BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF DALE FRANCES ERWIN-JONES

1. I, **DALE FRANCES ERWIN-JONES**, Nursing Officer Level 4, Fraser Coast District Health Service, c/- 185 Walker Street, Maryborough 4650, in the State of Queensland, acknowledge that this written statement is true to the best of my knowledge and belief.

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

3. I request that this statement remain confidential and not be placed on the internet but used to assess the reality of the Australian Orthopaedic Association ("AOA") report (*A Review of Orthopaedic Health Care in the Fraser Coast Health Region*). I would be happy to be interviewed, make further comment or produce supporting documentation.

Personal details

4. Attached and marked **DFE1** is a copy of my current Curriculum Vitae. I have set out a brief explanation of my qualifications and experience below.

5. I was awarded a Diploma in Health Sciences (Nursing) in 1989 from the University of Wollongong; I have undertaken ongoing studies in management (see CV).

6. I worked as the theatre manager for Shellharbour Hospital (Illawarra Area Health Service, NSW) Australia, for a period of five years. During this period I acted as the Deputy Director of Nursing for a period of 12 months. I have been a nurse for more than 27 years with 20 of those being in operating theatre from enrolled

nurse, anaesthetic technician, and scrub nurse, acting Nurse Unit Manager ("NUM") of Angiography, Centre Manager of a Free Standing Day Facility (Endoscopy) and NUM. I have also worked as a free lance consultant for the setting up of Day Procedure Units and sit on the Queensland Health Peer Review Committee for Operating Theatres and had input into the development of the Clinical Services Capabilities Framework document.

7. I am currently employed by the Fraser Coast District Health Service ("the District"). My substantive position is that of the NUM Operating Theatres Maryborough Hospital since May 2002. However, since January 2004 I have been in an acting position of Nursing Officer Level 4 ("NO4") across the two sites (Hervey Bay and Maryborough) Operating Theatre. This has been a trial position that was finalised in March 2005 with a report being submitted to the Executive. The outcomes of this have yet to be acted upon. In the interim however I am still working as the NO4 across the district and was in this position at the time of being interviewed by the AOA officers.

8. In this position my role entails the following (attached and marked **DFE2** is the position description):
   - Day to day management of nursing, administrative and operational staff including rostering, staffing allocations and Personnel Performance appraisals;
   - Working with the elective surgery co-ordinator for the selection and allocation of theatre cases, to meet utilisation, activity targets, benchmarking and budgets;
   - Working with the Directors of each speciality to ensure elective surgery rules/policies/procedures are maintained and fair and equitable access is available to the public;
   - Working with the on shift emergency anaesthetist and other medical officers booking emergency cases for fair and equitable access to the emergency block in order or priority;
   - Co-ordination of emergency theatres;
   - Supervision of pre admission clinics;
   - Chairperson of the Theatre Review Committee;

- Member of Finance, Infection Control, Surgical Management Advisory Group, Heads of Department, Nursing Executive (Maryborough, Hervey Bay and District), Clinical Pathways, Product Review, Medical Records and Elective Surgery/Pre admission Committees;
- Management and integrity of budget and performance targets;
- Management of material resources;
- Co-ordination of services across the sites, i.e. movement of staff and/or equipment as required; and
- Preparation of reports including budget and activity.

General comments about the AOA report

9. I believe that the community of Fraser Coast have had an injustice served on them by this AOA report and there were underlying political influences that caused it to be released. The release of the report has impacted on more than 1200 patients, either waiting for surgery or waiting to be assessed. This should be recognised by the Commission as a misdemeanour on the public who deserve an orthopaedic service. Not to mention the average of 50 cases per month of orthopaedic trauma now being referred to hospitals between 100 and 300 kilometres away.

10. I have worked for the District for the past three years and three months. I came from a much larger service (Illawarra Area Health Service) and I firmly believe that the efforts made in the District are in line with and on some occasions better than other health service districts.

11. We are in no way aligned with the issues that have come out of the unfortunate situation at Bundaberg. We have had until recently a very open and transparent management structure and were very clearly on a pathway of improvement. You cannot come in and change a service over night. It takes many months of cooperation from all areas to effect change and having worked in health for the past 27 years both public and private the biggest challenge is always the management of medical staff.

12. Medical staff has always worked on the premise that they are not accountable to anyone and we like every other health service have to work and have been working to change that to a level of cooperation for all staff within a health service. I cannot see any real change occurring in the next five years. Clinical governance is in its infancy and for it to succeed medical staff must take up the challenge. However, this fly's in the face of their historical management of their mistakes.

13. As an employee the District whose professionalism has been maligned by this AOA report and as a patient advocate and community member, I am appalled that this report was placed on the internet without consultation with those whose lives its would effect. This report has had a huge impact on service delivery and access for the people of the District when it is clearly flawed and in many cases not even factual.

14. I would hope that the Commission will consider my points prior to making any decisions on the future of services for the District, a District that really did have a bright future albeit with the same problems all health services suffer. However, at present we are in a position of limited services and endless reams of bureaucratic processes that will further damage our ability to move forward.

Detailed comments about the validity of the AOA report:

15. I understand that the review of the District's orthopaedic services was commissioned following an incident with a patient having a procedure performed by a Senior Medical Officer ("SMO"), orthopaedics. This incident was followed with Dr Sean Mullen making a complaint to the AOA and to the local media. The correct channels for complaints within the health service did not appear to be addressed. Dr Mullen's issues should have been lodged as a complaint and dealt with through the Theatre Review Committee and Surgical Management Advisory Group (these committees are the first level of clinical governance). I understand that representatives from the AOA then had a discussion with the District Manager and the Director of Medical Services which lead to a review of orthopaedic services.

16. After the appointment of Drs Peter Giblin and John North, interviews were set up for 2 July 2004. This was some nine months after the original concerns raised by Dr Christopher Blenkin to the DMS after it being raised by Dr Mullen.

17. At the interviews the participants were advised that any information given was done under the protective disclosures act and would be confidential.

18. No documentation was requested of me prior to the interview, however at interview I was given a document that outlined some major points and some documentation they would like me to forward (attached and marked **DFE3**). I did not remember to provide this information however when I realised about a month later I sent an email to the Peter Giblin apologising and asking if it was still required. From memory the response was no.

19. No feed back was given to the participants until the report was posted on the internet, which then left all of us exposed.

20. The Terms of Reference ("TOR") stated the review was to "include advice to assist the District in defining some guidelines for the senior medical officers". However, all the AOA report has achieved is to ruin the careers of medical staff and caused distress to their families, maligned the administration of the hospital, put those of us who where prepared to make a statement into a very difficult working position and inconvenienced the public of the Fraser Coast for an indefinite period. All of this has occurred without conclusive proof that the error or poor outcome rate in the District is any more unacceptable than in any other health service in Australia.

21. It is clear that points 1 to 7 in the TOR are the direct responsibility of the Director of Medical Services ("DMS") through his management of the Director of Orthopaedics. These two persons should be the only two under scrutiny through this process.

22. Under "The Inspection Process" the investigators stated "The functions of an investigator are to investigate and report to the Chief Executive". At what point did they report this to the Chief Health Officer, and why was it that the Director General had to request the report after many months of trying to have it released.

23. Recommendation One of the report states "the Director General cease all orthopaedic surgical health care activity in the public sector in the Fraser Coast Health Service District". Concern should be raised as to why they felt so strongly to write this but not to follow through on this statement. If the safety of the patients was of prime concern, that should have overridden any concern or issue related to their own personal indemnity. It is nice to see that medical staff put patient safety over money!

24. With regard to Inspection Documentation – 1(c)(iii) Operating Theatre, (both in normal hours and after normal hours), this information could have been given on the day. In fact most of the requested documentation could have easily been obtained. If the investigators requested and did not receive these documents from the DMS, why did they not contact the District Manager ("DM") to move this along?

25. To provide all of the information that was patient related and therefore could not leave the district could not have been perused on the day. There was far too much of it. In fact a day and a half for a review that ended in closing a service is totally inappropriate. The investigators did not even come to the operating theatres and did not see any of the medical staff actually perform any procedures. The investigators merely based their decision on the hearsay of those interviewed and the bitter agenda driven voice of Dr Sean Mullen.

26. The AOA report states that numerous interviews and phone meetings were held over ensuing weeks. If this is the case why are all of these names not mentioned in the report. An operating theatre nurse was interviewed at the end of the session on 2 July 2004 for well over an hour. The name of this nurse was not listed however comments made were clearly from this nurse. In addition, many comments made by myself were not in the report.

27. Why were the demographics listed in the report when the crucial piece of information – what the population is - was left out? This is important because it is the population that determines the needs of the district in terms of how many orthopod's are required not the geographical info.

28. On page 8, paragraph 4, in relation to leave, I advised the investigators that the elective surgery Business Rules stated that only one member of staff from each speciality should be granted leave at any one time and that this is the responsibility of the Directors. The Directors leave is approved by the DMS. It is clear that Dr Naidoo took an inordinate amount of leave however it had to be approved by the DMS. This consistently left holes in the roster, particularly on call, and left inadequate supervision for the SMO's.

29. With regard to page 9, paragraph 2 of the AOA report, why did the DMS accept references for Dr Naidoo from an anaesthetist and a District Manager. Surely references need to be obtained from peer's who understand the work that is carried out by the specialist.

30. With regard to page 9, paragraph 6 of the AOA report, Dr Sean Mullen's commitment to the District was extremely fractured. It was very dependent on what Dr Mullen felt like doing and not on what was required. At the time of interview he had only recently returned to the health service for his own gain and was meant to be allocating three sessions per week. However, records could clearly demonstrate that this rarely occurred and the only consistent time given to the District was that of private work.

31. All issues related to Dr Krishna are the responsibility of the Director of Orthopaedics and ultimately the DMS. They employed him and were meant to review him after 12 months of service. My advice to the investigators on Dr Krishna was that he worked within his scope of practise and that if he got into trouble during a case he always tried to get the assistance required. However, that was rarely forthcoming from either Drs Naidoo or Mullen who had both been called on more than one occasion during a case by the theatre nursing staff and

had refused to attend or no one was available. The issues related to whether or not Dr Krishna's qualifications were recognised or acceptable to Australian standards are again the responsibility of the recruitment team, i.e., Dr. Naidoo and the DMS. It is a well know fact that over the years that Dr Naidoo has worked for the District he often did on call from Brisbane.

32. All issues related to Dr Sharma are the responsibility of the Director of Orthopaedics and ultimately the DMS. They were the recruitment team. My advice to the investigators was that Dr Sharma worked within his scope of practise and if he required assistance would try to get it. Again, often this was refused or unavailable.

33. The Director of Orthopaedics does the roster for the orthopaedic department and ultimately is responsible if supervision is not adequate. The same situation applies in nursing. It is the NUM's responsibility to ensure that a junior or new employee has orientation, preceptoring, mentoring, assessment and that they work with a skill mix that is appropriate. If this was an nursing issue the NUM would be held accountable for allowing a nurse to work outside their scope of practise without supervision.

34. It is clear to me and the other staff that an SMO is not a **Specialist** Medical Officer. At no point did the staff believe that Drs Krishna and Sharma held themselves out as Specialists nor did the District. This was the perception of the investigators who were lead to believe this from talking with Dr Mullen. The consultant roster is called just that, a consultant roster. However all the rosters (at that time) in the district state consultant roster but none of them were solely serviced by consultants. This is clearly a misconception by the review team and Dr Mullen. But no staff in the district where of the perception that the doctors on these rosters where consultants. It is merely an on-call cover roster. The issue that should be noted is how often Dr Naidoo was on call in comparison to the SMOs. I also note that Dr Mullen's name was not on it either.

35. Teaching and learning opportunities are the responsibility of the Director of Orthopaedic's. If the District could or would not provide these then why did the

director not address this as an issue. This could have been driven through the Theatre Review Committee (of which I am chairperson) or the Surgical Management Advisory Group. There is no record of this in the minutes.

36. With regard to Facilities and Research, this also should have been driven through the above committees. However, once again you will find no reference to it in the minutes. I note that Dr Naidoo requested a software program for audits and it was my understanding that this was agreed to.

37. As Chairperson for the Theatre Review Committee, quality and safety are standing agenda items. However, requests from me to the Directors of each speciality were met with "we can't provide this as we do not have administration support". This support was then requested by the committee to the executive. Some part time support for this purpose was granted, however, currently no data has been submitted by any of the specialities. I understand they collect data but do not submit the data through the correct channels. Again I believe that this is the responsibility of each director. As the directors should be managed by the DMS, their lack of commitment to the organisation is a direct reflection on the DMS's ability to manage medical services as a whole. Whether this is due to workload or capability is not for me to judge.

38. Most of the recommendations of the AOA report had been resolved by the time of publishing of the report by the then acting Director (locum) covering Dr Naidoo's leave (yet again).

39. I gave advice on Dr Khursandi's clinical skills and ability (in my opinion as a theatre nurse) this was not published in the report.

40. I gave advice on Dr Padayachey's clinical skills and ability (as a theatre nurse) this was not published in the report.

41. I support the recommendation that these two should be recognised for the years and work they have committed to Queensland Health. However, I believe by not addressing their clinical ability maligns Drs Sharma and Krishna. I also believe

that Dr Sean Mullen's involvement in the outcome of this report was the factor that saved them from being hung out to dry as well. This would have been a protective agenda by Dr Mullen because of the relationship between Dr Khursandi and Dr Mullen in the private sector. One could only assume that Dr Mullen had a momentary moment of conscience not to malign Dr Padayachey given how close he is to retirement.

42. Dr Naidoo's report that he performs seven joint replacement a week was a major over statement. In a good week he may perform one or two at most. During periods of increased activity we had tried to get him to do two joints on a list. This only ever worked in Maryborough and only for a short period of time. One of the limiting factors must be stated that the anaesthetic department was not proactive in this and said it would lead to overtime that they were not prepared to undertake. I was asked my opinion of Dr Naidoo's clinical ability and I advised that his arthroplasties were fine. However, I did have concerns about his ability to manage trauma due to his constant lack of availability, i.e. as he was always on leave. I advised that there were major issues with his supervision of the SMOs again due to his availability. I outlined a couple of occasions where this had been a problem, but that my major issue with Dr. Naidoo was with his ability to be the director. Dr Naidoo clearly did not manage his department and did not support his staff, the executive, nursing staff or the organisation as a whole. I believed that he had enormous knowledge on how to manipulate the system and took every advantage of that. I had little knowledge on his private work within Fraser Coast but he certainly did not have a private operating session between January 2004 and July 2004. Although Dr Naidoo did have access to the one private list that had been allocated in Maryborough on a weekly basis but to my knowledge never used it. I did advise the investigators that I would not be surprised about what he gained from prosthetic companies however I had no real knowledge or evidence of this.

43. I believe that it is inappropriate for a nurse to have a major impact on the decision of whether a clinician is competent. We are able to give advice based on our knowledge and previous work with other clinicians of the same speciality. However, to make a statement that a clinician is incompetent based on the hearsay

clinician at work, or reviewing every outcome of every case is totally inadequate. Particularly given the outcome of this review.

44. With regard to the statements on page 16 under Surgical Performance "Nursing staff from the operating theatre referred to a procedure called cancellectomy as being Dr. Naidoo's speciality". This implies that many theatre nursing staff were interviewed when in fact I was interviewed and one other nurse. My understanding is that this other nurse had a personal grudge against Dr Naidoo. Therefore the opinion of that nurse should have been verified. Most of what is written in this section was not information given by me. As the only listed theatre person I should not have been named if the correct names could not be listed.

45. There is no name listed for information given by clinics. The Accident and Emergency NUM was interviewed, however the credibility of this information should be questioned. This nurse had a particular axe to grind against some of the executive. When data on clinics information was requested through the Surgical Management Advisory Group from clinics (for which this nurse was responsible), it was never available.

46. The item under Industry Involvement should never have been published if there was no evidence to support it.

47. I cannot recall if I was questioned about Dr Mullen's clinical ability. I have no real concerns regarding his clinical skills, however, his follow up of patients and his desire to manipulate the District to suit his own needs is of real concern.

48. I have three examples where Dr Mullen's interest in doing the right thing for the patient only ever related to what he could gain from it.

49. The first example was when Dr Mullen returned to the District after resigning a year or so earlier. I had knowledge of how he had previously abused the system for his own gain. I endeavoured to ensure that this would not happen again. Dr Mullen had consistently abused the access to emergency theatres on weekends as this was his available free time. He gave the majority of his time to the private

sector. On one particular weekend he wished to perform a hip arthroplasty on a patient with a sub capital fracture of neck of femur. Dr Mullen requested to operate in the emergency theatre on a Saturday. The staff anaesthetist had refused to anaesthetise the patient due to a slight chest infection and suggested that it would be better to start treatment for the infection and do the case in the emergency block on the Monday. Staffing on the weekend is minimal and the same staff cover the on-call for the entire weekend. There are no other staff members available to open a second theatre in extremely short time frames. The theatre staff are aware of the need to plan, manage and strategise for issues on the weekend. This patient had the fracture for some time, was slightly demented, was 87 years of age and lived in a care facility. The senior nurse contacted me at home after Dr Mullen had made a scene regarding performing this case in the emergency block. Dr Mullen was also demanding the use of a more expensive prosthesis than we had on hand. He demanded that we get a particular hip prostheses from the private hospital. The cost variant for that prostheses would be $5,000. Dr Mullen had advised the family that he could operate if they went private. He then organised a private anaesthetist and wrote in the chart that the patient was seen by this anaesthetist. However, this anaesthetist did not sight the patient but took advise from an orthopod over the phone and agreed to do the case. The chart states "seen by Dr Meijer", but it is clearly Dr Mullen's handwriting. The theatre staff contacted me at home regarding their concern that we would be using the emergency theatre for several hours and requested advice on what they should do. I advised that Dr Mullen could not do the case and to re-book for Monday when staffing could be facilitated for other emergencies. I stated that I would check this with the DMS. As I could not contact the DMS, I tried the DM, who I also could not contact. I made the decision that we should refuse, as I also had to make Dr Mullen aware that he could not abuse the emergency block as he had in the past and that this did not meet the Category One emergency, i.e. life or death or limb threatening. Dr Mullen was advised and swore and cursed about me to the nursing staff and said he would contact the DM himself, which he did. The DM advised that he could go ahead on the Sunday when we could implement a contingency plan for other emergencies. The case went ahead using the more expensive prosthetic Dr Mullen then did a second case on the same day, on a patient who was 85, lived at home on her own, was not demented, also had a sub

capital fracture which had occurred the within the last 24 hours. For this second patient he used the $550 prostheses. The general rule of thumb is if it can be done in the first 24 hours then that is best practise. However, the first patient had had the fracture for (from memory) two weeks. The first patient changed their mind about going private on the Sunday so the organisation had to carry the cost of this. I fail to see where two cases which have the same fracture but where one patient is clearly more in need of a long term product ends up with the cheap version and the patient that clearly could have had the cheaper version ends up with the most expensive. This is an extremely short version of events. I submitted my concerns regarding this to the DMS which I have a copy of but no reply.

50. The second example was that both of these patients remained in Hervey Bay hospital until discharge and were cared for by the very SMO's that Dr Mullen saw fit to dob into the AOA and the Courier Mail as working outside their scope of practise. Dr Mullen did not see either of the patients again. This is not consistent with his grave concern regarding the capabilities of these two SMOs. One should question the dedication of a medical officer to the District service who regardless of how busy he may be in private practise should still follow up patients he has operated on. The locum the District had in place at the time of the withdrawal of all orthopaedic services saw every one of the patients he operated on personally, post operatively in the ward and in clinic follow up which is the gold standard of practise.

51. The third example was where Dr Mullen also abused the emergency block as outlined above. Another incident that took place on a weekend was a patient that required emergency surgery in a timely manner but was not a Category 1 (Category 1 is a case that requires surgery immediately or / within 4 hours and is life or limb threatening, a Category 2 is a case that requires surgery within 4 – 24 hours that is not life or limb threatening but has the potential to increase in urgency). Therefore the NUM tried to persuade Dr Mullen that it would be best to wait until the staff came on at 10.00am (this was 7.30 – 8.00 am). Dr Mullen insisted that the team be called in. This has financial impacts on the unit but also impacts on the staff. The staff are then required to work 10 hours, these same staff are then required to be on-call for the next 48 hours and work a normal shift

the following day. On this particular occasion the scrub nurse overheard Dr Mullen advising the anaesthetist that he had to be out of theatre by 10.00am as he had a morning tea appointment with his mother. It was not about what was appropriate for the patient or the organisation but what suited his schedule.

52. Page 17, paragraph 5, of the AOA report states that Dr Mullen does not have support from the DMS or the DM. If this was the case why would they have allowed him to return to the District when he had previously withdrawn his services and had only returned to foster his own gains. It is a well know fact that Dr Mullen is working towards opening his own private hospital in Hervey Bay. It has been discussed at various meetings that Dr Mullen may lose his clinical privileges if he goes into competition with St Stephens. If this occurred he would therefore need access to overnight beds in order to continue to perform arthoroplasty and other major surgery until such times as his private hospital could accommodate overnight cases. It is also a standard that free standing private facilities must have a contractual agreement with the public sector to manage complications where there is no facility to do so on site.

53. I do not recall if I was questioned in the interview about Dr Mullen's clinical skills. I do not have any concern in this regard. Although, as I have outlined above his after care of patients leaves a lot to be desired. Following the release of the AOA report the Fraser Coast put into place a complaints hotline for patients with concerns about orthopaedic care. The Commission should review this data because all of the orthopaedic staff including Dr Mullen's have been noted.

54. My concerns with Dr Mullen's are his attitude and behaviour particularly in the operating room. He is abusive to staff, swearing and cursing when things do not go well or he does not get his own way (perhaps the AOA see that as standard practise) and he also continually abuses the system in terms of care of patients that are public verse private. For example, he will cancel a public patient at the drop of the hat but would always show up for a private list. In fact the last case he performed before resigning yet again just prior to the release of the AOA report, was a revision hip that was extremely expensive. He knew that he had resigned but still carried out this procedure which was complex to say the least and then

offered no follow up care for this patient but left the patient in a hospital that had no orthopaedic service. It should be noted that this case was a private case, that is, the patient opted to be private paying the doctors but was not actually insured and therefore the health service carries the burden of prosthetic costs (in this case around $25,000).

55. Dr Mullen will also not follow hospital policy. For example, the consent process. I have consistently advised him that it is Queensland Health policy to use the standard evidence based consent form and that they are only valid for 12 months. His response to this is that it is rubbish and he will treat his patients his way. In discussion with him regarding new processes or products he will not accept anything as being best practise or evidence based. When it comes from the nursing staff it is rubbish and not to be followed.

56. I did not raise the points in the AOA report related to both Drs Sharma and Krishna regarding working out of their scope of practise and blaming others. This information must have come from the only other theatre personnel interviewed. As this person was not named in the report this information should not have been included. There may have been a component of concern from the ward and accident and emergency however their comments should not be used to judge the clinical skills of these doctors. The investigators should have evaluated these doctors in action. Both of them have always tried to work within their scope of practise. The main problem for both was when undertaking surgery that was within their scope which became more complex and they had no cover. Dr Naidoo was often contacted to come and assist (this can be verified by theatre staff), however, he either would not come, was in Brisbane or would appear at the end of the case at which point the surgeon would have already gone through the processes. Dr Mullen was also never available to actually come and assist. For all his concern regarding these doctors he did not go out of his way to assist them in getting the mentoring required. I believe that after a period of time (about six months) both Drs Krishna and Sharma became extremely disillusioned with their treatment by Dr Naidoo. Dr Naidoo treated them like second rate citizens, he was rude to them and embarrassed them in front of staff on a regular basis. This may have contributed to their seemly poor communication and attitude to work. I have

to say that there was an extreme change in both of them when Dr Naidoo went on long leave and the AOA member (Australian trained locum) took over the department. During the period the locum was running the department both Drs Sharma and Krishna seemed to blossom, they were happier, and more involved in their work.

57. It is noted at page 19, paragraph 1 of the AOA report that Dr Krishna was "lacking basic surgical and clinical skill" and "often difficult to contact in the case of an emergency". This certainly was not a statement made by me. There was never a case, nor any evidence to say he was not contactable. If a doctor was not contactable the theatre staff would in the first instance contact the Director and if unavailable the DMS. It would be noted on the count sheet and an incident report would have been generated. This never occurred during my time as the manager.

58. The statement on page 20, paragraph 2 in the AOA report that Dr Khursandi did not service Hervey Bay hospital after the emergency department moved to Hervey Bay is incorrect. The emergency department is available in both Maryborough and Hervey Bay. Dr Khursandi does not offer services to the District and is not considered a District staff member. On review of session arrangements in 2003 the option of moving all major orthopaedic services to Hervey Bay did not go ahead. The executive supported the fact that Dr Khursandi would not operate in Hervey Bay and that he had given many years of service to Maryborough so we should continue to allow him access. Due to the AOA report this has now changed as only minor orthopaedic procedures can be performed in Maryborough. As Dr Khursandi does not want to service Hervey Bay he cannot do arthroplasties. We have since the release of the AOA report had to revise all of our practises in line with the clinical services capabilities framework. In doing so, no major surgery can be performed in Maryborough.

59. Page 21, paragraph 1, of the AOA report states that "the clear impression was gained that the nursing staff and had largely kept the orthopaedic unit at Hervey Bay hospital functioning (with the help of Dr Mullen) in the absence of leadership from the director". This is absolute rubbish. There is no way known to man that an orthopaedic unit could be held together by nursing staff. To say Dr Mullen

helped is laughable. More than 80% of the nursing staff find Dr Mullen extremely difficult to deal with. Many staff opt out of learning orthopaedics because of the stress they would have to deal with by scrubbing for him. His limited availability is also clear. How on earth it could be said that he in any way kept that department going is unimaginable.

60. The process for dealing with issues of a department again must be taken through the Theatre Review Committee or the Surgical Management Advisory Group. The Management Advisory Group ("the MAG") is a multidisciplinary forum which is the first step in clinical governance. The Executive supported this process and an executive member is the chairperson of each MAG. A review of minutes will demonstrate that nursing staff and Dr Mullen did not take any issues to either of these forums.

61. Page 21, paragraph 1. The statement that a shortage of staff was the only problem is incorrect. In the operating theatre we have worked to ACORN staffing standards since February 2004 this was fully supported by the DM. The executive supported my application to staff to ACORN formula which meant the addition of five full time equivalents. The reason for inadequate staffing prior to this would need to be discussed with the previous manager.

62. The wards were and still are staffed according to the Business Planning Framework and the use of TREND data. The NUM's are all involved with the Director of Finance in working up their budgets each year. If anyone states that they were working short staffed they must have a misconception of staffing methodologies or they had their own agenda to drive through the review.

63. It should be noted that there is not a problem with nursing staff submitting issues of concern through the correct channels. However, nursing staff were frustrated that often items that related to medical staff that went either to the Directors or the DMS where often lost in the black hole. This leads to a culture of not bothering.

64. The medical staff are extremely non-compliant with submitting incident reports which is an issue of concern. This is not only common to the District but occurs

through health nationally. If this district or any other health service for that matter ever wants to get clinical governance working then medical staff need to be accepting of criticism and not vilify the person reporting.

65. I had taken my concerns regarding the management of the orthopaedic department to both the DMS and the DM (verbally) and was happy that they were working towards putting processes in place to manage Dr Naidoo. I was also happy that the implementation of the Management Advisory Groups was the forum to take issues to. It should be noted that when dealing with medical staff and trying to ensure change and best practise it takes many years and although this is not acceptable, it is historical. Medical staff are a law unto themselves and nurses are constantly used to try and manage to get them on board with process and best practise.

66. Page 22, paragraph 4 of the AOA report states that RMO's from Royal Brisbane Hospital attended Hervey Bay, that they worked well and were often the life savers. In the 19 months that I have managed the theatres I have only known of two occasions that registrars, not RMO's, have attended the service to cover for weekends. This was in early 2005 whilst the locum was in attendance. This was to allow the locum some free time after being on call for nine weeks straight (as Dr Naidoo was yet again on leave). A Dr Gupta has also worked as an SMO for the service recently. I believe there were some concerns regarding his capabilities and certainly the nursing staff had verbalised these concerns.

67. I believe that comments related to nursing staff concerns regarding the orthopaedic unit were in the main related to Dr Naidoo and his management of the department. These comments have been taken out of context to mean that there were concerns re the SMO's clinical skill.

68. The comment in the AOA report that Hervey Bay would make an attractive training post has certainly been overridden by the release of this report. A clinical review of the service should have been done including supervision of the SMO's carrying out their work. The AOA report should not have been based on the

hearsay and innuendo of some staff who may or may not have their own agenda to drive.

69. Page 23, paragraph 7 of the AOA report states that there was little respect for the administration by medical staff. Who are these medical staff? Drs Naidoo, Sharma, Krishna, Hanelt and Mullen were the only doctors interviewed. How can the opinion of five out of 86 medical staff be taken as the consensus of all.

70. All concerns that arose through the Theatre Review Committee that could not be addressed locally were always taken up to the executive. This can be supported by reviewing minutes and copies of all letters sent to the DM and DMS. Responses were always forthcoming. I believe that the District always worked to try and ensure a safe service within complicated limitations.

71. Page 27, paragraph 3 of the AOA report states that there was "what appeared to be substandard patient care in the operating theatre as well as both pre and post operatively". I cannot comment on pre and post standards but to state that the theatre supplied substandard care is utter rubbish. At no point did I advise of any concerns of substandard care in theatre. I have a highly trained team, who have worked extensively not only in Queensland Health but nationally and internationally. If we had major concerns regarding anyone's clinical practise we would have acted upon it immediately. Our concerns relate to the way the orthopaedic department was managed. We all supported the SMO's and still do. We all believed that they were put into a situation where they needed support but it was also their responsibility to take that up. We did not see practises by any of the medical staff that could be reported up by nursing staff. If we had we would have been the first group to complain. In fact I can site at least two occasions where I have reported on the practises of medical staff (not orthopaedic). From time to time there are things that we would question with the medical officer concerned. This is not specific to any one speciality. If the response was acceptable then there is no need to report. We did not see any major poor outcomes from surgery. However, it is a management issue that the mortality and morbidity forums are not open to nurses (if they have them at all). This means we are not privy to poor outcomes unless they are noted through normal gossip

channels. I certainly am offended that the reviewers could make a comment about substandard patient care in operating theatres when they did not come to the theatre and did not have any documentation to support these claims.

72. Page 27, paragraph 7 of the AOA report stated that clinical pathways were not used. The nursing staff had been working on the implementation of clinical pathways for at least 12 months prior to the review. Dr. Naidoo had been given the arthroplasty pathways for review but he had not been forthcoming in implementing these. This can be noted through the Surgical MAG. It should be noted that Queensland Health had a project team for Clinical Pathways but then did not facilitate the resources at district level to implement them. It is not just a case of stating we will now use these. They have to be reviewed by the clinicians using them as some alterations may be needed. It should also be noted that Dr Mullen and Dr Khursandi were not agreeable to using the pathways. However, we have since implemented the pathways with the locum orthopod prior to the report being released and this was done through the MAG and put up by nursing staff.

73. The issues with cancellations by Dr Naidoo are correct. However the data needs to be reviewed prior to making assumptions that he was the only one doing "cancellectomies". Dr Mullen also cancelled patients at very short notice. Some of the issues related to the documentation and data must also fall on the previous theatre manager who did not keep clear records.

74. To say (at page 30) that the Director of Orthopaedics did not undertake continuing education seems to be in direct conflict with the fact that at least half of all his leave (and he had lots of it) was conference leave. The SMO's and a senior theatre nurse were also sponsored by Dr Naidoo and an orthopaedic company to a trauma workshop in late 2003. So clearly this statement is not one of fact.

75. In conclusion, I believe that:

- The AOA report is not factual enough to call a whole service to its knees;
- Drs Naidoo and Hanelt need to be reviewed in terms of their management abilities;

- Drs Sharma and Krishna have never and nor has the district held them out to be orthopaedic specialists. That while they are both still on a learning curve their ability to practise with appropriate supervision should be considered;
- This district does need a leader in orthopaedics but that Dr Mullen is not the right person for this position;
- In terms of a learning experience associations, such as the AOA, that hold themselves out to be the pinnacle in reviewing services should themselves consider some education and management; and
- A full apology should be given to the communities of Fraser Coast for the political influences and agenda driving forces that caused them considerable inconvenience.

76. It must also be said that it will be a long day before anyone puts themselves forward to be a part of a review ever again. On a personal note, I fully support the Fraser Coast and truly believe that we are working towards a great service but without the cooperation of the medical staff from all levels this will remain a long and slow process.

Signed at Hervey Bay on 15th August 2005.

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Dale Frances Erwin-Jones
Acting District Theatre Manager
Fraser Coast District Health Service

DFE 1

Curriculum Vitae

Name: Dale Erwin-Jones (Ms.)

Address:

Telephone:

Personal Details

Date of Birth		
Marital Status		
Transport	Own vehicle Current Class "A" Drivers Licence	
Education	School Certificate Warilla High School, NSW	1976
Tertiary Education	Reception/typist/telephonist Wollongong Technical College	1977
	Enrolled Nurse Eversleigh Hospital, Petersham	1981
	Anaesthetic and Operating Room Technical Diploma Royal Prince Alfred Hospital Camperdown	1988
	Diploma of Applied Science Wollongong University	1989
	Post Graduate Program Wollongong Hospital	1990
	Health Information Management University of New England	1996
	Master of Health Management University of Wollongong (Deferred)	1999
	Frontline Management Certificate Australian School of Commerce & Management	2001
	Graduate Certificate Health Management Queensland University of Technology	2004

Skills and Experience

Project Manager/Nurse Unit Manager District Operating Theatre Services
Fraser Coast District Health Service

Nurse Unit Manager
Maryborough Hospital, Fraser Coast District Health Service.

Acting Deputy Director of Nursing / Senior Nurse Manager / Bed Manager
Surgical Stream Director
Waiting List Co coordinator,
Shellharbour District Hospital

Nurse Unit Manager Level Three – Operating Theatre
Recovery and Central Sterile Supply
Preparation EQUIP accreditation (1999 and 2002)
Shellharbour District Hospital

Nurse Manager / Consultant
Setting Up and Organisation of Day Procedure Unit
The Illawarra Private Hospital

Centre Manager / Nurse Manager
Co-ordinator of Accreditation Program for 13th Edition of ACHS
Rosemont Gastroenterological Centre
Free Standing Day Facility

Theatre Nurse encompassing the following specialities:
Neurosurgery – major and minor
Vascular surgery – major and minor
Trauma
All specialities

- Anaesthetic Technician
- Sterile Supply including knowledge of all applicable standards
- In-charge shift positions in theatre and high dependency units
- Acting Nurse Unit Manager, Angiography Unit
- Education Program Anaesthetic Department, The Illawarra Private Hospital
- Computer Literate
- Business Owner and Operator

Employment History

2002 – current	Fraser Coast District Health Service, Maryborough Hospital Nurse Unit Manager
1998 – 2002	Illawarra Area Health Service Shellharbour District Hospital Nurse Unit Manager
1997 – 1998	The Illawarra Private Hospital Figtree Consultant
1994 – 1997	Rosemont Gastroenterological Centre Wollongong Nurse Manager
1992 – 1994	The Illawarra Private Hospital Figtree Acting Nurse Unit Manager / Registered Nurse
1990 – 1992	Illawarra Area Health Service Wollongong Hospital Registered Nurse
1984 – 1989	The Illawarra Private Hospital Figtree Anaesthetic Nurse
1983 – 1984	Mount Warrigal Nursing Home Warilla Enrolled Nurse
1981 – 1982	Illawarra Area Health Service Wollongong Enrolled Nurse
1979 – 1981	Dr. A.S. Raje Albion Park Rail Practise Manager
1978 – 1979	Balmain District Hospital Balmain Enrolled Nurse

Major Achievements

Project management for the Standardisation and Alignment of two separate theatre units, under a district umbrella.

Participation / preparation for Accreditation under EQUIP (three times)

Preparation and Achievement of 3-year Accreditation covering entire aspect of the accreditation process under the 13th Edition. (twice)

Managing all aspects of the day-to-day coordination, leadership and management of a freestanding day facility and operating theatres.

Excellent clinical skills in general, high dependency, gastroenterological and operating theatre nursing.

Recruitment and Selection of staff in all positions of the past ten years, including preparation of orientation and appraisal programs. Education, Occupational Health and Safety, Risk Management, Infection Control and Quality programs.

Organisation, co-ordination and control of waiting list program.

Preparation and commendation in Numerical Profile process.

Liaising with Directors of all committee's, including organisation of committee meetings (chairperson).

Organiser of numerous education seminars and conferences for gastroenterological and operating room nurses.

Conference presentation to ACHS on Day Surgery - 1995
Conference presentation to the GENSA, NSW - 1996

Preparation and implementation of all hospital manuals relative to position.

Preparation of business plans, budget reports, monthly reports and proposals.

Preparation for Self-Assessment Program with positive outcome.

Preparation for COSOP's and Y2K disaster planning.

Membership

Queensland Nursing Council (QNC)

New South Wales Infection Control Association

New South Wales Nurses Association (NSWNA)

Cleaners Managers Association

Illawarra Quality Improvement Network

G.E.N.S.A.

Operating Theatre Association (OTA) – NSW

Peri Operative Nurse Association Queensland (PNAQ) - QLD

Queensland Nurses Union (QNU)

Referee's

Ms. Julie Rampton
Director of Nursing
Maryborough Hospital
Phone:

Ms. Susan Harris
Clinical Director Surgical Services
Illawarra Area Health Service
Phone:

Mrs. Robin Peters
Director of Nursing
Kiama Hospital
Phone:

Mrs. Helen Webb
C.E.O.
The Illawarra Hospital
Phone:

Mrs. Jean Seidamann
Theatre Manager
Shellharbour Private Hospital
Phone:

Dr. Colin Jessup
VMO Anaesthetist
Wollongong Day Surgery
Phone:

Dr. C. Hatton
Specialist Gastroenterologist
Wollongong Day Surgery
Phone:

Dr. Simon Leslie
Medical Registrar
Shellharbour Hospital
Phone:

DFE 2

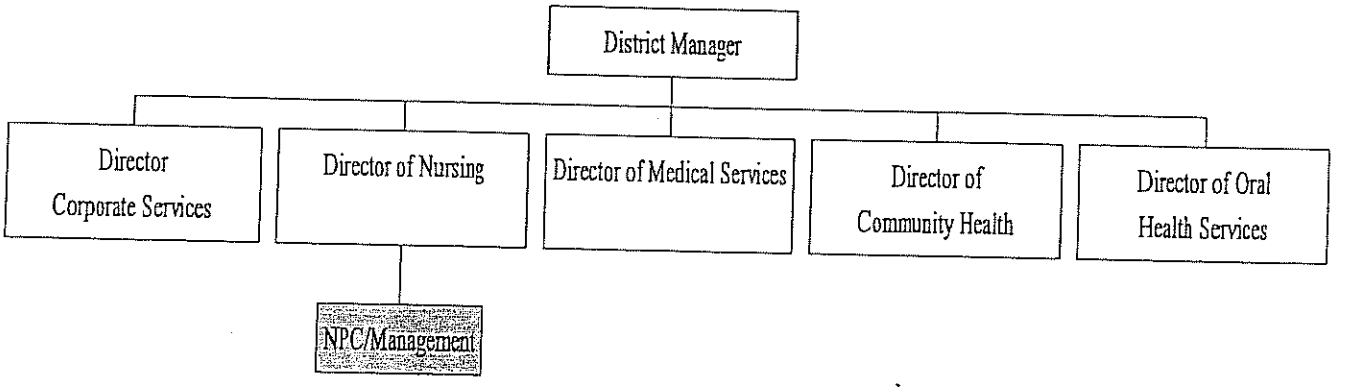
Queensland Government
Queensland Health

FRASER COAST HEALTH SERVICE DISTRICT

Position Description

POSITION:	Nurse Practice Coordinator/Management
CLASSIFICATION:	Level 3, Registered Nurse
LOCATION:	Fraser Coast District Health Service
REPORTS TO:	Director of Nursing
DATE OF REVEIW:	May 2002

Organisational Chart



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PURPOSE OF POSITION:

The successful applicant will be responsible for the coordination and management of the organisation's available beds and the provision and coordination of human and material resources for the facilitation of quality standard of efficient and effective patient care within a cost effective and evidence-based environment.

- Coordination and management of staffing requirements for the facility in collaboration with unit Nurse Practice Coordinators.
- The overall management of casual staff.
- The allocation of ward / unit staffing to ensures the provision of quality, cost effective care to patients / clients.
- Managing change proactively and being responsive to emerging needs.
- Monitoring standards of clinical practice after hours.

ORGANISATIONAL ENVIRONMENT & REPORTING RELATIONSHIPS:

The Fraser Coast District Health Service is responsible for the provision of inpatient and ambulatory health care services to the Hervey Bay-Maryborough communities and surrounding districts (Tiaro, Howard and Burrum Heads).

The Fraser Coast District Health Service comprises two major provincial hospitals (Hervey Bay Hospital and Maryborough Hospital) and the goal, strategies and priorities of the service are based on meeting the health care needs of these communities.

Accident and Emergency and Outpatient services are offered at both the Maryborough and Hervey Bay Hospitals.

A wide range of healthcare services are offered by the District Health Service. These include:

- internal medicine
- surgical
- maternity
- paediatrics
- intensive and coronary care
- mental health
- accident and emergency
- renal
- rehabilitation
- oncology
- ambulatory care services
- aged care
- medical imaging
- orthopaedics

Direct Reporting:
The Nurse Practice Coordinator/Management is directly responsible and accountable to the Director of Nursing.

Clinical Nurses, Registered and Enrolled Nurses within the area of responsibility report indirectly to the Nurse Practice Coordinator/Management.

Communication Requirements:
The Nurse Practice Coordinator/Mangement maintains effective communication with patients / clients, hospital visitors, nursing colleagues and the multi-disciplinary health care team.

The Nurse Practice Coordinator/Management maintains close liaison with Nurse Practice Coordinators, Clinical Nurses, Registered and Enrolled Nurses across the facility.

PRIMARY DUTIES AND RESPONSIBILITIES:

- Manage the integration of nursing services (operational level) through the appropriate allocation and coordination of human and material resources to provide quality cost effective care, reflecting hospital policy, guidelines and corporate objectives.
- Act as appropriate, under the authority of the District Manager, to address managerial situations after hours including acting as the emergency coordinator as per Emergency Procedure Manual.
- Coordinates and monitors nursing management systems; Trend Care, Casemix, Nursing Informatics and other activity and HRM data.
- Coordinates bed management and patient transfers.
- Collects and analyses data relating to staffing levels, turn-over rates and absenteeism with the Nurse Practice Coordinators of units for future planning.
- Coordinates and liaises with the Nurse Practice Coordinators with regard to deployment of nursing staff within the designated nursing units, according to patient dependency requirements.
- Maintains a management information database to determine staffing requirements for wards / units.
- Identify and advise of nursing professional development needs and contrite to the development and implementation of education strategies in collaboration with Nurse Practice Coordinators of clinical units.
- In collaboration with the Nurse Educator/Staff Development Co-ordinator, implements staff development programs orientation, in-service and ongoing education to casual/on call staff.
- Ensures the integration of organisational policies and procedures into nursing practice.
- Act as a management resource person for all staff.
- Maintains clinical knowledge to facilitate decision making and clinical problem solving.
- Provide clinical support and advice to nursing staff to:
    - Identify and resolve patient care problems;
    - Ensure compliance with infection control policies; and
    - Facilitate quality patient care outcomes through work improvement activities, research and policy review.
- Participates in business planning, budget preparation and financial management with Nurse Practice Coordinators of clinical units.
- Monitors cost effectiveness of staff allocation over 24 hour period.
- Manage human resource management for staff leave across the facility with the Nurse Practice Co-ordinators and coordinate human resource management for staffing levels in all units.

- Participates in the recruitment and selection of staff in accordance with associated law, standards and policies.
- Coordinate Performance Planning and Review to determine and ensure competent practice and to guide the professional development of self and staff.
- Maintains a high level of interpersonal and communication skills with members of the health care team / patients / clients and visitors to the hospital.
- Manages special projects, development of submissions and other activities to advance contemporary management practices.
- Initiates and participates in quality improvement and research activities and ensures that acceptable standards are met.
- Identifies issues which require policy review and participates in the development of policies and procedures.
- Promotes a safe and harmonious work environment
- Utilises and ensures compliance with contemporary Human Resource Management practices and principles including Employment equity, Anti-discrimination, Workplace Health and Safety and ethical behaviour.

PRIMARY DELEGATIONS AND ACCOUNTABILITIES:

- Facilitate quality improvement activities to support the provision of effective nursing services.
- Responsible for the efficient and effective management of human and material resources for a designated area.
- Act as a management role model for professional conduct and practice conducive to nursing excellence.
- Facilitate implementation of a culture of individual learning.

PROFESSIONAL ACCOUNTABILITIES:

Complies with the Codes of Conduct and Ethics.
Function in accordance with legislation and common law effecting nursing practice.
Maintains current professional knowledge and skills for competent nursing practice.
Acts to enhance the professional development of self and others.

QUALIFICATIONS:

Registered Nurse in Queensland with current Annual Licence Certificate.

ADDITIONAL INFORMATION:

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

The Fraser Coast Health Service District is an Equal Opportunity Employer.

The Fraser Coast 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 District Infection Control Policy Manual and Workplace Health & Safety policies and procedures.

A Fraser Coast Health Service District Code of Conduct is to be signed upon appointment.

SELECTION CRITERIA:

Your application for this position must specifically address each Selection Criterion below, a general resume will not be sufficient. It should also contain the names and contact details of at least three referees, one preferable from your current supervisor, who may be contacted with respect to your application. Short listing and selection will be based on these selection criteria. Verification of data may be sought with your permission.

KSC 1 Relevant registration with the Queensland Nursing Council and current practising certificate is essential.

KSC 2 Proven ability to effectively co-ordinate the management of Human and Material Resources facilitating the provision of quality patient care.

KSC 3 Proven ability to provide nursing leadership in a multi-disciplinary environment and contribute to nurse management perspective to professional nursing practice.

KSC 4 Proven ability in the application of highly developed interpersonal and communication skills, including;

* Working effectively with individuals, groups and members of a multidisciplinary health care team, and
* Negotiation, consultation, liaison and conflict resolution skills.

KSC 5 Proven ability to incorporate quality improvement activities and validated research into nursing practice and to identify specific areas for clinical and management research.

KSC 6 Sound knowledge of contemporary human resource management issues at both the broad and specific level, with particular reference to workplace health and Safety, equal employment and anti-discrimination.

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Director of Nursing
Hervey Bay Hospital
Fraser Coast Health Service District

.....

Date / /2002

.....

Director of Nursing
Maryborough Hospital
Fraser Coast Health Service District

.....

Date / /2002

HOSPITAL INSPECTION 2004
Hervey Bay Hospital
Maryborough Hospital

Name: Dale ERWIN.

Position: NUM OT

In Relation To: [illegible]

Address: Dr Peter Giblin
Honorary Secretary
Australian Orthopaedic Association
229 Macquarie Street
SYDNEY NSW 2000
[illegible]

Data Requests:

1. No leadership comments please
2. Director from time - manager
3. Document fractured ankle < cancelled 2 others cancelled
4. Document work past 5 pm ethic
5. (paid 8-6)
6. Idea on % ortho time in your OT Suite
7. Mention lack of anaesthetic support
8. (from RSA graduates)
9. Document 'lost' sessions
10. " anaesthetist o/c
11. Request for AT support on illegible — availability (in ortho) ([illegible])

I Dale ERWIN confirm that I will supply the document listed above to the AOA investigators within fourteen days in accordance with the instrument of appointment and under section 5[illegible] of the Health Services Act [illegible]

Signed: [signature]

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