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STATEMENT OF JON GALLAGHER

I, Jon Gallagher, of an address know to the Commission, makes oath and states:

1. I am currently employed by Queensland Nickel and am the Health Advisor on site for that company.

2. I previously worked for Queensland Health between 1995 and 2005 in a variety of roles. I am a registered nurse an Intensive Care Nurse. I worked as a level 2 intensive care nurse and a relief after hours nurse manager at the Townsville Hospital.

3. Between 2002 and June 2005 I was the patient safety project manager and then the patient safety officer at the Townsville Hospital.

Patient Safety at the Townsville Hospitals

4. In 2002 the Townsville Hospital Executive decided to implement a patient safety system based on "Root Cause" Analysis.

5. As patient safety project manager my job was to implement a system that would identify patient safety issues, and then develop tools and procedures to manage these issues. The role was also to develop systems to monitor compliance with the patient safety program.

6. The key system that I implemented was the Root Cause Analysis process. That is an investigation technique that was adopted from the Veterans Affairs Department in the United States.

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7. During the implementation process my position was funded when the Hospital accessed funds available from the Clinician Development Program (CDP). That funded my position as an AO8 project manager for 12 months. After that period expired the hospital executive accessed some additional funding available from the CDP and a further three months funding for my position was provided out of the CDP.

8. The CDP was funding provided by Corporate Office through the quality improvement enhancement program ("QIEP"). It was not specifically meant to be allocated for patient safety programs. I think that the Executive may have been a bit creative in the applications for funding to access those funds. The funding was obtained in order to get the patient safety program started. It was not possible to establish a self sustaining system in 12 months, however the funding allowed me to get the program started and was seen as important to the Hospital.

9. After the funding ran out, Dr Johnson and Mr Whelan funded my position as patient safety officer out of the hospital's own budget, however they could only fund an AO6 position so I dropped from A08 to A06.

10. Dr Johnson in particular has been very supportive of the patient safety program and provided me with a great deal of support during the development and implementation of the program.

11. In my opinion, the Townsville Hospital is at the leading edge of patient safety in Queensland. This has been achieved by the executive making funding available for my position and giving me as much support as possible to implement the program.

12. When I commenced in the position I was sent to a few short training courses. I went to a course in NSW on root cause analysis. I also attended the Human Error and Patient Safety (HEAPS) training course. Apart from that training I was required to pick things up as I went along.

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13. The patient safety framework in the Townsville Hospital is a risk management based approach to patient safety issues. The system involves having mechanisms in place within the Hospital to identify patient safety issues and the implementation of tools and processes to treat and monitor the outcomes for example adverse events reporting, morbidity and mortality meetings, and incident review meetings among the nursing staff.

14. When specific issues were identified as potential risks of a serious or critical nature to the patient, preliminary information is gathered, and in consultation with the executive, I then determined whether an RCA ought to be performed. The root cause analysis process is used to identify the underlying cause of specific incidents and to develop recommendations on how to address the underlying causes.

15. Where a specific incident occurs the RCA process involved putting together a multi-disciplinary team to investigate the incident. The team interviews all relevant staff and reviews all of the documents and prepares a report to the patient safety committee.

16. The investigation team uses a Root Cause Analysis guide and "triage cards" to assist its investigations. Those cards provide guidance on the methodology and questions to ask when investigating incidents. The process is about establishing the underlying causes and is not about apportioning blame for any particular incident.

17. It did take some time before the staff of the Hospital became convinced that the process was not about blaming or punishing people for mistakes. Initially some staff members were cautious about the program but over time have accepted it as a positive thing for patient care.

18. Once an RCA has been performed then the findings and recommendations are presented to the Patient Safety Committee. To my recollection that committee was made up of:

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- Executive Director of Medical Services – Dr Andrew Johnson
- District Director of Nursing – Ms Val Tuckett
- Emergency Department Consultant – Dr David Symmons
- Surgical VMO – Dr Sam Baker
- ICU Consultant – Dr Paul Lane or Dr Micahel Corkeron
- Operations Director, Medical Institute – Ms Sue Kelleher
- Senior ICU nurse – Anthony Williams
- Patient Safety Officer
- The Client Liasion Officer who was responsible for managing patient complaints.
- Quality improvement manager – Ms Penny Thompson.

19. The PSC would then discuss the incident and the recommendations made by the investigating team. At times discussions could be very robust in that forum.

20. A number of other committees also report to the PSC including the Infection Control committee, the morbidity and mortality committees, Incident review committees. Effectively anything that could impact on patient safety, and was of a serious nature and/or impacted on multiple areas, was referred to the Patient Safety Committee for review.

21. In my role as Patient Safety co-ordinator I was also responsible for reviewing adverse events within the Hospital. Adverse event forms came to me indirectly as they go through a number of channels before I received them. Firstly the adverse event form would go to the ward manager or the area manager who would then forward it to the Institute manager. After the Institute manager had reviewed the form it would then go to the Workplace Health and Safety department who would then forward it to me. I would then assess the incident and determine whether it warranted an RCA investigation.

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22. I also found out about what was going on in the Hospital through the grapevine. I had a pretty good network within the Hospital and that was also another good source of information about patient safety issues.

23. When I received an adverse event form the first thing that I would do was an investigation into the basic facts surrounding the incident. In my experience what is reported in the adverse event form may on occasion differ from what actually occurred. Once I had a good idea of what had actually occurred I would then put the facts through the risk matrix in the patient safety framework to analyse or determine the potential risk. Any situation where the potential risk was very high or extreme would usually result in an RCA investigation being completed.

24. When an RCA was performed all individuals involved in the initial incident would get feedback on the outcome of the investigation and also on the recommendations.

25. I also had the Nursing Informatics Manager put together a small database for me so that I could keep track of all the recommendations that had been made and I could follow up on the implementation of those recommendations.

26. If an RCA was not performed as an adverse event then the feedback to the unit was not as consistent. One of the things that I was attempting to implement before I left Queensland Health was a mechanism for reporting back to the unit about incidents. As part of that I developed incident review committees and started to get the Morbidity and Mortality committees to review incidents and adverse events in a more structured, accountable and visible way.

Sentinel Events

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27. Sentinel events came to me as patient safety co-ordinator. I would also look at any adverse events and determine whether they warranted being deemed a sentinel event.

28. The categories of sentinel events had been determined by Corporate Office and as I understand it are serious events that indicative of system vulnerabilities within the Hospital. They are based on a national list that I understand was developed from a similar system in the USA.

29. If I learn of something that I consider might be a sentinel event I would discuss it with senior management, usually Dr Johnson. If necessary we would also involve Ken Whelan in our discussions. In addition if we felt that the area was outside our expertise we might also involve other experts, for example Dr Michael Corkeron, Director of Intensive Care who has expertise in a broad range of areas, before we made the decision determining whether the incident warranted being a sentinel event.

30. During those discussions we would determine whether a particular event satisfied the criteria of a sentinel event. If we decided that something was a sentinel event then it would be reported to corporate office and an RCA investigation would be performed.

31. I believe that the Townsville Hospital during my time was at the leading edge regarding patient safety in Queensland. However that only came about because of the support that I received from the Executive, Mr Ken Whelan and Dr Andrew Johnson who were very supportive in setting up the patient safety program. They created funding for my position and provided me with the resources necessary to do my job effectively. When the funding ran out for my position, the executive funded the position within its own budget.

32. It was only as a result of Dr Johnson and Ms Val Tuckett's belief in the patient safety program that the funding for my position was provided.

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33. As I understand it, the position of patient safety manager was not considered by Queensland Health, at the time, to be an essential role. I also don' t believe that Queensland Health envisaged CDP funding being used to fund patient safety programs. It was only because the executive took the inititative and implemented the patient safety program that the funds were made available.

34. One of the reason that I resigned from by job at the Hospital was the fact that my position was not funded and although the executive had been trying to get funding for a patient safety officer it had been 12 months with my being on a temporary position and there did not appear to be any prospect of my position becoming permanent in the near future.

35. Also the Executive were unable to guarantee the funding for my position in the next year and were waiting on the budget to determine whether the position could continue. There had been plans developed by corporate office but timelines in those plans had been repeatedly extended and the plans modified.

36. I was very aware that most areas within our district are always seeking more resources and that there is only limited funding available. However despite the problems with funding the hospital executive did support the program.

Hospital Executive

37. I always found the executive to be accessible during my time at the Hospital. Members of the executive team would always find time to see me personally if I asked them although all of the Executive are very busy.

Corporate Office

38. Corporate Office has recently developed a patient safety centre that is developing policies to be implemented state wide. This has existed for

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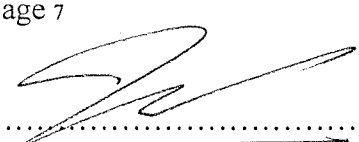

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about one year, however the Townsville Hospital has been implementing a patient safety program since March 2002. The Townsville Hospital developed this without the support of corporate office. It was developed internally by the Hospital.

39. I had numerous dealings with Corporate Office while I was working at the Hospital. Corporate Office is made up of numerous divisions and in my experience those divisions often did not communicate effectively to each other.

40. Over the years that I worked for Queensland Health my experience was that Corporate Office rolled out a great deal of uncoordinated change.

41. I believe that Corporate Office operated in silos and each division focussed on their particular area and the staff seemed to be unaware of what programs other divisions were developing.

42. For example as patient safety manager I recall Corporate Office rolling out the following programs that were relevant to my role:

- Pressure Ulcer prevention program
- Medication safety program
- Falls prevention program
- Risk Management program
- HEAPS program
- Root Cause Analysis program
- Open Disclosure program
- Incident Monitoring program.

There were a number of others but I cannot recall them.

43. Not all of these programs are given dedicated funding. Many of them are rolled out to the districts with an expectation that the district will implement them within its existing funding base and staffing level.

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44. The usual way those programs are rolled out is that corporate office develop the program and then one or two staff members from each district attends a training session for a "train the trainer" day. Those people are given the package and usually a CD of material and are then expected to take that information back to the district and implement the program. There is usually an expectation that that will be done in addition to the person's normal responsibilities.

45. They are then expected to implement the program across the district. They were expected to train all the relevant employees in how the program operates and what the expectation on staff was. The Townsville district has more than 3000 employees.

46. It is almost impossible to properly implement programs because it is impossible to get staff to attend the training. Most of the people that need training have full time clinical jobs and their positions are never backfilled to allow them to attend training. The reason positions are not usually backfilled is because the budgetary constraints or controls limit the planning that is required to enable casual staff to be employed and relieve people to attend training.

47. An example of this was the Human Error and Patient Safety Program (HEAPS). That program was very good and was designed to teach people to understand how people make mistakes and to set up systems to prevent errors and detect and mitigate mistakes. Four staff from the District, including myself and Dr Andrew Johnson attended the train the trainer day.

48. Dr Johnson has only limited time to conduct training due to his busy schedule however, he is very keen on patient safety and did conduct some training at the Hospital. It was necessary for me to find the time to train the staff of the various institutes. I tried to conduct the HEAPS training with the surgical institute but they were unable to get staff to backfill their positions so they could not release people to attend the training.

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49. I did manage to hold the training with the radiology department but that was only because they gave up their lunch hour to attend the training because they saw the value of the program.

50. In my experience everyone who I worked with was desperate to attend training because training is so hard to get with Queensland Health.

51. Corporate Office would roll out programs all the time but not give districts the required support in implementing those programs. There was just an expectation on the Districts to implement the programs that were rolled out.

52. There was no consideration of the size of the various districts or whether the district had the resources to adequately implement the program. Some districts might not have been able to support a full time position to implement things like the patient safety program.

53. I am not aware whether corporate office ever followed up on the implementation of the programs that they rolled out. Although in my experience I never had any one from the Executive chasing me up about implementing these programs. I expect that if Corporate Office were following up the implementation of these programs then they would have been putting pressure on the Executive to follow up on the implementation of those programs.

54. In my experience with Queensland Health there is almost as much change management going on as there is core-business. Programs are rolled out without planning by Corporate Office, and numerous programs in my experience overlap and impact on the same people/ areas at the "coal face"

55. There have also been many changes with the corporate governance of Queensland Health. There have been huge changes in the managers and directors of the various units within Queensland Health. The department has been restructured several times and afterwards there are always different people in the senior positions. While those restructures are going

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on it is almost impossible to get a decision made on what might be a key issue for a hospital. Everything is put on hold until the restructure is completed.

56. In my experience Ken Whelan and the other members of the executive are committed to providing the people of Townsville with a good hospital. He always seems prepared to try and get things done for the Hospital. He was also prepared to go into battle with Corporate Office to get things done for the Hospital

Resignation from Queensland Health

57. I resigned from Queensland Health in June this year for a number of reasons. As discussed above I was concerned about the fact that the Hospital could not guarantee the funding for my position.

58. I did not leave for financial reasons as I am actually getting paid "salary neutral" my current role.

59. It was poor treatment by the Queensland Health over a number of years. I became tired of not having sufficient resources to do by job properly, although I do not blame the Hospital executive for that lack of resources. They gave me all the support that they could within the budget.

60. I was also disillusioned about the lack of training opportunities. Over the 10 – 12 year period that I was involved with Queensland Health I can only recall being sent on external training course less than a couple of times. There was very little opportunity to attend external training courses, the 2 day course to NSW was considered to be extremely lucky by most of my colleagues. Attending external training is not only important for staff but it also has a lot of intangible benefits such as networking with your colleagues and also acts as a reward.

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61. I was also tired of the constant changes to the system. In my experience there is constant change being thrust upon the hospital staff and the staff are expected to cope with that change without any real support from Queensland Health. There is an expectation that staff will put in the overtime to get projects implemented whilst maintaining their core responsibilities.

62. From my experience on the wards there is also an expectation that you will put in overtime and help out whenever you can. As a nurse you are always aware of the fact that if you are sick or can't come to work one of your friends or colleagues will have to work overtime. The problem is that there is no recognition, of any significance, of that effort by Queensland Health. Queensland Health, as an organisation does little to make you feel valued and this does not encourage you to do the best job that you can do.

63. I believe that this is part of the reason why there are staff shortages. Staff are leaving the public hospitals and looking for alternatives. People get sick of working night shift every 3 weeks and are looking to become agency staff where you can pick and choose when you work. If you do not feel valued or recognised for your contribution you are less inclined to go the "extra mile" for the organisation and start to look after your own well being.

Dated this 2 day of August 2005

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