following:

Project Management

Mediation
Write Smart
Media Training
Mentoring Training

The above are used by the ADON in day-to-day, week-to-week activities, even though some to a lesser degree. The ADON volunteered to be a Mentor for Post Graduates in 2004.

The ADON assists nursing staff in setting up projects – an example being: The Family Care Home Visiting Guide – Community Nurses. These skills will also be utilised in setting up the Integrated Risk Management/Incident Analysis workshops soon to be commenced.

EDUCATION

COMPLAINTS HANDLING

The ADON is asked to investigate complaints (staff and patient). In 2002 the current ADON attended a two day workshop in Brisbane on complaints handling and on return conducted training for senior nursing staff (and others) in handling complaints. Investigating complaints involves thorough investigation of the incident, interviewing the person(s) concerned, offering solutions, writing a report for DDONS/executive.

INTEGRATED RISK MANAGEMENT/INCIDENT ANALYSIS

With other staff members, the ADON attended a workshop in Aug 2004 and commenced training staff in these areas in September this year.

BUSINESS PLANNING FRAMEWORK

The ADON conducted many sessions regarding the Business Planning Framework to Cost Centre Managers. This was also conducted for the DONS of the satellite hospitals.

IMMUNISATION CLINICS

Until recently, the current ADON who is immunisation endorsed, conducted Immunisation Clinics on a regular basis but as these have now ceased, the ADON assists with immunising staff against influenza each year and also assists with school immunisation clinics as they arise. In the past 12 months, all high schools were visited twice where thousands of students were immunised against Hep B and Meningococcal Meningitis.

NEW INITIATIVES

In the past, the ADON has been involved with new initiatives such as:

ESP – a member of the Steering Committee
HR/Payroll Integration

ISAP

The ADON is a member of the Leadership Group for ISAP and attends workshops as scheduled.

ASSISTANCE/SUPPORT TO CLINICAL STAFF

The ADON frequently assists ward/department staff in problem solving. This may be related to nursing staff issues or medical staff issues. It may also involve clinical issues relating to equipment, patient safety or just something the ward staff are unfamiliar with and the process they need to pursue.

A recent example of this is: collecting data on evening overtime for the Surgical Ward for a workloads issue. Because of the difficulty in collecting such data - not available through Payroll – it took 8 hours to obtain data from Trend, which wasn't entirely reliable, but the best that could be gathered.

Sometimes ward staff contact the ADON with difficult issues which may require the ADON to contact the District Manager for advice on their behalf and then get back to ward staff with a response. An example of this occurred on 16/8/04.

The ADON assists NUMs in investigating staff sick leave.

The ADON frequently assists staff in completing Business Cases. This can take several weeks - to assist in collecting data, collating the data and then typing up.

HEART START/WALKING TRACK

The nursing office is required to assist in manning the walking track on the 5th Monday of the month. This occurs several times a year and because the previous DDONS lived out of town, the ADON usually attended to this chore.

ROUNDS

Daily ward/department rounds by the DDONS and ADON were reintroduced some time ago as a result of a level 3,4,5 nursing review. Staff complained that these two offices were not visible enough so all wards and departments (with the exception of IMHU) are visited every

day. This is on a rotational basis and staff are extremely pleased with this arrangement knowing they will see one member of the nursing office every day. There are occasions when neither nursing officer can visit the areas and staff understand this.

MEAL RELIEF

The ADON relieves in the wards on occasions when the After Hrs Nurse Manager has difficulty in finding staff to do this.

RELIEF

In the past, the ADON has relieved the DDONS for annual leave, conference leave, LSL etc. (She) has also filled in at short notice to attend L& M meetings etc when the DDONS has been on sick leave or away.

The ADON has also relieved at Mt Perry for short periods (max. of 1 week at a time) and at Childers as DON for a period of 8 months.

YEARLY PLANNING DAY

The ADON attends this planning day and in conjunction with other members of Nursing Administration, writes the Business Plan for the area which is integrated into the Operation Plan for the Health Service. (2003)

BUDGET

The ADON is responsible for the Nursing Administration budget and prepares a monthly report for the DDONS for the monthly executive budget meeting. This often requires a deal of delving to ascertain where funds have gone and frequently needs adjusting by the finance manager on the advice of the ADON. The ADON also assists NUMs and acting NUMs to complete their monthly budget report as required.

ASSISTANCE TO DDONS/DM

The ADON frequently assists the DDONS with projects, investigations and other items which (she) may require assistance with. The ADON also stands in for the DDONS at meetings and in other instances which (she) cannot attend. The District Manager also asks the ADON for assistance with some tasks from time to time.

NURSING OFFICE – ON CALL

The ADON position does 26 of the 52 weeks of the year on call for the nursing office, sharing this with the DDONS. On most occasions the problem reported can be dealt with by 'phone but at times the ADON is required to present to the hospital to assist with work loads or assist the After Hours Nurse Manager solve a problem.

If "on-call" when a disaster occurs, the ADON presents to the hospital and resumes the role of DDONS/ADON until not required.

The current ADON has also been required on a number of occasions to retrieve equipment from satellite hospitals or transfer patients to satellite hospitals when the bed situation reached crisis point.

INTERVIEW PANELS

The ADON sits on interview panels as required. This occurs when a NO3 position has been advertised but also to assist NUMs when they have difficulty in filling an interview panel. The current ADON has also sat on interview panels for other hospitals for eg. Maryborough when NO3 positions were advertised.

POLICY REVIEW

The ADON assists in reviewing policies and protocols as required through the relevant committees. This includes policies relating to SP&E, HR and Nursing Polices.

The ADON also wrote the policy for Cellulitis patients to prevent admission to hospital when the patient can be cared for at home.

NURSING ADMIN ROSTER

The ADON completes the Nursing Admin roster on a monthly basis, checking for variances before final computer entry with ESP. This includes PAC staff and Infection Control's roster also.

MEETINGS/COMMITTEES

The ADON attends a considerable number of meetings and committee meetings, some of which (she) is required to chair or record minutes for.

The ADON frequently reports back to meetings with issues which required investigation after having been raised at previous meetings.

The ADON was initially involved with the Nursing Workloads Committee but now attends meetings only when requested. The ADON has assisted in drawing up new flowcharts for use in reporting workload issues. The ADON investigates workload issues as required, according to flowchart.

Until recently and as a responsibility for the 56Educators meeting, the ADON collected performance indicators regarding staff annual competencies and suggested actions to be taken when these were not achieved. A different format for collecting indicators is now used and completed by Education staff.

SP&E COMMITTEE

As a member of the SP&E Committee the ADON recently investigated the functionality of evacuation mattresses used within the Health Service. This resulted in the need to design a new mattress for evacuation purposes.

The ADON was also been asked to review the Internal Disaster Plan and conduct a desktop internal disaster in 2004. This was done in August. The plan was changed again in 2005 following the Tilt Train Disaster in Nov 2004.

OTHER COMMITTEES

The ADON is currently a member of the following committees/meetings:

Committees:
Product Review
Workplace Health & Safety
HRM
Infection Control
Nursing HOD

Meetings:
DDON/ADON/AH Nr Managers
Heads of Department
3,5,6
DDON/ADON
Clinical Pathways
Meetings with CQU regarding new Model which the University will introduce in 2005.

OTHER ISSUES

The ADON also communicates with the DONS of the satellite hospitals and informs them of new initiatives and changes to policies which may affect their hospital services. The ADON is currently involved in reviewing the Health Service's Chemotherapy Policy to improve the manner in which staff obtain their initial competency are the manner in which they are reassessed annually.

The ADON organises the Nurses ANZAC Day memorial service each year in conjunction with the local RSL.

The ADON has assumed the role of organising volunteer staff for the past few years when staff have had "stop-work" days because of Union issues. This is quite a challenge to ensure that all ward areas have sufficient volunteer staff to deliver meals and to assist in the kitchen in preparing meals.

The ADON orders supplies through FAMMIS each week.

ADON RESPONSIBILITIES & JOBS (PAST)

Patient incidents

All patient incidents are sent to this office. This includes:

patient falls
abusive patient incidents
process incidents (eg caused by faulty equipment)
some patient complaints
etc etc

Each report is read and the necessary action taken. Some investigations can be a lengthy process while awaiting an outcome and staff education is instigated as required. Quite often a report is required for executive or the DON regarding a certain incident. When complete, the ADON signs the form off and either passes it on to the WPH&S officer or files it. It is also recorded on a spreadsheet which is forwarded electronically to QDSU where it is graphed 3 monthly for executive.

Patient incidents also come from Childers, Gin Gin, Mt Perry, and Community Health for the ADON to address.

Medication incidents

Medication incidents are dealt with in a timely manner by the ADON, and Education Staff as required. Both the pink incident form as well as the Medication completed, the tool indicating the degree of severity of the incident and the action to be taken. Depending on the score, Education Centre staff give the nurse a major or minor package to be completed and returned to them and the ADON. Counselling is given by the ADON or NUM according to severity.

Medication incidents perpetrated by Medical staff and Pharmacy staff are also handled by the ADON initially and then by the relevant personnel.

A report is presented at the monthly Nursing Services meeting.

Staff incidents (eg. falls) are handled by the relevant director.

Security incidents are handled by WPH&S.

Falls Register

The ADON currently enters data on the falls register after falls incidents have been recorded as above. This data is then available for the 'falls" team to review or the forums to discuss at their meetings.

ROUNDS

Daily ward/department rounds by the DONS and ADON were reintroduced some time ago. Staff had complained that these two offices were not visible enough so all wards

and departments (with the exception of IMHU) are visited every day. This is on a rotation basis and staff are extremely pleased with this arrangement knowing they will see one member of the nursing office every day. There are occasions when neither nursing officer can visit the areas and staff understand this.

COMPLAINTS HANDLING

The ADON is frequently asked to investigate complaints (staff and patient). In 2002 the current ADON attended a two day workshop in Brisbane on complaints handling and on return conduced training for senior nursing staff (and others) in handling complaints. Investigating complaints involves thorough investigation of the incident, interviewing the person(s) concerned, offering solutions, writing a report for DONS/executive.

In 2002, the current ADON was part of Queensland Health's inaugural Mentoring Program. This program ran for just over 12 months during which time the ADON gained skills by attending workshops in the following:

*Project Management
*Mediation
*Write Smart
*Media Training
*Mentoring Training

All of the *above are used by the ADON in day-to-day, week-to-week activities, even though to a lesser degree.

BUSINESS CASES

The ADON frequently assists staff in completing Business Cases. This can take several weeks - to assist in collecting data, collating the data and then typing up.

AUDITS

CARE PATH VARIANCES

This year the ADON took over the role of auditing care paths for completion and for completion of variances. Time permitting, one carepath is audited every 2 months and approx 20 patient charts are audited each time. A report is presented at the Nursing Services meeting.

OTHER AUDITS

The ADON, as requested, assists the Nursing Informatics Nurse Manager to audit patient charts for completeness, content etc.

The next audit the ADON is to be involved in, is that of medication sheets. This will be conducted within the next month and is in readiness for new medication sheets which QH is introducing.

MEAL RELIEF

The ADON relieves in the wards on occasions when the After Hrs Nurse Manager has difficulty in finding staff to do this.

IMMUNISATION CLINICS

Until recently, the current ADON who is immunisation endorsed, conducted Immunisation Clinics on a regular basis but as these have now ceased, the ADON assists with immunising staff against influenza each year and also assists with school immunisation clinics as they arise. In the past 12 months, all high schools were visited twice where thousands of students were immunised against Hep B and Meningococcal Meningitis.

RELIEF

In the past, the ADON has always relieved the DONS for annual leave, conference leave, LSL etc. (She) has also filled in at short notice to attend L& M meetings etc when the DONS has been on sick leave or away.

The ADON has also relieved at Mt Perry for short periods (max. of 1 week at a time) and at Childers for a period of 8 months.

MEETINGS

The ADON attends numerous meetings some of which (she) is required to chair or record minutes for. As a member of the SP&E meeting the ADON has recently investigated evacuation mattresses within the health service and assisted in designing a new mattress for this purpose. (She) has also been asked to review the Internal; Disaster Plan, conduct a desktop disaster in 2004.

As a responsibility for the 54Educators meeting the ADON collect **performance indicators** regarding staff annual competencies and suggests actions when these are not being achieved.

The ADON frequently reports back to meetings with issues requiring investigation which were raised at previous meetings.

BUDGET

The ADON is responsible for the Nursing Administration budget and prepares a monthly report for the DONS for the monthly executive budget meeting. This often requires a great deal of delving to ascertain where funds have gone and frequently needs adjusting by the finance manager on the advice of the ADON. The ADON also assists NUMs and acting NUMs to complete their monthly budget report.

ASSISTANCE TO DONS/DM

The ADON is frequently called on to assist the DONS with projects, investigations and other items which (she) may require assistance with. The ADON also stands in for the DONS at meetings and in other instances which (she) cannot attend. The District Manager also asks the ADON for assistance with some tasks from time to time.

ASSISTANCE/SUPPORT TO CLINICAL STAFF

The ADON frequently assists ward/department staff in problem solving. This may be related to nursing staff issues or medical staff issues. It may also involve clinical issues relating to equipment, patient safety or just something the ward staff are unfamiliar with and the process they need to pursue.

NURSING OFFICE – ON CALL

The ADON does 26 of the 52 weeks of the year on call for the nursing office, sharing this with the DONS. On most occasions the problem reported can be dealt with by 'phone but at times the ADON is required to present to the hospital to assist with work loads or assist the After Hours Nurse Manager solve a problem.

If "on-call" when a disaster occurs, the ADON presents to the hospital and resumes the role of DONS/ADON until not required. The current ADON has also been required on a number of occasions to retrieve equipment from satellite hospitals or transfer patients to satellite hospitals when the bed situation reached crisis point.

HEART START/WALKING TRACK

The nursing office is required to assist in manning the walking track on the 5th Monday of the month. This occurs several times a year and because the previous DONS lived out of town, the ADON usually attended to this chore.

INTERVIEW PANELS

The ADON sits on interview panels as required. This occurs when a NO3 position has been advertised but also to assist NUMs when they have difficulty in filling an interview panel. The current ADON has also sat on interview panels for other hospitals for eg. Maryborough when NO3 positions have been advertised.

POLICY REVIEW

The ADON assists in reviewing policies and protocols as required.

NURSING ADMIN ROSTER

The ADON completes the Nursing Admin roster on a monthly basis, checking for variances before final computer entry with ESP. This includes PAC staff and Infection Control's roster.

WALKING TRACK

LMM5

COMMITTEES/FORUMS/MEETINGS

(a) **Leadership and Management Committee** - This committee consisted of all the five Directors, including the District Manager and myself. This group met each Monday morning from 0900-1100 and dealt with a wide variety of governance issues. All other major committees/meetings report through to this committee. This committee discussed the issues surrounding the need for an updated ICU admission/transfer policy. Gail Aylmer, Clinical Nurse Consultant Infection Control, provided reports to this Committee and utilized a QH corporate computer system called CRISP to input infection control data. Ms Aylmer did not report any issues with postoperative complications/infections concerning Dr Patel to this committee after my arrival at Bundaberg or to me personally as her immediate supervisor. Additionally there is an Infection Control Sub-committee of the Safe Practice and Environment Committee which has the Director of Corporate Services, Ms Aylmer and ADON on the same. No issues concerning Dr Patel were reported on from this committee to me.

(b) **DDON Meetings with District Manager** – Initially these meetings took place weekly but later in 2004, they changed to fortnightly. These meetings usually lasted approximately one and half to two and half hours depending on the issues which needed to be discussed.

(c) **Integrated Strategy and Performance Meetings** - These meetings were started later in 2004 to look at corporate introduction of a new format for strategic direction for each health service. They were stand-alone workshops/meetings and then, after the strategy map was developed, were incorporated into the Improving Performance Committee Meetings. This strategy map set out the direction where we were headed which was determined during workshops with clinicians and heads of department representatives.

(d) **Improving Performance Committee** – This committee consisted of the executive and Jenny Kirby, Manager of District Quality and Decision Support Unit ("DQDSU"), Leonie Raven, Quality Officer, and the Rural Directors of Nursing from the three rural facilities. In 2005 the Chair of the District Health Council also became part of the committee. This committee met monthly and focused on quality

processes including accreditation. The meetings lasted for one to two hours. Agendas and minutes were kept. At no time since my arrival were issues regarding the quality of care provided by Dr Patel raised while I was present at these meetings.

(e) **Executive Council Committee** – These meetings are held monthly with all the Medical Staff Heads and the executive, as well as DQDSU Manager and Quality Officer. These meetings usually lasted between two and three hours. Agendas and Minutes were kept. At no time since my arrival were issues regarding surgical outcomes or the quality of care provided by Dr Patel raised while I was present at these meetings.

(f) **Clinical Service Forums** – These clinical forums were sub-groups of the Executive Council and were held within clinical areas with both the Medical Director of the area, and the NUM and other medical/nursing staff. Additionally an executive member sat on each of these forums. There were six clinical service forums in total which included Integrated Mental Health, Paediatric, Medical, Family Unit, Department of Emergency Medicine, and ASPIC. ASPIC included the surgical ward, ICU, theatre, day surgery unit and pre-admission clinic. Ms Hoffman sat on this committee as NUM of ICU, as did Di Jenkins NUM of Surgical ward, the Acting NUM of Theatre which was either David Levings or Gail Doherty, the Acting NUM of Pre-Admission Clinic who was Margie Mears and the NUM of Day Surgery, Gwenda McDermid. The executive members on this forum were Mr Leck and Dr Darren Keating, Medical Director. Ms Hoffman also sat on the Medical Services Clinical Forum as ICU dealt with both medical and surgical patients. These forums were in place to deal with issues in the various clinical areas, for the development of clinical policy/procedure and for strategic planning within the specific areas. The outcomes of these Clinical Services Forums formed part of the agenda of the Executive Council Meetings, as the Medical staff reported back on activities of each clinical service forum. Additionally, each Clinical Services Forum was to have a sub-group called "ErrorMed" or similar name (such as Significant Incident Review Committee or Perinatal Morbidity and Mortality) which reviewed any clinical care concerns or incidents/near misses or potential incidents from a medical/nursing clinical perspective. I was the executive participant in the Department of Emergency

Medicine clinical service forum. It was held monthly and the meetings lasted for approximately one hour.

(g) **General Heads of Department Meetings** – This was a monthly meeting with all Heads of Department including Medical, Nursing, Operational, Administrative, Mental Health and Allied Health and the Executive. Opportunities existed for staff to raise any issues. These meetings were minuted and usually lasted between one and one and half hours. Ms Hoffmann attended these meetings. No issues concerning Dr Patel were mentioned at any time whilst I was in attendance.

(h) **Ward Level Nursing Meetings** – Each ward level was to have a regular meeting that the NUM managed and arranged with all levels of nursing staff. I was in the process of reviewing these meetings in early 2005 because I had received some indication from the QNU and a couple of RNs that these were not taking place regularly or being documented appropriately. I had requested the ADON to provide me feedback about this just prior to my going on annual leave in March 2005 and she provided me with a summary document detailing each clinical area, the frequency of their meetings and the manner in which the meetings were documented. Attached is the document marked LMM # No issues concerning Dr Patel were forwarded to me from ward level meetings from the NUMs or staff except as set out below.

(i) **Nursing Heads of Department Meetings** – I chaired this monthly meeting with all the Nursing Heads (levels 2/3/4/5) at Bundaberg Health Service, including Ms Hoffman, plus the DONs from the other three facilities. This meeting had an agenda and all staff had the opportunity to put items on the agenda and each meeting was minuted. The meetings lasted for approximately one to one and a half hours. The meeting dealt with District-wide nursing issues. No issues were raised concerning Dr Patel at these meetings. At no time did any of the four Directors of Nursing from the three rural facilities raise with me any concern about Dr Patel or any of his post-operative patients from their facilities or areas of responsibility. Ms Kylie Male (DON Mount Perry) did raise an issue with me in relation to the family of a palliative client who I believe had surgery both in a private and public facility.

She did not identify the surgeon and because this was a matter outside my area of responsibility, I requested she immediately refer the matter to the District Manager.

(j) **Level 3/4/5/6 Nursing Meetings** -This was a monthly meeting chaired by myself with an agenda done by the ADON (staff could and did put items on the same) and minutes. It had all the Nurse Unit Managers (Level 3) including Ms Hoffman, Clinical Nurse Consultants (Level 3 or 4), the Assistant Director of Nursing (Level 5) and myself (Level 6). The meetings lasted for approximately two hours. This meeting was very interactive and in fact I was provided with feedback from the staff to the effect that it was very different than with the previous Director of Nursing where staff could not and did not raise issues. It was my practice that if a sensitive matter or a matter which concerned only a particular person or clinical area was raised outside the agenda items, I would request the person raising the matter to see me personally outside the meeting. I did so for reasons of confidentiality and fairness, as well as to enable the meeting to deal with agenda items which I explained to the staff. I saw this meeting as one of my opportunities to impact on the culture at the Bundaberg Hospital within nursing and start to mould behaviours and expected performance. I would have expected that this was the meeting at which staff would have raised any issues concerning surgical outcomes or behaviour of medical staff because they were very vocal in this meeting, but no such concerns were raised, save for the meeting on 25 August 2004 where Ms Hoffman raised what is recorded in the minutes as "staff stress over medical incident and difficulty accessing EAS". This is a reference to the Bramich case to which I refer below. After most meetings I stayed behind for an additional 15 to 20 minutes so that staff could talk to me individually if they wished, and this did occur.

(k) **Bed Manager and After Hours Nurse Managers Meetings** - This was a monthly meeting with the ADON, After Hours Nurse Managers, Nurse Manager Bed Management and chaired by myself. The meetings lasted for up to one and a half hours and had agendas (with relevant staff raising items) and minutes. Generally this meeting was known previously as a complaining session according to the ADON who said it was a waste of time, and that was demonstrated to me on my arrival. I had to deal with a number of formal complaints about the behaviour certain members in this group. I was slowly

changing this meeting to be solution focused and was seeing success in that respect. The only issues raised from this group that could be seen as connected to Dr Patel were in relation to bed management and doctors attitudes when beds were required (including in ICU). Reference was made to a number of doctors (including Dr Patel) in this context, and Ms L Douglas attempted to go into the details of a complaint that had been lodged by Dr Patel about Ms L Douglas's behaviour. I focused the group on addressing this wider issue by looking at strategies to resolve it overall, rather than going into the confidential detail about a specific incident with Ms Douglas and Dr Patel that had been the subject of a complaint in July 2004, which had been resolved . The strategies included reinforcing the ability for the After Hours Nurse Managers to be able to contact and receive support from ADON, DDON and the Medical Director both in and out of normal hours and asking the Bed Manager to go to the orientation of new doctors each year to discuss their role which are noted in the minutes over a number of months from August 2004. Specifically with ICU, I asked Ms Hoffman to include the After Hours Nurse Managers in her review of the admission/transfer policy (to which I refer later in this statement).

(l) **Nurse Educators Meetings** - I met with the Nurse Educators and ADON on a monthly basis and agenda and minutes were kept. The meetings usually lasted about one and a half to two hours. No issues with Dr Patel were ever raised.

(m) **Meetings with Assistant Director of Nursing** - These meetings were held weekly and lasted for approximately one hour. I made notes on relevant documents that we discussed at these meetings. I was giving the ADON specific tasks to complete as part of managing her performance and developing her skills in relation to what was expected. I also met with the ADON at additional times when required and communicated by telephone and email regularly. The ADON did regular rounds at specific times within the hospital and NUMs and staff could raise any issues they had. It was expected as part of the ADON role that she raise any relevant issues with me that were raised with her during her rounds. She did not raise issues with me about Dr Patel. In this context, I should mention

that Ms Kennedy socialises with Ms Hoffman and Ms Aylmer outside the work setting and I would have expected her to be aware of any concerns either Ms Hoffman or Ms Aylmer had about Dr Patel.

(n) **General Nursing Meetings** - These meetings were poorly attended when I commenced at Bundaberg. No-one else attended the first meeting and the second had three nurses in attendance. In evaluation of these meetings, it was determined to give them a break and then to re-start these meetings in May 2005 for which dates were set prior to my going on annual leave. In the meantime, I expected that the no 3/4/5 staff would act as conduits of relevant information obtained at level 3/4/5/6 meetings and nursing heads of departments meetings to their staff at their regular ward level meetings. The new meetings were to be called General Nursing Forums, and all nursing staff could attend and be updated with professional nursing issues and raise items from the floor. I had discussed this plan with the both the Level 3/4/5/6 at our meetings and the QNU representatives and dates for May 2005 had been established to start this forum.

(o) **Operational, Allied Health, Community Health, Mental Health, Medical and Administration staff Meetings** - Each Executive Member had regular standard meetings within their departments. There was a specific meeting of medical staff called the Medical Staff Advisory Committee which the Medical Director and District Manager attended. There were no issues raised at Leadership and Management from this committee in relation to Dr Patel.

(p) **Continuum of Care Committee** - This group met monthly and had minutes and an agenda. It was initially chaired by the Director of Medicine; however I took over the chair in September 2004. The Director of Medicine, Director of Allied and Community Health, Director of Integrated Mental Health and Nurse Unit Managers or a delegate from each of the Clinical Service Forums (i.e. Medical, ASPIC, Department of Emergency Medicine, Paediatric and Family Unit), a representative from the Division of General Practitioners and a GP from the community attended. This committee was focused on clinical care (including clinical policy/protocols) across the continuum of care (i.e. hospital and community), and had a number of sub-committees i.e. Stroke Improvement, Clinical Pathway, Falls Monitoring,

Pressure Ulcer and Consumer and Community Participation. Ms Hoffman did not attend these meetings, however, she sent a delegate in her place. No issues were ever raised by internal staff or the Division of GP representative and the local Medical General Practitioner in relation to Dr Patel.

(q) **General Staff Forum -** This was held monthly in the staff dining room and was chaired by District Manager. The entire Executive attended these meetings. An update was provided by the DM monthly and by an Executive Directors relative to their area on a rotational basis. An opportunity existed for staff to raise issues from the floor and individually with us as we circulated amongst staff during the barbeque lunch which followed the meeting. Ms Hoffman could attend, but I did not see her at these meetings on a regular basis. No issues were ever raised with me re the Director of Surgery during this forum.

(r) **District Consultative Forum** - This was a monthly meeting with all of the union groups, the executive management, Quality Co-ordinator, and Manager HRM with agenda items and minutes. This was a very interactive meeting with the unions raising numerous issues. The meeting generally lasted between one and two hours. Since my arrival at no time were issues with the Director of Surgery raised in the meetings I attended.

(s) **Pre-District Consultative Forum Meeting** – This was a monthly meeting prior to the District Consultative Forum attended by the executive and the HR manager. These meetings lasted for approximately one to one and a half hours.

(t) **Local Consultative Forums** - Two consultative forums exist in the Health Service which are forums with the relevant unions and a specific area or stream. One is a forum within the Operational Stream and the Director of Corporate Services is responsible for this forum. The other is a newly formed Integrated Mental Health forum which was formed as a result of Dr M Waters' review of the Mental Health Service. I was asked to attend these meetings as professional line manager for mental health nursing staff. The meetings usually ran for approximately one hour.

(u) **Nursing Workload Committee** - This addressed nursing workload issues. This group was previously under the auspices of the ADON role, however was not functioning on my arrival at Bundaberg, so I re-started it. It consisted of three QNU representatives and three management representatives with myself always being one. The other management representatives were chosen according to the issues on the agenda (i.e. different clinical areas). No workload issues were raised in relation to ICU. If they had have been I would have invited Ms Hoffman to attend the meeting.

(v) **Meetings with Queensland Nursing Union** - Monthly meetings were held as a minimum with the local QNU Officer Organiser, Vicki Smyth. Branch members of both the Hospital QNU branch and the Mental Health Sub-Branch began to attend the first part of these meetings mid year in 2004. Additionally Kym Barry, Professional Officer from the QNU Brisbane Office, often flew up to Bundaberg and was present for monthly meetings and ad hoc meetings. The meetings generally lasted for approximately one hour. No issues with Dr Patel were raised with me until October 2004 as set out below.

(w) **District Health Council Committee** - These meetings were held monthly in the evening with community representatives appointed by the Minister of Health and the entire executive attended these meetings. The meetings lasted for between two and three hours and had agendas with minutes. Part of the role of the District Health Council was to be the voice of the local community in regard to health issues. The Council Chairperson was Mr V Chase, and there was representation from across the District including members from all the local shire councils of Gin Gin, Childers, Bundaberg, Mount Perry and Miram Vale as well as two Medical Practitioners in the community. The Council did raise issues with the District Manager and Executive, however in my time as DDON no issues were raised at the meetings I attended with respect to the competence of Dr Patel.

(x) **Renal Services Meetings** – From later in 2004, these meetings took place quarterly between the Hervey Bay District and the Bundaberg District. The meetings were attended by the two District Managers, the two DONs, the two NUMs, Dr Peter Miach and the two Medical Directors. The purpose

of this meeting was to have integrated renal services across the two Districts, with Bundaberg to be the lead district. No issues were ever raised in these meetings in relation to Dr Patel.

(y) **Finance Committee** – This was a monthly meeting at which we dealt with finance matters at District and Zonal levels. The meetings usually went for about three hours.

(z) **Media Meetings** – This was a monthly meeting between the executive and local media (television, radio and paper). The meeting usually took about one hour. We presented activities within our stream and answered any questions.

(aa) **Pastoral Care Meetings** – This was a quarterly meeting attended by local pastoral care representatives, Mr Leck as chairperson and me as minute taker. The meetings lasted between one and one and half hours.

(bb) **Rural Tour Meetings** - This occurred monthly, and the District Manager and any available executive member went on the same to visit the rural health facilities. I attended a number of meetings (but not all) at Childers, Gin Gin and Mount Perry. No issues re Dr Patel were ever mentioned by the DON, Medical Director or staff when I was in attendance.

(cc) **Consumer and Community Participation Project/Sub-Committee** - I was the executive sponsor on this project looking at consumer and community participation in two clinical areas of Department of Emergency Medicine and Surgical Ward. These meetings were held on a minimum monthly basis for approximately two hours. On completion of the project I became the Chairperson of the Consumer and Community Participation Sub-Committee that was looking at recommendations with consumer/community representatives for more involvement. This sub-committee met monthly for approximately one and a half hours.

(dd) **Product Review Committee** - I was requested to come on this committee to try to ensure more clinician involvement and advance NO 3/4 involvement in the same. It met monthly for approximately

one hour. The meeting was representative by NUMs of Surgical, Theatre, and Medical. Ms Hoffman did not express interest in attending, but could have done so if wished.

(ee) **Clinical Pathway Sub-Committee** - I attended this as required initially which was monthly meeting for approximately one to one and a half hours. Due to my meeting commitments I began to only attend if requested as the ADON attended the same and the meeting reported to me as chair of the Continuum of Care meeting. Ms Hoffman did not attend, but one of the staff from ICU did so.

(ff) **Stroke Sub-Committee** - Initially I attended this monthly meeting, but again due to meeting commitments, having two NO 3 in attendance, and this committee reported to me as chair of the Continuum of Care Committee I declined from further attendance unless specifically requested.

(gg) **Orientation** - I attend the nursing orientation on a monthly basis welcoming and introducing myself to the new nursing staff. This was a 15 minute session.

(hh) **Value Clarification/Complaint Management Education Sessions** - This was begun by myself and held twice a month for two one-hour sessions. I met with nursing staff and discussed QH values and what that meant for nursing, described the importance of consumer feedback processes and the District and nursing stream process for management of complaints.

(ii) **Patient Liaison Officers Network Teleconferences** - This was a network related to management of consumer complaints, which had monthly teleconferences of PLOs in various hospitals. Although I was not a PLO, I still had a strong interest in consumer participation/feedback. However after arriving at Bundaberg I found my workload did not allow me to continue to participate in the teleconferences in person, so I sent apologies and followed minutes in lieu of the same.

(jj) **Critical Care Nurse Education Teleconference-**These were done monthly with a Bundaberg Nurse Educator and Zonal DONs and Nurse Educators. These lasted approximately one to one and a quarter hours. Ms Hoffman was welcome to attend as a clinician, but did not attend in my time, and nurse educators stated to me that it was hard to get clinicians to do so.

(kk) **Nurse Informatics Meetings -** I met with the Nurse Informatics nurses monthly initially for a period of one hour. Due to matters to be resolved these meetings were becoming longer, so usually met twice a month for up to one to two hours overall.

(ll) **Zonal DONs Meetings -** These were held quarterly in different venues i.e. Brisbane or Gympie. I only managed to attend one which was a two day affair in Brisbane. The Gympie meetings were a day with travel included.

(mm) **Central Six DON meetings -** These were meetings of the Dons of the central six Districts within the Central Zone, however called by a different name. Two were held which I was unable to attend, (the last being on Fraser Island) so unsure how frequent they are. I followed the meetings by minutes/email.

LMM6

From: Linda Mulligan
To: Jennifer White
Date: 6/1/04 2:46pm
Subject: Re: Toil

no worries. L

Mrs Linda Mulligan
District Director of Nursing Services
Bundaberg Health Service
PO Box 34
Bundaberg Queensland 4670

Phone 07 4150 2025
Fax 07 4150 2029

>>> Jennifer White 06/01/04 02:33pm >>>

Hi Linda,
I'd like to take an hour's TOIL this afternoon for an appointment as the unit is not busy.
Thanks Jenny.

LMM7

From: Toni Hoffman
To: Linda Mulligan
Date: Mon, Mar 29, 2004 1:11 pm
Subject: ICU Information

Dear Linda,

Please find attached what I have written about ICU. If you wanted more or less, please let me know,

Thanks Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph: 07 4150 2311
Fax: 0741 50 2319

OVERVIEW OF (INSERT HEALTH SERVICE DISTRICT NAME)

- History – when hospital/facilities first opened, major events, when most recently re-developed.
- Identify district and zone, plus linkages with other hospitals and facilities.

- Identify number of staff employed at the hospital.
- Identify number of beds (and/or other infrastructure – eg renal dialysis chairs, etc).

- List services provided (eg major specialty areas).

- Number of Emergency Department Attendances year to July 2003 and year to date.
- Number of births.
- Total number of admissions in year to July 2003.
  - Number of same day admissions
  - Number of multi-day admissions.
- Number of surgical admissions in year to July 2003.
  - Provide breakdown (eg dot point number of general surgery; orthopaedic, vascular, etc).
  - Number of eye operations (if appropriate).
  - Number of joint replacements (if appropriate).
- Number of outpatient occasions of service in year to July 2003.
  - Provide breakdown (eg number in each specialty).
- Dot points.
- Brief.

OVERVIEW OF INSERT HEALTH SERVICE DISTRICT NAME) MAJOR ISSUES

- Identify current major issues and personalities involved.
  - Identify positive changes, innovations, activities.
  - **When identifying negative issues, include what is being done to resolve.**
- Identify any awards that staff or hospital have been awarded recently.
- Identify any ground-breaking work being conducted.
- Identify pressures, recent or impending changes, future challenges and what strategies have been developed to address.
- Dot points.
- No medical jargon.

INFORMATION RELEVANT TO CLINICAL AREA 2 – (ICU/ CCU)

Issues

.ICU/CCU.

Combined unit. 8 beds with 5 funded beds. Around 1000 pts a year. 60%-40% Ratio.

Demographics appear to be changing with an increase in ICU patients.

Try and send out to Brisbane, patients with Acute Coronary Syndrome as soon as we can. Have tripled number sent in last three years (according to best practice guidelines) Around 10-15 per month. Follow the Prince Charles Guidelines

Most admissions ACS, Post operative patients (elective and emergent), trauma, respiratory failure. Can admit any age from Neonate to the elderly.

Currently involved in two cardiac initiatives: ACS study sponsored by MSD and the cardiac collaborative.

Have Organ Donor "Link Nurse" One day a fortnight to promote awareness of organ donation. Funded from Queenslanders Donate.

Running the transition program (I staff member finished another about to)

3 staff currently enrolled in external Programs. By the end of the year, all but one staff member will have a post grad qualification in ICU or CCU.

Issues: Main issue is difficulty in maintaining ventilated patients for longer than 24-48hrs.

Personnel

Director of Unit: Dr Martin Carter.

Nurse Unit Manager: Toni Hoffman

15.4 FTEs.

Currently doing 12 hr shifts and loving them.

Discussions with Level Three Nursing Officers

LMM8

Name: Toni Hoffman. Date: 11/05/04.

Department: ICU. 0800 = 1630.

Professional Background incl. qualifications	• PA Brisbane. '75. → overseas → travel. Tasmania – medical. 1 midwifery ICU – Eng. Certificate ICU – Kings College Hosp London. 1980s – BA – Political Science / Ancient History + Religion Oxford Graduate. 1988-1993 Saudi ICU / Paeds ICU – 5½ yrs. Nambour – Post Grad Bachelor of Nursing
Responsibilities Level 2's Level 1's EN's AIN's FTE's Part time vs Full time	AINM – 3 years Nambour. → Saudi – Managed ICU. Masters Bio-ethics – / Grad cert management 2003 (Monash) 2003. Here June 2004. 15.4 FTE – overall. 2 FT. 3 part-time Level 2 – 4.0 (just one). 8 FT RNs 4 PT RN.
Relevant Staff's Qualifications	• All but 2 by end of year will have quals. year. • ICU 1 2 masters • Grad dip in ICU. • 6 certificates. • 3 study.
Plans re Staff Development	• possibly due further study. • 2 people start transition studies next year. ADON – advised DDON → relieve. → several spots
What would you change / What do you really think are done poorly? Solutions?	(1) Communication – ≠ honesty – between nursing staff + other streams. • Level 3 – has improved, still room for improvement, • core clinical areas – just good understanding. • Debrief / not professional development • proactive vs reactive.

Major accomplishments and issues incl. Budgetary status	• Standards of care developed. / policies / procedures. • changed roster systems. / [illegible] system • portfolio – QI, Research, standards management, IC, WP H+S education. • Paeds / ICU study. • LINK nurse; organ donations. • Budget – since [illegible] [illegible] within budget.
The profile of nursing services, and your viewpoint on that.	• huge potential → work on relationships / how to achieve potential – how to get most out of people. (NUMs) (area/services) → team focused. • ICU – excellent body of nurses / supportive [illegible] [illegible] in area. • cohesive, professional, strong ← need to be – (OODSU) → strength + growth period hopefully.
Time frames for PAD.	[illegible] Dec. → make in June 2004. • like to do new things, ICU not unsettled.
Other	• huge interest in pt measures. • [illegible] / consumer issues member → • Ethics – DMS / ICU – Num / P [illegible] / Lawyer / Bundaberg Counsellor / Pastor ASOK. / Medical Services Forum, Heart Start Support Group / Cardiac Arrest Data. / [illegible] NI

NUM ICU
A/D DEM
DMS

[illegible]

LMM9

From: Linda Mulligan
To: Leonie Raven-Quality Manager
Date: 3/10/05 5:19pm
Subject: Consumer Feedback Systems

Hi Leonie-I have attached the new policy related to this which has gone through L and M. It replaces the old complaint policy under L& M and Policy 2.4C2 Compliments and Suggestion Boxes policy under L & M. There is also slight changes to the complaint registration form that was also endorsed by L& M when reviewing the policy.

Also in order to meet the requirements for this policy related to compliments it is requested that the Monthly Cost Centre Report under Section 6 Complaints/Compliments that we actually have a table which CC Managers tally the number of compliments with a total. In order that CC Managers are all counting the same items, if the table could have the following categories with space for numbers and then a overall total. The categories would be:

Cards/Letters
Verbal Appreciation
Tokens of Appreciation (ie flowers, chocolates etc)

Also thanks for working on a poster, I will hand over to the relieving DDON the same.

Thanks Linda

Mrs Linda Mulligan
District Director of Nursing Services
Bundaberg Health Service
PO Box 34
Bundaberg Queensland 4670

Phone 07 4150 2025
Fax 07 4150 2029

CC: Peter Leck District Manager

Queensland Government
Queensland Health

Bundaberg Health Service District
Policy & Procedure Document

Title:	Consumer Feedback Systems
Manual Name & No:	No 2 - Leadership & Management
Section:	Section
Policy Number:	Manual/Section/Number

Applicable to:	**Description**
Effective Date: March 2005	The process by which consumer feedback in the form of compliments and complaints within the Bundaberg Health Service District will be addressed.
Last Review Date: May 2001, December 2004	
Next Review Date: December 2006	
Initiator:	
Authorised: ______ District Manager	
Ratified: ______ District Director of Nursing Services	**Definitions**
Originals kept in the District Quality and Decision Support Unit	<u>Consumer</u>: The term consumer is used to refer to users of Queensland public healthcare services and may include Patients/Clients, Relatives, Friends, Carers, Advocacy Group and Visitors.
Replaces: Complaints Management System 2001	<u>Compliment</u>-An expression of satisfaction received regarding the provision of health services.
References: Australian Health Agreement 1998-2003 *"Making the most of a visit to your healthcare service"*- Queensland Public Patients' Health Service Charter 1999 *"10 tips for safer health care"*, Queensland Health and Safety and Quality Council 2005 Australian Standard AS4369-1995 Complaints Handling Queensland Health Complaints Management Policy 2002 Guidance Document to Queensland Health Complaints Management Policy 2002 ACTU Consumer Feedback Standards 2003	<u>Complaint</u>-Any expression of dissatisfaction or concern received re the provision of health services.

Policy Statement

Bundaberg Health Service District recognizes the importance of a formal mechanism for managing feedback, both positive and negative received from consumers or staff. This feedback is essential in order to provide quality health care services that meet the consumer and community needs.

Outcome

All feedback from consumers will be actively encouraged. Investigations of complaints will be supportive and considerate of all parties involved ensuring consumer and staff rights are upheld, and done in a timely fashion.

Evaluation Method

- All staff are expected to demonstrate commitment to effective and fair resolution of complaints and be aware of the guidelines for the acceptance and investigation of complaints.
- Consumer and staff rights are upheld throughout the complaint management process.
- All complaints will be dealt with in expected time frames.
- All compliments will be captured and reported

Procedure

- All compliments will be received with appreciation and provided to the Head of the Department for recording as these play an essential role in allowing us to review what the health services do well, and where we have good systems or processes in place. These will then be reported to DQDSU for data collection and for feedback to staff and executive.
- All complaints will be seen as opportunities to review and improve the services provided by the Bundaberg Health Service District about our core business in helping Queenslanders to better health. They will not be seen as an attempt to place or apportion blame.
- Complaints may come through a variety of manners to the Health Service which may include the following pathways:
  - Directly from the consumer- verbally or written
  - Via significant other of a consumer
  - Via a District Health Council Member
  - Via the District Manger
  - Via Queensland Health Corporate Office, Minister's Office or Premier's Office
  - Via a Local Member of Parliament
  - Via the Health Rights Commission
  - Via a relevant professional body
  - Anonymous-verbal or written
- Consumers of all health services will be informed of their rights through the "A Guide to consumer Health Rights and Responsibilities". Additionally all staff and clients will be aware of the feedback systems for compliments and complaints through the Patient Information Booklets, and Advertisement throughout the Health Service by signage posted to make consumers aware of the availability of feedback mechanisms to the health services for compliments, complaints or suggestions.
- Staff will be informed of their rights and expected behavior in the workplace through an Orientation Program at the District and local level which will include the "Queensland Health Code of Conduct 2000, and information on conflict resolution methods i.e. Informal discussion, formal mediation, complaint procedures, and grievance procedures. The Bundaberg Health Service District Policy and Procedure Manual will be a reference for staff in relation to this matter.
- Fundamental to the consideration and resolution of consumer/staff complaints is the principal that all complaints, wherever possible should be resolved at the point at which they originate. Every staff member is responsible for listening to our consumers and/or other staff and attempting to resolve any concerns they may have in a conciliatory manner. This means listening to the concerns in a calm attentive manner and attempting to resolve their concern. Staff must continually be sensitive and perceptive to when there may be a problem, and offer an opportunity for this problem to be discussed/resolved. If it is not possible to solve the problem, it is expected this concern be referred to the

line supervisor/head of department to further attempt to resolve the concern. It is important that all complaints are resolved as quickly and informally as possible.

- A complaint may refer to consumer's rights and/or responsibilities in relation to: (See Complaints Data Collection Forms)
  - Access
  - Communication
  - Corporate Services
  - Privacy/Discrimination (Rights)
  - Consent
  - Costs
  - Professional Conduct
  - Grievances
  - Treatment

- If at this stage the matter can not be resolved it s expected that the consumer/staff member be offered their options, including access to the Bundaberg Health Service District internal formal complaint process.
- The complaint allegation will be investigated internally unless it is of a very serious nature, which may have legal, criminal or professional ramifications. In those cases certain requirements are expected and the case must be referred immediately to the District Manger for consideration, or at any stage of investigation as it evolves. In this case an external investigator may be appointed or it may be required to be referred to the appropriate agency.
- The District Manager and each relevant Executive Director will proceed with managing the process surrounding the formal complaint mechanisms of a complaint in their area of authority including acting as resource person for those involved, facilitation of communication through the process, assisting with counseling/mediation skills to facilitate resolution of the issues, investigation of the matters, and monitoring to ensure completion of relevant documentation and outcomes fro resolution within appropriate time frames.
- All complaint investigations will be confidential to those directly involved. It is very important staff are considerate of their peers' rights to confidentiality and a fair process.
- The Executive Offices will be the central filing location of complaints for document management and retrieval.
- The Complaints Management process will be monitored to improve organizational performance and quality of care. As a result the DQDSU will only hold relevant data related to complaint management which is required to effectively monitor and trend the complaint management process, and to provide reports to the Leadership and Management Committee.
- The Quality Coordinator will provide education on procedures for complaint handling to all staff of the Bundaberg Health Service District.
- In the event of a complaint against a service or person that the Bundaberg Health Service District is not directly responsible for e.g. private practitioner, the complainant in the first instance should be encouraged to speak directly to the health professional concerned. If this is unsuccessful, then alternatives to the complainant should be provided.

These will include lodging the complaint with the Health Rights Commission and/or the Registering authority responsible for that professional discipline

Equipment NIL

Alerts

Any complaint in the following categories may be additionally graded as sensitive:

- A political issue
- An issue being investigated by the media
- An issue that has the potential to lead to litigation

All sensitive complaints must be immediately reported to the relevant Director and the District Manager.

Strategies to improve access to the complaints/compliments process

- Signage is located in all patient waiting areas and lounge rooms, outpatients department, emergency department, and the front foyer of all buildings to provide information about complaints management, including the contact number to call if there is a need to make a complaint or compliment.
- Suggestion Boxes are located in various areas throughout the Bundaberg Health Service District. To maintain the integrity of the information, the DQDSU staff empty the Bundaberg Hospital boxes and the District Manger empties the rural facilities boxes on a monthly basis. Feedback mechanisms are in place to provide information from the suggestions boxes to a department/rural facility on a monthly basis. It is expected that the information is discussed by the relevant department/facility and action taken where possible, with a feedback report to DQDSU within a 14 day period. A six monthly report will be provided to Leadership and Management Committee, and all areas on the improvements that have been made based on this feedback.
- The corporate brochure "Making the most of a visit to your health-care service" is provided within admission and waiting areas and the corporate pamphlet "10 tips fro safer health care" is provided at admission.
- The Queensland Public Patients Hospital Charter will be available for all patients upon entering the hospital.

Handling of Consumer Complaints

Verbal Complaints

<u>In Person:</u>

If a patient makes a complaint or a person presents at the organization to make a complaint:

- The individual staff member/relevant Head of Department should make every attempt to resolve the complaint at the point of contact. The process for appropriate complaints handling is outlined below.
- If the Head of Department is unable to resolve the complaint to the complainant's satisfaction, the relevant Director should be contacted.
- After hours the Nurse Manager will manage complaints outside business hours and will notify other appropriate member if urgently required.

By Telephone

If the switchboard operator or any person who receives a phone call that they recognise as a complaint, they must:

- Refer the complaint to the relevant Department Head.
- If the Department Head cannot be contacted, or cannot resolve the complaint, the phone call should be forwarded to the relevant Executive Director within business hours. Outside of these hours the After hours the Nurse Manager are to deal with the issues.

Process for Person taking Phone Calls

- Identify yourself, listen and record details and determine what the complaint is about and what the complainant wants
- Confirm the details received
- Record the name and contact information for the individual making the complaint
- Record the time and date that the complaint was made
- Determine the nature of the complaint
- Explain the courses of action available
- Do not attempt to lay blame or be defensive
- Resolve the complaint if possible or commit to doing something immediately, irrespective of who will ultimately handle the complaint
- Ensure that the complainant is informed that the complaint is receiving attention, without creating false expectations
- Check whether the consumer is satisfied with the proposed action and if not, advise alternative courses of action
- Provide acknowledgment e.g. Thank you letter, phone call
- Follow-up as appropriate and monitor to ensure the customer remains satisfied as well as receives feedback

Complaints received in writing

In principle, this is the same as processing telephone or verbal complaints. However, in this situation, a response should be provided promptly (within 3 days) in writing. An initial response can be to advise the complainant that the complaint has been received and is being investigated. A final reply should be forwarded within 35 days of receipt of complaint.

Most letters of complaint will be received by the District Manager or by an Executive member.

All written complaints should be advised to the relevant Executive Director. The Executive Director will ensure that a registration form is sent to the Complaint's Coordinator at the completion of the process.

Complaints Management Process

- All complainants will receive acknowledgment of the receipt of their complaint within 3 working days.
- All complainants will be informed of the progress of the investigation into their complaint within 21 calendar days of receiving the complaint
- The outcome of all complaints will be finalized within 35 calendar days
- Patients will not to be discriminated against or victimized if they lodge a formal complaint.
- No record of the complaint will be kept in the patient's record.
- All efforts should be made to try and resolve the complaint at the point of service. The Head of Department or the most senior person on duty at that particular time shall be deemed responsible for following the complaint up.
- Staff members that are able to resolve complaints to the satisfaction of all concerned (patient/ consumer/staff) at the point of service will complete a Complaints Registration form and forward it to the Complaints Coordinator for data collection. (Complaints that are very trivial in nature, and can be resolved very easily, may not need to be registered on the Complaints database).
- If a complaint cannot be resolved at the point of service, the relevant Executive Director should be contacted for further action in relation to the complaint. The complaint is then formalized and registered the complaint on the database.
- All Complaints are categorized on receipt under the following guidelines:

Assessment	Examples	Action Plan
Minor	Complaint minor in nature and resolved easily	• Resolve at point of service • Forward completed Complaints Registration Form to Complaints Coordinator
Routine	Legitimate consumer complaint but causing no lasting detriment	• Acknowledge receipt of complaint within 3 working days • Inform complainant of progress within 21 calendar days • Resolve complaint within 35 calendar days • Where possible the Head of Department should attempt to resolve the complaint to the complainant's satisfaction. If this is unsuccessful, the Executive Director should be contacted • Forward completed Complaint Registration form and send to the Complaints Coordinator
Substantial	Significant issues regarding standards, unlawful actions, denial of rights, complaints which clearly impact on the quality of care or service delivery	• These complaints are covered by statutory reporting obligations and involve allegations of assault, abuse etc. Mandatory reporting requirements of sexual and physical assault must be followed in these instances. • Forward the complaint to the relevant Executive Director, who will immediately

		inform the District Manager

- The investigation process is to be coordinated by the nominated work unit line manager or executive member. Following the investigation process the line manager is to identify the cause of the complaint, isolate contributing factors and identify opportunities for improvement that prevent the circumstances of the complaint recurring. All quality improvement activities undertaken as a result of the complaint investigation process are to be registered with the Quality Management Unit, and forwarded to the Improving Performance committee as appropriate.
- When the complaint is resolved relevant notification to the DQDSU for completion of the data registration. Staff that have had allegations made against them will received feedback at the end of the investigation.
- The Quality Coordinator will compile all complaints into a Complaints Register for quality improvement purposes. This will include date complaint received, name of complainant, service area involved, the source of the complaint, the nature of the complaint, and the adherence to specified time frames for resolution.
- The Quality Coordinator will provide a quarterly report to the Leadership and Management Committee. Ongoing trends will be reported with recommendations on how the hospital can improve the service area identified.

BIBLIOGRAPHY

COMPLAINT CATEGORIES AND DESCRIPTIONS

1. Access to Services — Refers to availability of services in terms of location, waiting lists and other constraints that limit the use of the service

Subcategory	Definition
Attendance	Provider fails to keep an agreed appointment; or failure to attend to give emergency treatment
Delay in Admission or Treatment	Delays in treatment, admission or any other delay, including delay in provider attending. For example, long waits in the emergency department or waiting rooms. (Excludes 'Unreasonable wait for elective surgery'. See 'Waiting Lists')
Discharge or Transfer Arrangements	Premature, unsuitable or delayed discharge or transfer; inadequate discharge planning; or refusal to discharge
Referral	Refusal to refer or inappropriate referral
Refusal to Admit or Treat	Refusal by an institution or health provider to accept a person as a client. Refusal to provide a service where a service is available.
Service Unavailable	Service or resources unavailable within reasonable proximity to the consumer
Transport	Ambulance and patient transit problems including inter-hospital transfers
Waiting Lists	Unreasonable wait for elective surgery or further postponement after a date has been set. (Excludes 'Delay in Admission or Treatment')

2. Communication — Refers to appropriateness, completeness and reliability of information; the way information is

	communicated, or special communication needs.
Attitude	Provider's manner is rude; discourteous; negative; lacks sensitivity; or is patronizing or overbearing. (Excludes 'Discrimination')
Information Inadequate	Information is inadequate; incomprehensible; difficult to understand; or is incomplete. (Excludes 'Interpreter/Special Needs Services')
Information Wrong/Misleading	Information is wrong; incorrect; misleading; or conflicting. (Excludes 'Consent not informed/Failure to warn' and 'Information on Costs')
Interpreter/Special Needs Services	Failure to provide interpretative or special needs services for consumer to assist in communication e.g. Spoken language, sign language, and disability support.
3. Consent	Refers to consumer's right to be involved in decision-making and to be given sufficient information on which to base their consent to treatment or service.
Consent Invalid	Consent considered invalid when the patient was not competent to consent; did not understand information; was coerced; or consent was not specific to the treatment performed.
Consent not informed/ Failure to warn	Not enough information was given for the consumer to make an informed choice regarding treatment options. (Excludes 'Inadequate Information')
Consent not obtained	Treatment provided or action taken without the current consent of the consumer or consumer's legal representative.
Failure to consent consumer	Failure to involve the consumer in decision-making in relation to any aspect of treatment or care.
Involuntary admission	The admission or treatment of a patient when not agreed to. Also detained, scheduled under a mental health act.
4. Corporate Services	Refers to support services such as hotel services, administrative procedures and the standard of facilities including hygiene and safety. (Excludes 'Billing Practices')
Administrative Services	Administrative processes such as clerical; reception; administrative record keeping; and bookings/admissions.
Hotel Services	Services and physical environment provided during a patient's visit or stay. Includes car parking; cleaning; catering; grounds; laundry; maintenance; security and accommodation. (Excludes 'Hygiene and Environmental Standards')
Hygiene/ Environmental Standards	Hazards in physical environment; unsanitary conditions; unsafe storage of sharps; inadequate or substandard conditions in relation to fire safety; way finding; noise and lighting. (Excludes 'Infection Control')
5. Cost	Refers to fees; discrepancies between advertised and actual costs; charges and rebates; and information about costs and fees.
Billing Practices	Unfair/unsatisfactory billing practices including item numbers used to disadvantage; insufficient or wrong information on bill; extra fees for services normally included in global fee; unreasonable penalties for late payment; refusal to consider financial circumstances; etc. (Excludes 'Overcharging')
Government Subsidies	Government subsidies for treatment or services are unavailable or inadequate. For example schedule fee, availability of drugs under PBS, travel subsidy.
Information on costs	Information about costs was not offered prior to treatment; or the information was partial; misleading or incorrect.
Overcharging	Fee or account is too high including unnecessary provision of services.
Private Health Insurance	Complaints about Private Health Insurance and claim handling if the respondent is the fund.
Public/Private Election	Patient classified as private rather than public (or vice versa); failure of a hospital to explain options for choice of status; or confusion between fee-for-service and public status.

6. Grievances	Refers to action taken by a provider in response to a complaint.
Inadequate/No response to complaint	Inadequate or non-existent response to a complaint made directly to a service provider by a consumer.
Reprisal/ Retaliation	Any direct or indirect action or threat of action against a consumer, or detrimental change in treatment or care as a result of the complaint; or disadvantage in employment for staff who lodge a complaint or report or who give information about a complaint.
7. Privacy/ Discrimination	Refers to breaches of consumer rights or acts of discrimination in relation to service provision; or breaches of privacy.
Access to Records	Restriction or refusal of access to information in any personal health record.
Discrimination	Claims that a consumer receives less favorable health treatment or refusal of treatment on once of the civil (race, sex, age, religion, color, disability) grounds in anti-discrimination law or covenant. (Excludes 'Attitude' and 'Refusal to Admit or Treat')
Discrimination Public/Private	Public patient treated less favorably than private patient (or vice versa); or pressure to accept private treatment or service.
Inconsiderate Service	Failure to treat with respect, dignity and consideration. (Excludes 'Attitude')
Privacy/ Confidentiality	Failure to ensure personal privacy or confidentiality; or breach of privacy principles.
8. Professional Conduct	Refers to unethical and illegal practices as well as issues of competence. (Excludes 'Negligent Treatment' and 'Referral')
Accuracy/ Inadequacy of Records	Failure to create and maintain adequate, accurate, complete and up-to-date health records.
Assault	Physical aggressive or violent actions against a consumer. (Excludes 'Consent not obtained'. For assaults of a sexual nature see "Sexual Misconduct')
Certificates/Reports	Failure to provide a correct certificate or report; deliberate falsification of certificate or report; or provision of an incorrect; biased or misleading report.
Competence	Failure to meet a standard of practice because of lack of or failure to use clinical knowledge, skills, judgment or care.
Financial Fraud	Claims that a provider has tried to make a profit dishonestly; gain an unjust financial advantage; become beneficiary of a vulnerable person's will; or commit Medicare fraud.
Illegal Practices	Alleged breaches of trade practices law, deceptive claims; assuming bogus qualifications; extortion; criminal actions; fraudulent claims of curative properties; or dishonesty. (Excludes 'Financial Fraud')
Impairment	Failure to meet a standard of practice due to mental or physical condition related to drug or alcohol addiction; mental illness; physical impairment; or illness to a degree where it impinges on a provider's ability to practice safely.
Sexual Misconduct	Any touching of a sexual nature or any sexual relationship with a consumer whether or not initiated by the consumer; or behavior such as gestures or comments that are sexually demeaning to a consumer.
9. Treatment	Refers to quality or appropriateness of treatment
Diagnosis	Missed, wrong or inadequate diagnosis; or failure to investigate adequately.
Infection Control	Inadequate measures taken to control sources of infection; sterilize equipment; or to adhere to standard (universal) precautions.
Medication	Failure to prescribe; over or under prescribing; wrong or incorrect prescribing; or inappropriate use of medication. Also incorrect dosage administered.

Treatment Coordination	Uncertainty about who is managing the patient; no one taking overall responsibility for the patient, conflicting decisions; or poor communication between providers about treatment or care.
Treatment Rough/ Painful	Rough treatment or unnecessary pain inflicted during an examination or treatment.
Treatment Withdrawn/ Denied	Removal of treatment; or denial of additional treatment or service perceived to have a therapeutic benefit. (Excludes 'Refusal to Treat')
Treatment Wrong/Inappropriate	The incorrect or inappropriate choice of therapy has been made but not where proper therapies are performed wrongly.
Treatment Negligent	Explicit allegations of legal liability under tort law. (Distinct from 'Competence')

Documentation

The relevant Documentation for this process follows:

Queensland Government
Queensland Health

Bundaberg Health Service District

Complaint Registration Form

This form is to be completed the staff member who is registering the complaint.

Complaint Identifier:______________________________ Office Use Only

Type of Complaint: (taken by) Name__________________ Position__________________

☐ Written ☐ Verbal ☐ Telephone

Name of person handling complaint: ______________________________
Name and Designation of Staff handling the complaint

1. Facility:	Bundaberg	Childers	Gin Gin	Mt. Perry

2. Source of Complaint	☐ Patient/Client	☐ Relative/Carer	☐ Friend/Advocate
	☐ Staff Member	☐ Volunteer	☐ Anonymous
	☐ Other – Please specify		

3. Complainant Details	Name:		UR:
	Election Status:	Admission Status:	
	Gender:	DOB:	Post Code:
	Complainant Name If different to above:		

4. Complaint referred by: If from an external source	☐ Ministerial	☐ Local MLA	☐ Other QH Department
	☐ HRC	☐ MP	☐ Staff Referral
	☐ Response to Survey	☐ Other	☐ Not Known

5. Complaint Handling Details Please provide the date each action was completed	Complaint submitted:	Complaint registered:
	Acknowledgment:	First progress report:
	Date of Resolution/Closure:	

6. Complaint Issue See Complaint Categories and Description	**Category** 1. Access to Services 2. Communication 3. Consent 4. Corporate Services 5. Cost 6. Grievances 7. Privacy/discrimination 8. Professional Conduct 9. Treatment	**Description**
7. Service Type	Location of Incident:	
8. Staff Category	Staff involved in the complaint:	

9. Severity of Complaint	☐	**Level One:** Trivial, misconceived, subject matter not warranting acceptance for investigation
	☐	**Level Two:** Complainant could have resolved complaint easily with support from staff involved
	☐	**Level Three:** Legitimate consumer complaints, especially about communication or practice management, but no lasting detriment
	☐	**Level Four:** Significant issues of standards, quality of care, or denial of rights, complaints with clear quality assurance implications
	☐	**Level Five:** Long-term or severe damage, including death, serious adverse outcome, professional misconduct

10. Complainant Objective What does the complainant want to happen?	❒ Register concern ❒ Obtain refund ❒ Change policy	❒ Receive explanation ❒ Access service ❒ Compensation	❒ Obtain apology ❒ Change procedure ❒ Disciplinary action
	Please provide details:		

11. Resolution Mechanism/ Outcome By what means was the complaint resolved?	❒ Concern registered ❒ Costs refunded ❒ Policy change ❒ No action taken	❒ Explanation given ❒ Services provided ❒ Compensation received	❒ Apology provided ❒ Procedure/practice change ❒ Disciplinary action taken
	Please provide details:		

12. Recommendation/ Action taken What action has been taken as a result of this complaint?	❒ Staff member/contractor counseled ❒ Duties changed ❒ Quality improvement activity initiated	❒ Training/education of staff provided ❒ Dismissal/ termination of contract ❒ No action taken
	Please provide details:	

13. Notification of verbal complaint	Date:________________ Time:__ **Details of Complaint** (attach additional information if necessary):

14. Adverse Outcome	

15. Office Use Only Performance indicators Reported in trends analysis	Acknowledgement letter – 3 days	Progress report – 21 days	Resolution – 35 days
	Date		

LMM10

QUEENSLAND HEALTH

BUNDABERG HEALTH SERVICE DISTRICT

JOB DESCRIPTION

VACANCY REFERENCE NO: BB05-0201

POSITION TITLE: District Director of Nursing Services

LATTICE POSITION NO: 022080

LOCATION: Bundaberg Base Hospital
Bundaberg Health Service District.

CLASSIFICATION LEVEL: NO6

SALARY LEVEL: $84 751 per annum

REPORTS TO: District Manager

AWARD: Nurses (Queensland Public Hospitals) Award – 2004 & Nurses (Queensland Health) – Section 170MX Award 2003

REVIEW DATE: August 2004.

DELEGATE AUTHORISATION:

Name: Peter Leck, District Manager **Signature:**

Date:

PURPOSE OF POSITION

The Director of Nursing Services Bundaberg Hospital functions as a member of the Executive Management Team to ensure the effective operational management and evaluation of facility services as well as to contribute to strategic planning, the implementation of change, and performance evaluation within the District.

The Director of Nursing has responsibility for advice relating to professional nursing issues for Directors of Nursing at Childers and Gin Gin hospitals and the Mount Perry Health Centre, as well nurses in other Health Service Divisions as outlined in the organisational chart.

ORGANISATIONAL ENVIRONMENT AND KEY RELATIONSHIPS

The Bundaberg Health Service District provides comprehensive Hospital and Community based health care. The District extends from Miriam Vale Shire in the north to Isis Shire in the south, and includes Town of 1770 and Agnes Water, Bundaberg City and surrounding coastal towns from Moore Park Beach to Woodgate, the towns of Childers, Gin Gin and Mount Perry. The District services a population of 82,211. The Bundaberg Health Service District maintains a 136 bed hospital in Bundaberg, a 17 bed hospital in Gin Gin, an 18 bed hospital in Childers, and Health Centre in Mount Perry.

The Bundaberg Base Hospital is a Level 4 hospital, and provides services including accident and emergency; surgery; orthopaedics; obstetrics and gynaecology; paediatrics; medicine; intensive care/coronary care; theatre and anaesthetics; rehabilitation; palliative care; renal dialysis; ambulatory services/specialist outpatients; medical imaging; pathology; mental health services; and allied health services. Community health services provided by the District include oral health; BreastScreen Queensland; social work; indigenous health; Alcohol Tobacco & other Drug Services; health promotion; aged care assessment; home medical aids; palliative care; sexual health; Transition to School Developmental Assessment team; Home and Community care; diabetes education; stomaltherapy; community & family health.

Bundaberg Health Service District has approximately 600 full time equivalent employees.

ROLE OF THE DEPARTMENT

District

Bundaberg, Childers and Gin Gin hospitals, and the Mount Perry Health Centre, as well as various Community Health services within the health district provide a wide range of health services to the customers within the catchment area of the Bundaberg Health Service District.

Vision

The Bundaberg Health Service District Vision is consistent with the Queensland Health Vision Statement *"To provide, and be recognised for providing, Queenslanders the best health, and health related, services in the nation."*

Mission

Helping the people of Bundaberg and District to better health and well-being.

Our mission will be achieved by:

- Focusing the purpose and role of Bundaberg Health Service District on:
  - Prevention, health promotion and early intervention
  - Evidenced based clinical practice
  - Partnership with all health care providers (including private sector and non-government bodies) and
  - Managing the public health risks to Bundaberg residents
- Maintaining a high quality of health care
- Prioritising resource allocations to meet demonstrated need and principles of equity
- Encouraging individual responsibility for health care
- Fostering research and education to continuously improve health services

Values

The Bundaberg Health Service District is committed to the following values, which underpin the basis of our principle objectives:

- Quality and recognition –
  We strive to excel in everything we do and are proud of our achievements
- Professionalism –
  We are professional in what we do in that we treat all people with dignity and respect and we look for opportunities for improvement
- Teamwork –
  We work together in an open, honest and supportive way to achieve collective goals
  - Performance accountability –

  We accept accountability for our performance, our actions and our learning

One or two points about the department

REPORTING RELATIONSHIPS

The position has responsibility and accountability for nursing services at Bundaberg Base Hospital and reports directly to the District Manager. The Assistant Director of Nursing, Nurse Unit Managers, Nurse Managers, Clinical Nurse Consultants and Nurse Educators report to this position.

ORGANISATIONAL CHART

See attached.

POSITION REQUIREMENTS

Queensland Health is committed to achieving our mission of promoting a healthier Queensland and our vision to be leaders in health – partners for life. We recognise that Queenslanders trust us to act in their interest at all times. To fulfil our mission and sustain this trust we share four core values of: quality and recognition; professionalism; teamwork; and performance accountability.

In addition we will be successful in promoting a healthier Queensland through the following five strategic intents; healthier staff; healthier partnerships; healthier people and communities; healthier hospitals and healthier resources. The primary duties and assessment criteria outlined in this job description reflect the commitment to our mission, vision, values and strategic intents which are required by this position.

POSITION REQUIREMENTS - DUTIES, RESPONSIBILITIES, KNOWLEDGE AND WORK BEHAVIOURS

- Ensure effective corporate and clinical governance for nursing services in the District.
- Participate as a member of the District Executive to assess, plan, implement and evaluate the outcomes of services provided, ensuring their efficiency and effectiveness in meeting community needs in line with Queensland Health Mission, Values and Key Performance Objectives.
- Manage the performance appraisal and development of subordinate staff.
- Provide ethical decision making in the achievement of organisational goals.
- Provide innovative leadership and direction in the strategic planning and management of Nursing Services to meet the needs of the Health Service District.
- In conjunction with the Leadership & Management Committee, is responsible for the operational management of the Bundaberg Base Hospital and specifically nursing services.
- Promote and enhance professional conduct and practice within legislative and professional parameters to advance excellence in nursing practice and patient care.
- Manage nursing staff, services and budgets to achieve agreed levels of performance in the delivery of patient services.
- Develop and implement nursing workforce planning strategies to efficiently meet emerging needs, using workload analysis and information from clinical and management information systems consistent with strategic policy direction.
- Ensure compliance with industrial relations policies and protocols to promote effective workplace industrial relations.
- Develop standards and accompanying policies and protocols to enhance the effectiveness and efficiency of nursing services.
- Ensure nursing care standards and management practices are evidence based and provided within a culture of continuous quality improvement.
- Advance the professional role of nursing and lead the development of initiatives for nurse education and staff development to maximise professional and financial resources.
- Develop and implement strategies to ensure staff are appropriately skilled to achieve position responsibilities and assume full role accountabilities.

- Enhance organisational transformation to achieve a culture of individual and team learning.
- Provide nursing consultation and collaboration at an executive level within a multi-disciplinary environment to enhance patient outcomes.
- Foster and promote a spirit of trust and cooperation within the Bundaberg Base Hospital to achieve a strong team/group culture.
- Ensure health service management and nursing practice is responsible to current trends and contemporary theory through active participation in professional and health related activities.
- Provide leadership and be accountable for portfolio responsibilities as delegated by the District Manager.
- Provide professional advice and support to all Directors of Nursing in the District and to Nurse Managers, Nurse Unit Managers and Clinical Nurse Consultants in all District Health Service Divisions.
- Ensure a strategic approach to the development and implementation of contemporary human resource practices and polices including workplace health and safety, equal employment opportunity, anti-discrimination and ethical behaviour.

PRIMARY DELEGATIONS AND ACCOUNTABILITIES

The Director of Nursing Services, Bundaberg Base Hospital is accountable for:

- Human Resource Management delegation as specified in the Queensland Health Delegations Manual.
- Financial Delegations as specified in the Queensland Health Financial Delegations Manual.

MANDATORY CRITERIA:

Qualifications & Registration

Registration with Queensland Nursing Council and current practicing certificate is mandatory.

Appointment to this position requires proof of qualification and/or registration with the appropriate registration authority, including any necessary endorsements, to be provided prior to commencement of duty.

Vaccinations & Inoculations

"Health Care Workers in Queensland whose occupation poses a potential risk of exposure to blood and body fluids must be immunised against Hepatitis B according to the National Health and Medical Research Council Australian Immunisation Handbook, current edition and the Queensland Health Infection Control Guidelines.

Hepatitis B immunisation is a condition of employment for Health Care Workers in Queensland Health who have direct patient contact (eg medical Officers, nurses and allied health staff), as well as those staff who, in the course of their work, may be exposed to blood or body fluids, for example by exposure to contaminated sharps eg (but not confined to) plumbers.

Proof of vaccination must be provided at application. Proof of vaccination can be provided via a letter from a General Practitioner, infection control or occupational health department and should consist of a titre level or documentation of seroconversion. (Please note that "non-reactive" does not constitute evidence of seroconversion and will not be accepted as evidence).

ADDITIONAL FACTORS

Queensland Health is a "smoke free" employer. Smoking is not permitted in any Queensland Health facility except where specifically defined.

Post-graduate qualifications in leadership and management are desirable.

The Bundaberg Health Service District requires all employees to adopt appropriate and recognised measures to minimise the risk of infection and workplace injury to themselves, other staff and clients and to adhere to the Districts Infection Control Policy Manual and Workplace Health and Safety policies and practices.

Driver's License

The possession of a license to operate a 'C' class vehicle would be considered desirable, but is not mandatory.

Probation

All new permanent employees to Queensland Health will be required to undertake a period of probation upon commencement of duty. This period will be (insert appropriate amount of time as per IRM) months in length with a possible 3 (three) month extension if performance objectives are not met.

Pre-Employment Checks

This position may be subject to pre-employment history checks including a working with children suitability check (Blue Card), criminal history, identity or previous disciplinary history checks for the preferred applicant.

The Bundaberg Health Service District is an Equal Employment Opportunity Employer

ASSESSMENT CRITERIA

Applicants need only provide a Curricula Vitea (CV) and a letter outlining their skills and abilities for the position as outlined in the Primary Duties of the Job Description. An interview may be conducted at the discretion of the District Manager.

It should also contain the names and telephone numbers of at least two referees, who may be contacted with respect to your application.

Assessment Criteria below are weighted equally.

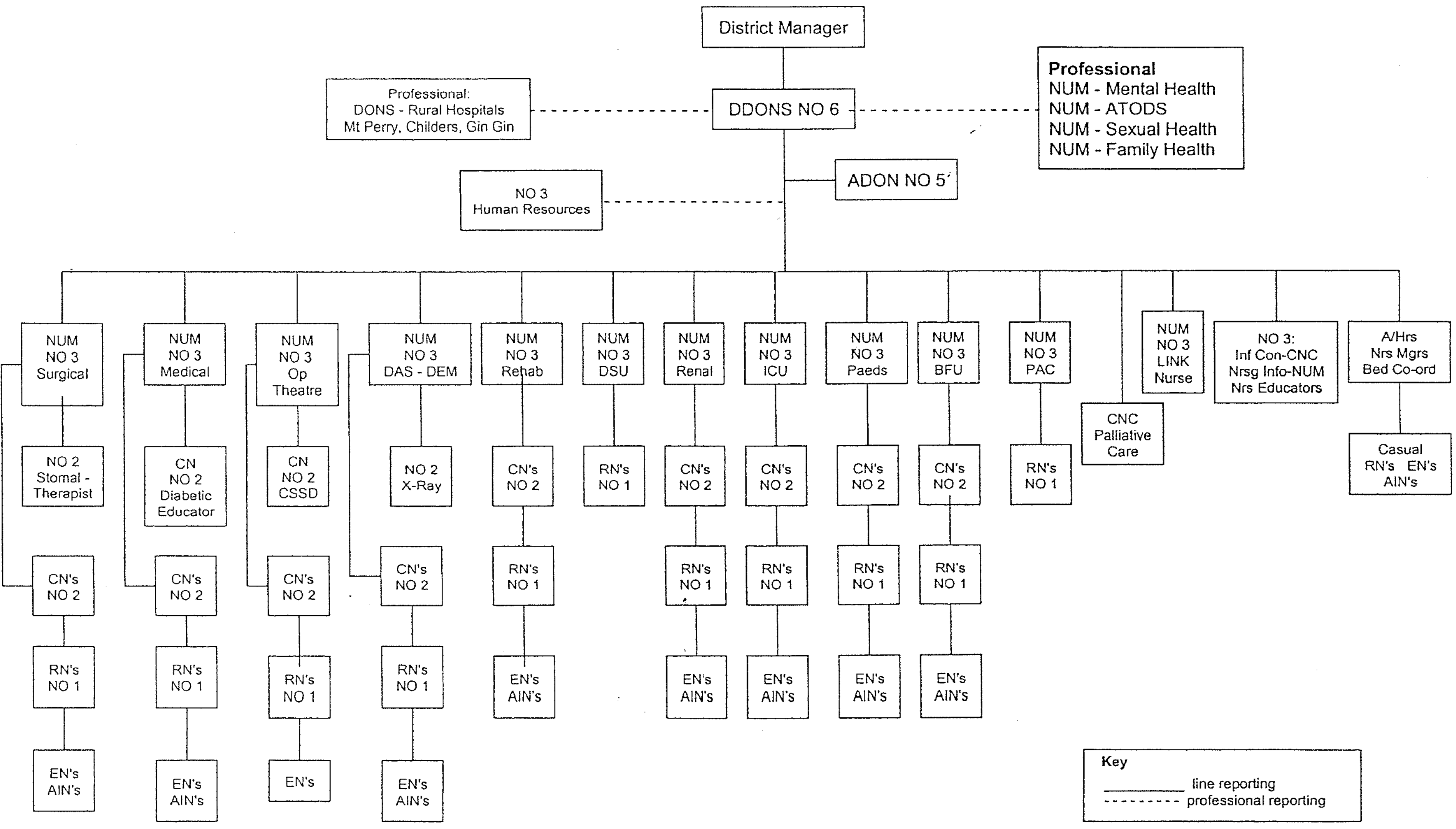
AC1 Proven ability in the effective management of a service budget, personnel and the delivery of clinical services in an acute health care facility.

AC2 Proven ability to provide strategic planning, decision making and coordination for nursing to ensure that the health facility meets the needs of patients/customers, using a quality framework.

AC3 Demonstrated ability to provide nursing leadership.

AC4 Demonstrated effective interpersonal and communication skills in a multidisciplinary environment including the demonstrated ability to consult and negotiate effectively at a senior level.

AC5 Demonstrated ability to supervise and manage staff in line with quality HRM practices including employment equity, anti-discrimination, occupational health and safety and ethical behaviour.



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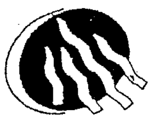

Queensland Government
Queensland Health

PERFORMANCE APPRAISAL & DEVELOPMENT AGREEMENT

NAME: Toni Hoffman EMP. I.D: 033625

POSITION: NPC ICU/CCU CLASSIFICATION: III

FACILITY/WORK UNIT: ICU/CCU.

	☑ Initiate Agreement	☐ 6 Month Review	☑ 12 Month Appraisal
Supervisor	Date completed: 4/12/02 Initials:	Date to be conducted: 2/6/03. Initials:	Date to be conducted: 8/07/04. Initials:

Supervisors Comment - 6 Month Review:

loyees Comment – 6 Month Review:

Performance Results :

12 Month Appraisal:

☐ Exceeds requirements ☐ Meets all requirements ☑ Meets some requirements (most done) (per. ???) ☐ Does not meet requirements

Conduct:
12 Month Appraisal: Not all goals achieved however new timeframe for repeat agreement discussion ie ALS / visit to Brisbane

☑ Satisfactory ☐ Unsatisfactory

Supervisors Comment – 12 Month Appraisal:

Employees Comment – 12 Month Appraisal:

UPON COMPLETION	6 MONTH REVIEW	12 MONTH APPRAISAL
EMPLOYEE	Name: Signature:	Name: Toni Hoffman Signature: Toni Hoffman
REPORTING OFFICER	Name: Signature:	Name: L. Mulligan. Signature: [signature]
REVIEWING OFFICER (*As Required*)	Name: Signature:	Name: Toni Signature:
DATE REVIEW COMPLETED	/ /	/ /

1. Supervisor to retain original. Employee to retain copy.
2. Copy to be forwarded to the Human Resource Management Unit & the Reviewing Officer.

PERFORMANCE PLAN

Key Responsibilities	Performance Targets	Timeframe
Maintain budgetary integrity within the ICU/CCU	Aim to keep ICU/CCU budget within range. Identify strategies to reduce costs and improve efficiency	12mths ✓ ongoing.
encourage and maintain quality activities within the unit	- participate in quality activities within the unit.	ongoing. ✓
Coordinate the safe and effective care of critically ill patients with complex needs.	maintain own skills in care of critically ill patients based on current evidence based practice. Attend ANZICS conference next year. maintain competencies.	12mths → Oct 04
Facilitate education regarding critically ill patients within ICU and act as a resource person for other areas of the hosp	encourage & support staff to study through use of transition program +/- external study. Encourage rotation of other hosp staff through critical care areas ✓	12mths (yes - here staff come in, but not informal training)
Coordinate the overall management of the ICU/CCU	→ promote quality care of ICU/CCU patients, ensure & encourage staff to broaden horizons and act in higher positions. ✓ → [illegible] Level 1's all acted up to level 2, level 2 acted up to level 3 (some outside [illegible])	12mths. to transition program.

DEVELOPMENT PLAN

Skills & Knowledge required	Developmental Activities	Timeframe
Management development.	Attend workshops and conferences as available to improve managerial activities. Have completed Grad cert in Management.	12mths — [illegible]
	Act up into higher posn when able, including other areas if appropriate.	12mths — Acting as ADON, DON.
maintain updated clinical skills.	Try and attend RBH or TPCH in Brisbane to review current practice in tertiary referral hosp this year. → not completed due to lack of funding! Do new ALS → Booked for [illegible]	12mths
maintain current expertise/knowledge in allied critical care	ongoing responsibilities with peripheral issues, Ethics committee, Heartstart, transitional program, arrest team data collection, education	12mths.

Sign off of Performance & Development Plan

EMPLOYEE
Name: Toni Hoffman Date: 4/12/02
Signature: Toni Hoffman

REPORTING OFFICER
Name: [signature] Date: 4/12/02
Signature: G. E. Goodman

REVIEWING OFFICER (If Required)
Name: Date: / /
Signature:

LMM11

Queensland Government
Queensland Health

PERFORMANCE APPRAISAL & DEVELOPMENT AGREEMENT

NAME: Toni Hoffman		EMP. I.D: 033625	
POSITION: NUM ICU/CCU		CLASSIFICATION: NUM	
FACILITY/WORK UNIT: ICU/CCU			
	☑ Initiate Agreement	☐ 6 Month Review	☒ 12 Month Appraisal
Supervisor	Date completed: /11/01 08/07/04. Initials:	Date to be conducted: Jun 05 __/__/__ Initials:	Date to be conducted: __/__/__ Initials:

Supervisors Comment – 6 Month Review:

Employees Comment – 6 Month Review:

Performance Results :

12 Month Appraisal: ☐ Exceeds requirements	☐ Meets all requirements	☐ Meets some requirements	☐ Does not meet requirements

Conduct:
12 Month Appraisal:

☐ Satisfactory ☐ Unsatisfactory

Supervisors Comment – 12 Month Appraisal:

E[illegible]yees Comment – 12 Month Appraisal:

UPON COMPLETION	6 MONTH REVIEW	12 MONTH APPRAISAL
EMPLOYEE	Name: ____ Signature:	Name: ____ Signature:
REPORTING OFFICER	Name: ____ Signature:	Name: ____ Signature:
REVIEWING OFFICER (*As Required*)	Name: ____ Signature:	Name: ____ Signature:
DATE REVIEW COMPLETED	/ /	/ /

1. Supervisor to retain original. Employee to retain copy.
2. Copy to be forwarded to the Human Resource Management Unit & the Reviewing Officer.

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*Please refer to Position Descriptions when setting key performance responsibilities and targets.

PERFORMANCE PLAN

Key Responsibilities	Performance Targets	Timeframe
Maintain professional standards and accountability in the Acute Care Setting.	up to date and intact protocols & procedures.	During 12mths.
Enable and encourage completion of ACS	completetion of ACS within next 6 mouths	within timeframe for feedback.
Enable and encourage Quality activities within the unit.	ACHS standards / indicators Follow best practice guidelines	throughout the year
Encourage Educational activities within the unit	facilitate education & communication (Facilitator v 2 staff) Facilitate staff completing tertiary courses.	
Maintain inventory compliance	rotate stock, maintain equipment.	ongoing 12mths.
Encourage & enable CHI collaborative, support staff in collection of data.	All pts with ACS + CHF will be on ACS guide	ongoing.

DEVELOPMENT PLAN

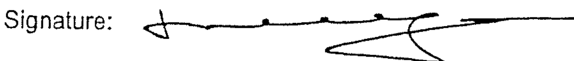
Skills & Knowledge required	Developmental Activities	Timeframe
Continually update knowledge in ICU / CCU (2 very seperate areas)	Attend Angies conference in Melbourne in Oct. Followup on conf / workshops attended	Oct 2004
Maintain current competencies in Intensive Care	Attend all compulsory activities / inservices. (ie Brisbane Intensive ...) as available.	Ongoing throughout the year.
Utilise the educational opportunities already taken ie. Grad Cert & Masters. Evolved workshop	Participate in hospital wide educational activities that reflect current knowledge. Participate in hosp activities related to qualifications - Broaden the horizons.	
Attend workshops/seminars on Legal issues.	Attend workshops	throughout the 12 12mths
attend workshop / seminar on investigation.		throughout the 12mths. year
Experience in other positions	ACT up into higher positions where appropriate.	

Sign off of Performance & Development Plan

EMPLOYEE Name: Toni Hoffman Date: 8.7.04.

Signature: Toni Hoffman

REPORTING OFFICER Name: L. Mulligan Date: 8/7/04.

Signature: 

REVIEWING OFFICER (*As Required*) Name: ____________________ Date:

Signature:

Queensland Government
Queensland Health

Bundaberg Health Service District

LMM12

Adverse Event Report Form

Ensure that any person involved is safe and that all necessary steps have been taken to support and treat this person and to prevent injury to others. Ensure medical records are factual and up to date.

DQDSU Use Only

Registration No		Date Registered		Date Received
Risk Assessment	Consequence: Major	Likelihood: Possible	Risk Rating	RECEIVED 02 AUG 2004 DQDSU
Risk Level	Very High			
Assessed by	J T Nussott			
Action required	Fwd to DDM, DMS, DON 2/8/04			

Please print clearly using a black pen (Attach extra sheets if required)

Site	☑ Bundaberg	☐ Childers	☐ Gin Gin	☐ Mt. Perry

Patient/Visitor Adverse Event

Bundaberg Hospital
BRAMICH
DESMOND
SEX M
UR NO 086644
Ph (B)
Anglican
PLANT OPERATOR

Department	ICU		
Sex of subject	Male (circled)	Female	Not stated
Subject is	Patient (circled)	Visitor	Other
MHS Clients	Involuntary	Voluntary	Unknown
Reporter's Details	Name: Karen Fox Contact No.: Ext 2310		
Reporter's Classification	Please specify: RN.		
1st Witness	Name & Contact No.: D. Aitken, Ext 2310		
2nd Witness	Name & Contact No.		
Place of Adverse Event	ICU.		
Date of Adverse event	27/7/04	Time	
Current patient diagnosis/problems	Ventilated #ribs		
Adverse Event Type	ICC drain, no water in underwater seal section.		
Next of kin notified?	Yes / No (circled) / N/A	Name:	
Medical officer notified?	Yes (circled) / No / N/A	Name: DR PATEL.	

Staff Adverse Event
Enter details in this column

Full Name				
Employee Number				
Department				
Employment Type	Fulltime	Part time	Casual	Temporary
Shift Type	Fixed	Standard	Rotating	Other
Date of Event		Time		
Shift time	From	To		
Position title				
Supervisor's Details	Name Contact No.			
Task	What were you doing at the time of the adverse event?			
Experience in this task	years			
Place of adverse event				
Cause of injury				
Equipment details	Including Asset Number			
1st Witness				
2nd Witness				
Medical officer notified?	Yes / No / N/A	Name:		

Medical Officer's examination (This section to be completed for patient or staff adverse event where relevant)
If relevant, please describe the assessment of the subject's condition and list treatments/investigations ordered. Ensure the medical record is complete.

Medical Officer's Signature:					Date & Time:	
Open Disclosure Process initiated?	Yes	No	N/A	Name:		

Please complete all sections on page 2 for all adverse events (Patient or Staff)

Description of Adverse Event - Please describe exactly what happened including who was involved

On doing checks - noted no water in underwater seal drain section of ICC drain.

If this adverse event is a fall, pressure area or occupational exposure, please complete the relevant minimum data set form

Contributing factors - Identify causes/conditions/practice/human error/patient behaviour/staffing/experience etc that contributed to the incident

?Busy, unstable pt.
From previous shift

Treatment/investigations ordered - Indicate what treatments or investigations were required as a result of this incident

Put water into appropriate section.

Impact or Outcome - What has been the outcome of this adverse event?

Unknown

Minimisation of Outcomes - What factors minimised the outcome or if this was a near miss, what stopped the event from occurring?

Rectifying the situation

Prevention - How could this adverse event have been prevented?

More time, checking.

Signature	[signature]	Date	28/7/04.

Thankyou for completing this form. Please give this form to your Shift Supervisor

Shift Supervisor/Management Report

Comment on action taken or action needed to be taken to prevent recurrence

↑ awareness of need for H_2O in underwater sealed drainage, unsure of who set up unit. Emergency situation.

Has the adverse event been documented in the medical record?	Yes	No	If not, why not?
Name: Terri Utman	Signature: Terri Utman		

Please forward this form to the District Quality and Decision Support Unit

Director's Comment (Where required)

WHSO Comment (Staff Adverse Event Only)

DQDSU Comment

Queensland Government
Queensland Health

Sentinel Event Report Form

Sentinel events are rare and serious events that require prompt and in-depth investigation
Sentinel events must be reported verbally to the District Manager, Director of Medical Services, Director o Nursing and other relevant Director within 12 hours.
This written report forwarded to DQDSU within 48 hours

Please print clearly using a black pen

Site	☒ Bundaberg	☐ Childers	☐ Gin Gin	☐ Mt. Perry

Details of the subject of the sentinel event (fill in applicable details)

	Or affix Patient Label		
Last Name:	BRAMICH	Sex of Patient:	☒ Male ☐ Female ☐ Not stated
First Name:	DESMOND	IMHS Clients:	☐ Voluntary ☐ Involuntary ☐ Unknown
UR Number:	086644	Unit	Inpatient Unit ICU
DOB/Age:	15.4.1948		Unit where event occurred ICU
Reporters Details	Name: Toni Hoffman	Signature	Toni Hoffman
	Contact No. 41502310	Date	2.8.04
Reporters Classification:	☒ Nurse ☐ Medical Officer ☐ Allied Health Professional ☐ Other - specify		

Sentinel Event

Please indicate which Sentinel Event has occurred:

- ☐ Procedures involving the wrong patient or the wrong body part
- ☐ Retained instruments or other material after surgery requiring re-operation or further surgical procedure
- ☐ Haemolytic blood transfusion reaction resulting from ABO incompatibility
- ☐ Medication error leading to death of a patient reasonably believed to be due to incorrect administration of drugs
- ☐ Infant discharge to wrong family
- ☐ Maternal death or serious morbidity associated with labour or delivery
- ☐ Intravascular gas embolism resulting in death or neurological damage
- ☐ Suicide of a patient in an in-patient unit
- ☒ Any serious and rare event

Date of Event	27.7.04			Time of Event	1300 onwards hours
Reported to:	☐ DM	☐ DMS	☐ DON	Time reported	
Also reported to:	☐ DCAHS	☐ DCS	☐ Service Director IMHS	Time reported	hours

Narrative Provide details of how this event occurred, including people involved, outcomes etc Attach additional sheets if insufficient space

Pt readmitted in extremis, Anaesthetist c̄ pt, trying to stabilise pt, insert lines, give blood, surgeons with pt, pt had period of ventricular standstill during central line insertion. D/W surgeons need to T/F pt to Brisbane where facilities. Dr Gaffield pt's attending surgeon. Dr Patel informed staff pt did not require thoracic surgeon or transfer. See attached notes and sequence of events. Initial attempt to obtain bed @ RBH then PAH resulted in a bed being available & booked @ 1430 hrs. Delay due to subsequent events or demise of pt.

ICU ISSUES WITH VENTILATED PATIENTS;

BBH ICU is a
Designated level one unit, capable of ventilation for short periods of time 24-48hrs.
Consistently exceed this. Can do this for short periods of time, but not longer than a few days.
Level of Unit made clear to surgeons and this has appeared to distress one of the surgeons when their patients are going to require long term ventilation and be moved to Brisbane.
Usually the process works well except when Dr Patel's patients are involved. When Dr Patel first came to BBH it was explained to him that we do not have the resources to ventilate long term patients. He then stated he would "not practice medicine like this and would resign". He stated that he "would not transfer his patients to other hospitals". He has consistently denigrated the ICU and made such comments such as:

"This would not have been missed on the wards" (Gentamicin being written up by physicians.)

He stated to one of the R.N's that he had "contacts" in Brisbane and would use them to block a patient being transferred. Dr Patel consistently vents his frustration at the current system by being insulting to the nurses and the ICU. He consistently talks loudly to his PHO and JHO about "How difficult it is to work in this ICU" How backward it is and how it is like working in the third world for him. He does not usually do ward rounds with the ICU physician and this causes problems with the ICU nursing staff when they are receiving conflicting orders about treatment. Dr Patel will not converse with the NUM. Dr Patel has attempted to cause conflict with the staff in ICU, By stating the NUM is unsupportive of her staff.

The Director of the Unit, Dr Carter, is usually supportive and proactive about transferring patients, except when Dr Patel's patients are concerned. Dr Patel creates such an atmosphere of fear and intimidation in the unit that his behaviour is rarely challenged. Dr Patel has repeatedly threatened to
A) Resign
B) Not put any elective surgery in ICU.
C) Complain to the Medical Director
D) Refuse to complain to the Medical Director any more and go "straight to Peter Leck" as "I have earned him ½ million dollars this year."

Dr Carter has approached the NUM several times about increasing the Nursing FTEs so that we can "care for Dr Patel's patients properly". It was explained to him that it is a complicated process that requires much more than an increase in FTE's. We do not need more nurses when we are acting in our designated capacity. It is when we consistently act outside of this role for extended periods of time that these issues arise.
. There is such a feeling of disunity in the ICU at present, it is upsetting to the nurses, every time we have a patient of Dr Patels's the staff anticipate an argument. When Dr Patel's ventilated Patients require ongoing care or have been ventilated for longer than 24-48 hrs ,it needs to be reiterated that they will need to be retrieved to Brisbane after 24-48 hrs , or sooner if there are two ventilators in ICU. The admission and discharge policy of ICU must be adhered to.

On several occasions when Dr Patel's Patients have been in the ICU, he has refused to transfer his patient to Brisbane, even when the patients have deteriorated and have been in ICU for much longer than 24-48 hrs. He has done this when a bed has already been obtained. This has, on several occasions placed the patient in jeopardy as they have further deteriorated

I have voiced my concern regarding the level of care required for some of Dr Patel's patients several times. I have accompanied Dr Jon Joiner to meet with Dr Darren Keating when the issue of doing oesophagectomies has arisen in the unit.

This week we had a critically ill patient transferred back to ICU in extremis. He was a 46 year old male with a crush injury to his chest, multiple # ribs and a flail segment. He was shocked, in pain, tachycardic and hypotensive. The Anaesthetist in charge attempted to place an arterial line and a central line as well as transfuse the patient. At one point the patient went

into ventricular standstill. Dr Patel was seen to make a comment to another surgeon and laugh. Dr Patel repeatedly stated in a loud voice the comments that this patient did not need to be transferred to Brisbane. He stated the patient did not need a thoracic surgeon. He asked the PHO "how much trauma had he done". He went on to say "no more trauma should be done at this hospital, if we cannot handle it" All of these comments were said in front of staff and other patients. A bed was arranged at PAH, and booked at around 1430 hrs. The clinical coordinator only needed to be notified to organise the retrieval. It was decided, before the clinical coordinator would be called a CT needed to be done. There was a delay in obtaining an anaesthetist due to one being required for a perforated bowel. Dr Patel insisted the surgery for the perforated bowel be performed prior to the CT, despite the patient requiring ongoing resuscitation. I called Dr Carter and he agreed to transport the pt to CT. On return from CT it was agreed the patient would be transferred to Brisbane. I had previously voiced my concerns to Dr Gaffield that although I had heard Dr Patel say the patient did not need transfer as he did not need a thoracic surgeon, there were other issues such as a lack of pathology and blood bank support and the fact we did not have an intensivist or other equipment. The patient was sent to CT and then it was decided to definitively transfer him to Brisbane. There was some delay in contacting the clinical coordinator as they were doing a ward round. After about fifteen minutes the clinical coordinator phoned back and spoke with Dr James Boyd. This was about 1930 hrs, 4-5 hrs post the initial confirmation of the bed being available at the P.A. During this time Dr Younis had been trying to resuscitate the patient, insert central and arterial lines, administer blood and intubate and ventilate the patient. Three ICU nurses were involved with this patient throughout his stay. The Retrieval team arrived about 2215 and whilst attempting to prepare the patient for transfer he deteriorated and died.

My concerns are:

The staff in the ICU is expected to function outside of the role of the level one unit, repeatedly when the limitations of the unit are well known.

The behaviour of Dr Patel in intimidating, bullying, harassing and insulting the staff in ICU continues.

The interference of Dr Patel with this particular patient which delayed his transfer. (Dr Patel was asked to review the patient). This delay may have contributed to the outcome of this patient.

My concern that the personal beliefs of Dr Patel concerning the types of patients he can care for here, actually endangers the lives of the patients as these patients that would be transferred to Brisbane are not being transferred early enough.

A Secondary concern of mine is the level of surgery which is performed that should only be performed in a tertiary hospital.

LMM13

From: Jane Truscott
To: Darren Keating; Linda Mulligan; Peter Leck
Date: 8/3/04 1:06pm
Subject: Adverse Event

Yesterday, I sent through to you an Adverse Event regarding an ICU patient so that you would be notified immediately upon its receipt by DQDSU. As followup, you will be receiving two forms, the Adversed Event Analysis Report and Critical Incident/System Analysis Form today. Since we are still in the process of finalising which form is best for us to use when addressing incidents I thought it best you had both forms to work from.

We may need to discuss this further.

Rgds,
Jane

CC: Leonie Raven

5/08/04 - Discussed c Dr D. Keating - has requested details for Dr's involved. TO discuss c DM in [illegible]