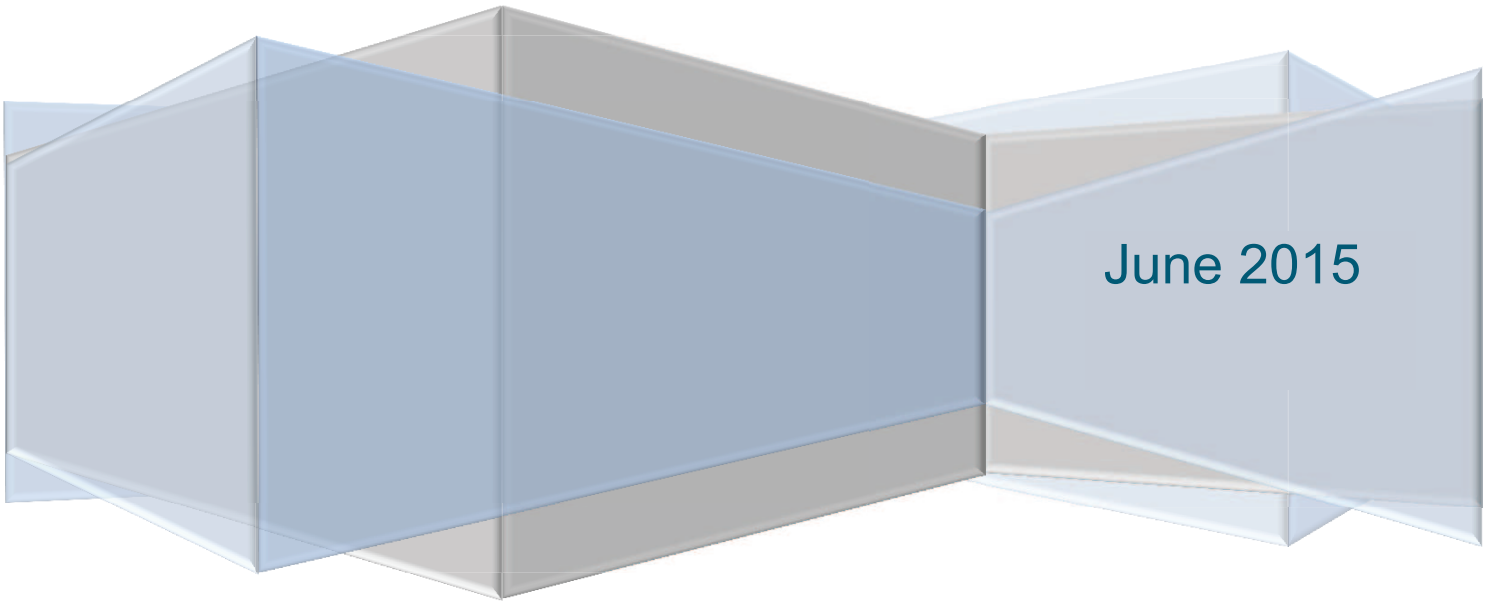
AUSTRALIAN COMMISSION on SAFETY and QUALITY in HEALTH CARE
and MMK Consulting

Review of operational clinical and patient care at Fiona Stanley Hospital



Acknowledgements

The reviewers gratefully acknowledge and recognise the valuable contribution made by:

- patients and their families and/or carers who generously gave of their time and willingly shared their experiences
- FSH staff and departmental staff groups who provided submissions, feedback and data
- FSH Consumer and Community Advisory Council
- FSH volunteers
- Australian Medical Association (AMA) WA
- Australian Nurses Federation (ANF) WA
- Health and Disability Services Complaints Office (HaDSCO)
- Health Consumers' Council (HCC) WA.

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1. Establishing the review

Background to the review

Fiona Stanley Hospital (FSH) opened on 4 October 2014 in a four phased sequence which was completed on 16 February 2015.

Following the commissioning and operationalisation of FSH there was considerable media focus on:

- specific patient examples pertaining to the quality and the delivery of clinical and patient care
- complaints by clinicians of inefficiencies in the delivery of care
- unexpected volume of patients being seen at the FSH.

In response, the Acting Director General, Department of Health, instigated an independent review. The independent review was undertaken by the Australian Commission on Safety and Quality in Health Care and MMK Consulting. The independent review team was appointed to assess FSH's processes, systems and practices against best practice and relevant standards.

Purpose of the review

The purpose of the review was to assess whether FSH is delivering operationally on its key vision and values as outlined in the Leaders of Care and consistent with the National Standards for Quality and Safety in Health Care.

The review took into account the recently received Interim Accreditation of FSH by the Australian Council on Health Care Standards, following the ACHS review of FSH conducted in March 2015.

Scope of the review

The review team was requested to consult with key stakeholders to gather views, information and evidence to:

a) Review all of the complaints received by the hospital since commissioning, interview selected patients (and families) to gain additional detail and review the hospital's strategies to address the relevant issues

b) Evaluate the delivery of operational clinical care, including the impact on patients and clinicians, highlighting examples of what has worked, what needs improvement, and any risks and opportunities

c) Evaluate the patients experience of their care and make recommendations for improvement

d) Outline where the hospital is operationally performing well and efficiencies are being made; and assess where there are particular inefficiencies in the delivery of care and make recommendations for improvement

e) Examine the resources currently provided and highlight areas of clear deficiency

f) Examine the role, responsibilities and working relationships of the various staff groups.

Stakeholders consulted

As part of the review process, the review team invited patients, their family/carers and staff of the hospital to provide submissions. The review took into account the views of patients and their families/carers, medical, nursing and other health professionals and other staff at all levels together with other key stakeholders.

In summary, key stakeholders consulted were:

- patients and their families/carers
- clinical and non-clinical FSH staff
- FSH Executive Team staff including, but not exclusively, the Chief Executive FSH Commissioning, Director of Clinical Services, Director of Nursing and Midwifery, Director of Allied Health and the Director of Safety Quality and Risk, Co-Directors of Services 1 – 4, Heads of Specialties, Nursing Unit Managers, Outpatients Manager and Allied Health Leads
- FSH Consumer and Community Advisory Council
- FSH volunteers
- Australian Medical Association (AMA) WA
- Australian Nurses Federation (ANF) WA
- Health and Disability Services Complaints Office (HaDSCO)
- Health Consumers' Council (HCC) WA.

The reviewers were most grateful for the time and input of all who agreed to be interviewed or provided advice to the review team. Some stakeholders were unable to meet with the review team face-to-face and agreed to take part in telephone interviews. Patients and their families/carers generously gave of their time and shared their experiences, and FSH Executive Team and staff were open and transparent throughout the review, assisting the review team to explore practical solutions to issues or concerns identified.

A wide range of information was received during the course of the review, not all of which was directly in scope but which was important to understand the context in which care is being provided and the concerns raised through the complaints, correspondence and interviews with staff. In the respective sections describing the matters directly in scope of the review, it was neither possible nor intended to capture all the matters raised by clinicians, support staff, patients and their families/carers. Many of these issues were already part of internal processes and staff were well engaged in developing solutions.

Many of the staff interviewed expressed their appreciation of the Chief Executive (Commissioning) and the FSH Executive Team for their assistance and guidance during the operational commissioning of the hospital.

2. Conduct of the review

The independent review was conducted over a four week period commencing 24 April 2015 to 22 May 2014 and concluded with the submission of the final report to the Acting Director General, Department of Health.

During this period, the review team considered and analysed information provided by:

- interviews with staff, patients and families/carers
- visits to clinical areas
- review of incidents reported to have occurred between the date FSH opened and the time of review
- review of complaints received by the hospital since the FSH's opening
- review of complaints and relevant correspondence received by the Minister for Health and by the Department of Health since FSH's opening
- review of complaints directly received by the review team
- other relevant correspondence received by FSH
- a range of data and documentation of relevance to the scope of the review.

The independent review was conducted by:

Australian Commission on Safety and Quality in Health Care

- Dr Robert Herkes, Clinical Director, Australian Commission on Safety and Quality in Health Care
- Ms Sharne Hogan, Director of Nursing, Concord Repatriation General Hospital

and

MMK Consulting

- Ms Michele Kosky, AM

with technical advice provided by:

- Dr Suellen Allen, Program Director, Australian Commission on Safety and Quality in Health Care (Maternity Services)
- Mr Mike Wallace, Chief Operating Officer, Australian Commission on Safety and Quality in Health Care.

3. Overview of Fiona Stanley Hospital

FSH is a 783-bed major tertiary and quaternary hospital located in the south metropolitan area of Perth, Western Australia, approximately 15 kilometres south of the Perth CBD.

FSH governance structure

To provide high quality services across Western Australia, the administration of WA Health has been divided into five key areas; Department of Health, North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service and the WA Country Health Service. As of 1 July 2015, FSH will be a member of the South Metropolitan Health Service.

The FSH Executive Director will report directly to the South Metropolitan Health Service Chief Executive and be accountable for the management and performance of FSH. The FSH Executive Director will be supported in this role by the FSH Executive Team:

- Director of Clinical Services
- Director of Nursing and Midwifery
- Director of Allied Health
- Director Safety, Quality and Risk
- Director of Finance and Corporate Services
- Director Facilities Management
- Director Workforce
- Medical Co-Directors Services 1, 2, 3, and 4
- Service Co-Directors Services 1, 2, 3, and 4.

There have been a number of changes in senior management personnel since the hospital commenced operations. It is important that the management of the hospital be stabilised. Senior management plays a key role in setting goals for health facilities and ensuring that resources are available to achieve those goals. The achievement of set aims within complex organisations requires a stable environment and the development of trust between management and clinical staff. Management stability reduces the natural cynicism associated with change and provides staff with the assurance that the directions set will remain unchanged until achieved or better alternatives found.

The Hospital Executive Committee is the peak governance committee whose role is to provide definitive advice to the Executive Director, FSH with respect to the current and future direction and management of FSH. The current Hospital Executive Committee membership includes:

- Hospital Executive (as above)
- Chief Executive, FSH Commissioning
- Executive Director, Clinical Commissioning
- Executive Director, ICT
- Manager, Communications

- Advisor, Institute for Healthy Leadership
- Chair, Consumer and Community Advisory Council.

The Clinical Governance Committee reports directly to the Hospital Executive Committee. Its function is to support and promote health service excellence and patient safety by planning, continuously monitoring and evaluating clinical performance and ensuring the implementation of appropriate strategies to improve outcomes. Governance committees for the National Standards have been established and these report to the Clinical Governance Committee.

Commissioning governance

In recognition of the significant complexity of commissioning the hospital, in November 2012 a fixed term Chief Executive FSH Commissioning was appointed to work closely with the Chief Executive of South Metropolitan Health Service and reporting directly to the Acting Director General, Department of Health. This has ensured robust commissioning project governance and accountability.

Once fully operational, FSH became the main specialist/quaternary facility for metropolitan residents living south of the river and other metropolitan residents requiring quaternary medical care, along with patients being transferred for care from regional and remote areas of Western Australia.

4. Complaints and serious adverse incidents

Complaints

The review team assessed the 105 complaints received by the Minister for Health since the opening of the hospital. The complaints submitted to the Acting Director General, Department of Health, and to FSH or by email directly to the review team were also reviewed. The complaints were categorised and are shown as percentages of the total complaints received.

Clinical issues	22%
Clinical communication	21%
Waiting times	18%
Lack of denominational prayer rooms	12%
Parking	10%
General communication (administrative)	7%
Smoking within or near the hospital	7%
Food service	3%

All identified clinical and non-clinical issues were investigated by the review team with the relevant teams and responsible line managers respectively.

In accordance with the scope of the review, interviews were held with selected patients and/or families/carers and others that had made formal complaints (12 individuals and 1 general practitioner), inpatients (6 individuals) and outpatients (16 individuals). Interviewees were asked to tell of their experience, the current situation and what changes and/or suggestions they may wish to make to improve patient care at FSH.

Many of the patients and/or family/carers interviewed were complimentary in other aspects of their care received at FSH. In making their complaint or comment, they indicated that they were interested in improving the experience of future patients and their families/carers, and for the hospital to achieve its full potential.

For the purpose of this review, the following key patient care themes were identified:

Access rights and information:

- confusion around procedures to visit patients
- information regarding late advice of outpatient appointments resulting in patients missing appointments
- access to wards after-hours.

Timeliness of care:

- waiting times in the emergency department
- unreasonable delay for surgery caused by duplication of tests
- delayed processing of medication prescriptions, particularly for discharge.

Communication with staff:
- lack of explanation for poor patient care or delay in surgery – no apology
- lack of discussion of care planning/case management with patients and their families/carers
- appropriate discharge information not communicated to patients
- poor communication amongst staff regarding clinical handover/patient care
- lack of consistency in written and oral advice provided to patients.

Quality of care:
- issues with cleanliness and change of bed linen
- walking aids not made available in the orthopaedic wards.

Physical environment:
- noise pollution, particularly in outpatient facilities
- room cleaning occurring at unacceptable hours (e.g. 9:30pm)
- lack of hospital volunteers on wards
- lack of child-friendly waiting rooms and other areas.

Complaints with access to food (not quality):
- food availability
- food delivered but not as ordered
- slow eaters discouraged from finishing meals.

Patients, their families and carers were also interviewed throughout the period of the review in both inpatient and outpatient settings. A number of their reported experiences have been used as examples within this report and many of the recommendations stem directly from their input. Several patients reported that they felt their feedback to the hospital was received well. However, feedback mechanisms need to be introduced so that staff at the interface with patients understand how they can improve the care provided and the experience of patients, their families and carers.

It has been suggested that the Consumer and Community Advisory Council at FSH commence work with the Safety, Quality and Risk Unit to develop and implement key performance indicators around the 'Patient Experience' approach to improve the patient journey, and the role of family members and carers. This should be undertaken as soon as possible.

Waiting times in the Emergency Department varied in accordance with patient load and time of day. A number of patients and their families/carers that had used the Emergency Department reported that a display board indicating waiting times would be helpful.

Patient's relatives expressed a concern that considerable time elapsed between the patient being admitted to hospital and advice on the location of the patient and/or their condition. While patients' privacy is paramount, FSH may want to consider a means of notifying family/carer(s) of a patient's progress.

Patients spoke of what they perceived as confusion at clinical handover and cited instances of missing notes, incorrect information being provided to them and poor communication with staff. It is noted that many of these complaints related to experiences immediately following the opening of the hospital. One patient reported having seen 9 different doctors and another 6 for single episodes of care.

A number of complaints concerned the length of time patients waited for pharmaceuticals on discharge. In one instance a family waited in excess of 7 hours before being able to take their elderly relative home. An improved system needs to be introduced to avoid excessive delays on discharge.

Other complaints discussed with reviewers included: receiving prescriptions by mail three days after discharge with no information about the drug(s) or the reason for it being prescribed; details of outpatient appointment times were, reportedly received by mail several days after the scheduled appointment date; staff talking over patients during rounds; failure to acknowledge the role of families/carers; and in a number of cases reportedly providing inconsistent advice.

Several complaints from patients receiving cancer care were due to long delays and confusion about bookings. These complainants noted that on further ongoing visits, many of these issues had been corrected. Unreasonable delays in accessing surgery and the perception that FSH was insensitive to the personal circumstances of the patient were identified. In several instances patients' had tests which had recently been conducted, reordered and in one instance, a patient presented with a previously diagnosed malignancy which appeared to be missed in the patient's notes with the result that an additional set of tests was ordered. It is understood that this was not an isolated incident with similar circumstances reported to the reviewers by clinicians. Duplicating tests is clinically inappropriate, anxiety provoking for patients and expensive.

At the time of the review FSH was still implementing its access systems. These need to be completed and clearly articulated to staff so that when advising patients the advice accurately reflects FSH's procedures. Patient stories included: patients being referred for direct admission to wards, where on arrival they were refused admission and returned to the Emergency Department; a patient was refused admission to a ward despite being advised by telephone that a ward bed had been prepared and was waiting for the patient; and patient movements between wards without explanation to the patient. Such incidents create additional anxiety for patients and their families/carers.

FSH has installed a Patient Entertainment System (PES) which provides both entertainment (e.g. television and radio) at the bedside and allows patients to order their own food from the menu. Many patients found this system extremely challenging to use and as a result, a number of patients received no food, inappropriate food or food they believed they had not ordered. Complainants also stated that they were provided with little or no assistance or education with using the PES.

A further issue for patients was the late night cleaning of ward areas. It was reported that this occurred as late as 9:30pm, creating disturbance for the patients.

A significant number of the complaints submitted by patients and their families/carers related to problems associated with the changing of bed linen including: soiled linen not changed in a timely manner; beds remaining unmade; and staff not responding to patient's requests for linen changes. It is understood that at the time of the review, linen changes were not made unless requested by clinical staff. This was reported by a number of complainants and, being easily corrected, justifies being addressed as soon as possible.

Suggestions provided by this cohort of patients and/or families/carers for improvements at FSH include:

- no delay in surgery without explanation
- better infection control through improved cleaning methods
- improve training of staff in communication
- stress importance of clinical handover with staff
- consistent and accurate patient information in written formats and as well as verbally communicated
- sandwiches to be provided in snack box as an option
- slow eaters supported on the ward, not hurried
- one free phone call from ward to family should be offered to all patients who have an unplanned admission
- wheelchairs and crutches should be available on the orthopaedic ward
- need for better communication between staff and their managers
- theatre management needs to be revised and surgeons involved in the discussion
- PathWest need to create a more child-friendly waiting room and treatment room, and perhaps learn from other child-friendly parts of FSH
- PathWest door is signed as a fire door which when entering is confusing as is not clear it is the door to PathWest. The door has no window and opens outward into the main corridor which is an occupational, safety and health risk when leaving PathWest and needs to be addressed immediately
- training of staff in patient-centred care and communication
- reconfiguring the design of the Short Stay Ward so noise is reduced from the thoroughfare and other wards
- improving discharge information
- every patient should have a care plan which is easily available and explains the patient journey.

Patients stated that they understood that several of the issues identified were easily corrected and no doubt a consequence of the 'newness' of the facility and, in many instances, offered suggestions for improvement. Only 2 of the 35 individuals interviewed indicated that they would not seek further treatment at FSH.

The relatively small number of patients who felt sufficiently concerned to submit a complaint about their treatment as a proportion of the total number treated during the first 6 months of FSH's operations indicated patients want FSH to succeed in providing safe and high quality health care – a sentiment expressed a number of times to the reviewers.

Serious adverse events

FSH has a Clinical Governance Structure which includes a Director Safety, Quality and Risk who is part of the FSH Executive, who reports directly to the Executive Director. The Director Safety, Quality and Risk leads a Clinical Governance Team which reviews all clinical incidents across the facility.

Documents summarising FSH's Severity Assessment Code (SAC) 1 incidents, processes undertaken and the outcomes, were examined. Re-investigation of the SAC1 incidents was outside the scope of the review's terms of reference. Relatively low numbers of major issues had occurred since the hospital's commissioning, they are categorised as follows.

Medication errors:

- wrong dose of insulin
- epidural medicines administered intravenously
- medication delivered intravenously rather than subcutaneously
- failure to monitor side effects of medication
- incorrect quantity of medication.

Falls in hospital:

- fall while awaiting surgery – fractured neck of femur
- fall from unsupervised commode chair – splenic and renal lacerations
- fall while recovering from surgery – fractured neck of femur
- fall while walking in corridor – fractured neck of femur
- fall on wet bathroom floor – fractured neck of femur
- fall climbing out of bed – subdural haemorrhage.

Mental health:

- suicide of an inpatient.

Maternity services:

- twin pregnancy due to have induction of labour was delayed – Cardiotocography (CTG) decelerations in one twin not managed, resulting in urgent caesarean section.

Delay in recognising and responding to clinical deterioration:

- MET call set as 'test' only and the MET had to be called again when the team did not arrive.

Hospital process issues:

- patient presented to Emergency Department and died less than 24 hours after discharge.

Consistent with the Department of Health *WA Clinical Incident Management Policy 2014*, all Severity Assessment Code (SAC) 1 incidents are thoroughly investigated with contributing factors/ root causes identified and recommendations made to prevent or reduce further harm to patients/ consumers. 'Open Disclosure' process occurred in all applicable clinical incidents.

A review of these incidents revealed no recurrent themes. The actions taken within the hospital following clinical investigations and review appeared appropriate. When the incident profile was compared to hospitals of similar size and complexity over the same timeframe, the number and severity of incidents was considered average. Many of these incidents were avoidable and the hospital must ensure that it has a structure in place to review incidents and implement learnings to ensure that patients within its care are in the safest possible environment. This particularly necessitates aligning the remedial actions with the 'craft' group involved in the incident. For instance while it may be useful to educate nursing staff in using epidural analgesia, if the incident involved medical staff, remedial action should be targeted at this group of staff.

5. Review of clinical services

Clinical management, structure, leadership and communication

FSH is currently organised into four Service streams each of which is comprised of clinical specialities clustered to form centres. These Services are led by a Service Co-Director (1.0 FTE) and Medical Co-Director (0.5 FTE).

Service 1: Medical and Surgical Specialties

Centre for Cardiovascular and Respiratory Medicine
- Cardiology
- Advanced Heart Failure and Cardiac Transplant Services
- Respiratory Medicine
- Vascular Surgery

Centre for Renal and Endocrine Diseases
- Endocrinology
- Nephrology
- Urology

Centre for Oncology and Haematology
- Dermatology
- Haematology
- Oncology
- Palliative Care
- Radiation Oncology (provided by Genesis Cancer Care WA)

Centre for Aged Care
- Geriatric Medicine

Service 2: Perioperative/ Investigative Medicine and Clinical Support Services

Imaging Services
- Medical Imaging
- Nuclear Medicine

Centre for Immunology and Infectious Diseases
- Infectious Diseases
- Immunology
- Infection Prevention and Management

Perioperative Care, Elective and Demand Management Services
- Anaesthesia and Pain Medicine
- Central Sterilisation Supply Department - Theatre Sterile Supplies Unit
- Day Medicine Unit
- Day Surgery Unit
- Endoscopy Suites
- Pre-Admission

Theatres
Elective Waitlist Management

Pharmacy

PathWest
Pathology
Mortuary

Service 3: Rehabilitation, Mental Health, Women, Children and Neonates

Mental Health Services
Mental Health Assessment Unit
Youth Unit
Mother and Baby Unit
Mental Health Liaison Services

Centre for Women, Children and Neonates
Gynaecology
Neonatology
Obstetrics
Paediatrics

State Rehabilitation Service
Acquired Brain Injury
General Rehabilitation
Spinal Rehabilitation
Neurology Rehabilitation

Service 4: Emergency, Intensive and Acute Care Services

Acute Care Services
General Surgery
Emergency Medicine
General Medicine
Hyperbaric Medicine
ICU

Centre for General Surgery and Gastroenterology
Gastroenterology and Hepatology
General Surgery

Centre of Plastic and Reconstructive Surgery
Plastic Surgery
State Burns Service
Breast Service

Centre of Ophthalmology, ENT and Maxillofacial
Ear, Nose and Throat (ENT) Services
Maxillofacial and Dental Surgery

Centre for Musculoskeletal Diseases
Orthopaedic Surgery
Rheumatology

Centre for Neurosciences
Neurology
Neurosurgery.

Allied Health Services

Allied Health Services was based on an integrated allied health model of care. The Director of Allied Health is the single point of accountability for professional governance, strategic direction and operations. Patient care is supported by an integrated team involving doctors, nurses and allied health staff. Allied Health Services include:

Dietetics
Physiotherapy
Psychology
Social Work
Speech Pathology
Occupational Therapy
Exercise Physiology
Audiology
Podiatry
Ambulatory Care
Pastoral Care
Aboriginal Hospital Liaison.

The management structure adopted by FSH seeks to directly engage with its clinicians through these clinical service streams. This structure aims to place clinicians under the direct management of other clinicians and decentralises management locating it closer to where patients are receiving their treatment. In practice, clinicians have found the structure cumbersome. In some cases this is because of the clinical service mix within the stream and, as a consequence, senior clinicians perceive that the interests of their patients would be better served if the senior clinicians had direct access to senior management. Senior clinical managers (doctors, nurse managers and allied health staff) throughout the facility reported insufficient contact with FSH Executive.

In particular, Service 3 contains an unusual grouping of clinical specialties which, given the aims of model, make it difficult for management to reflect and refer the specific concerns of all specialties within the stream.

Service 4 is larger than all other streams oversighting 75 per cent of hospital activity and while the issue is different, staff within the Service stated that the current structure does not adequately represent their concerns to senior management.

There was a widespread view that issues raised with the Service Co-Directors may be filtered and not escalated to the FSH Executive. Many of the concerns highlighted in outpatients, maternity and surgical services (as discussed in this report) may well have been allayed through more direct access by specific clinicians to senior management.

There are examples across Australia where the clinical service stream model works well and achieves the aims of decentralised management including enhanced clinician engagement. In these instances the services within the streams appear to be more appropriately clinically aligned than is evident at FSH and generally are smaller than Service 4. Furthermore, in these hospitals and health services, appropriate delegations are in place to allow management decisions to be taken at service stream level and the service streams have been sized to provide clinician managers with appropriate access to decision-makers.

Some hospitals have successfully implemented clinical councils. These councils are made up of the facility's senior doctors, nurses and allied health clinical managers (the equivalent of department heads at FSH) who meet regularly with senior management at times suitable to clinicians and have agendas which allow for transparent decision-making on matters relating to the development, enhancement and maintenance of clinical services. Introduction of a clinical council would provide clinician managers with enhanced access to management and offer the hospital the opportunity of directly engage its clinicians with the issues facing the hospital.

The Centre for Women, Children and Neonates sits uneasily in Service 3 and should be separated to form a fifth stream. This would provide this important service with direct access to senior management where its particular concerns can be heard separate to the business of the mental health and rehabilitation services which have a different set of management issues.

To reduce the size and complexity of Stream 4 the Centre for Musculoskeletal Diseases and the Centre for Neurosciences should form a sixth stream. This will reduce the complexity of Stream 4 providing it with a greater opportunity to focus on the needs of its constituent parts and allow for the further development of the specialities within the Centres for Musculoskeletal Diseases and Neurosciences. Service 4 would still remain large and intricate, and may need further reorganisation and modification into the future.

Further, consideration should be given to locating hospital-wide services including Laboratory Services, the Mortuary, Central Sterilisation Supply Department - Theatre Sterile Supplies Unit, and the Elective Waitlist from the clinical stream structure, placing it in an administrative setting. This will allow these services to better develop a hospital-wide service model.

Policies and procedures

In the main, FSH had policies and procedures in place at commissioning, and is adjusting these as required. In many instances, policies and procedures were reassigned from either Royal Perth Hospital or Fremantle Hospital if

deemed to have worked successfully, or hybrid documents combining positive aspects of both were developed. As FSH units were, in some instances, amalgams from Royal Perth and Fremantle Hospitals, some staff were initially unfamiliar with the procedures. A number of issues experienced by patients and staff during the commissioning and operationalisation of the hospital may have had their origin and cause in this period of familiarisation.
Staff throughout FSH at all levels of seniority have, and continue to demonstrate, extraordinary dedication and effort to making systems work; embedding policies and procedures some of which are new to them, and ensuring the safety and wellbeing of patients remains paramount. In some instances, staff have been required to develop and implement work-arounds when planned policies and procedures failed or required adjustment.

The hospital needs to now formally and progressively review and, where indicated, revise its policies and procedures to ensure that they are meeting its needs and the needs of staff given that the environment at FSH differs from the conditions and environment where the policies and procedures were initially developed.

Staffing

Overall, FSH staff have managed to transition successfully from other institutions and are progressively forming into a cohesive team. Areas with strong medical and nursing leadership have been able to implement new, adapted models of care for their patients. However, some units have not transitioned easily to the new hospital and there are persisting tensions regarding workforce levels and models of care. These concerns were most noticeable within the Maternity Services.

The Allied Health Services team have implemented a hospital-wide model of care with the allied health clinicians responsible to the Director, Allied Health Services. This has ensured strong leadership and is a well-resourced department.

Staffing levels within the Allied Health Services have been benchmarked against two interstate hospitals of similar size and complexity and were noted to be between 23 per cent and 38 per cent higher than the staffing levels at the comparable hospitals. This does not necessarily mean that the staffing levels within the Allied Health Services are too high but it does suggest that management should benchmark with comparable hospitals to further understand the current and future staffing levels.

The external service provider, Serco, has made a deliberate decision to identify its staff as Serco employees and separate from the hospital's staff. This may be contributing to a 'them and us' mindset seemingly developing between FSH and Serco staff. While the relationships are still new and numerous examples were seen of attempts by Serco management to integrate its staff within the operations of the hospital, there remained notable differences between the two staff groups. This is an issue that the FSH Executive will need to continue to address if the current arrangement is to provide patients with the best and most seamless service.

Of the numerous clinical groups interviewed as part of this review, the Infectious Diseases and Infection Prevention and Management Clinicians were the sole group to include a Serco employee to attend the meeting. These clinicians are responsible for infectious diseases, infection control, staff vaccination and pre-employment screening. The clinicians attested that they had a close and functional working relationship with Serco. This seems to have been the result of Serco employing staff to implement the *Hospital Acquired Infection Standard* for accreditation, and the strong desire of all staff within the group to achieve excellent infection control.

It was reported by many of the clinical staff interviewed that clerical staff within the hospital had initially found IT systems difficult to negotiate, and were unprepared for the nuances of clinical practice where some doctors were credentialed differently and performed completely different roles to others. This initially led to patients being booked to inappropriate clinics. As clerical staff becomes more experienced in their new roles, this should not continue to be an issue. In the meantime, the hospital should ensure that systems are in place to provide appropriate orientation and support to clerical staff and therefore, minimise clerical booking errors.

Newly commissioned hospitals need time to fully access and understand their clinical demand, can be estimated through planning, but can only be tested through experience. Staffing levels were largely determined on ‘demand planning’ and should now be reviewed across the hospital and benchmarked against other hospitals to ensure that the number and skill mix is as required.

Emergency Department

The hospital’s Emergency Department opened to significantly greater demand than was anticipated and initially staff were stretched to meet this greater than planned workload. Demand has reduced with time, although the Emergency Department is still subject to a ‘honeypot’ effect (i.e. popular local attraction).

Throughout FSH, there is general support for the Emergency Department. However, there were comments from some clinicians that the Emergency Department is merely triaging and transferring patients to wards for treatment and is as yet to take on the role of treating and discharging appropriate patients directly home. This may be the result of the greater than anticipated patient load. Patients who experience their entire episode of care within the Emergency Department will assist in reducing demand in other more expensive areas of the hospital. After the opening of the hospital in February 2015, the percentage of patients arriving at the Emergency Department who were treated within the recommended time (4 Hours) was 70.27 per cent and by May 2015 it had improved by 7.68 per cent to 77.95 per cent.

Inpatient wards

FSH as a whole has managed the very complex task of commissioning well. This is reflected in its ability to cope with patient surges and increased workloads.

Overall, FSH staff have managed to transition from other institutions and are progressively forming into a cohesive team. Areas with strong medical and nursing leadership have been able to implement new adapted models of care for their patients with relative ease.

A large number of clinical services are working very well, particularly evident where there is an enthusiastic team with high level computing skills allowing them to easily access and integrate clinical notes. It was noted that FSH is about to roll out a pharmacy application and dispensing system, which will further assist. The reviewers noted a number of instances where the model of care works appropriately and the clinical team is cohesive and highly functional.

A specific example is the treatment of fractured neck of femur where patients are admitted quickly, have early access to pain control and surgery, and where multidisciplinary clinicians are in agreement with the model of care. The intensive care unit is another example of a well-functioning unit.

The reviewers noted that clinical teams have been formed from different backgrounds and unless the model of care from their past institution was adopted by FSH, they are new to the care model. A number of the concerns raised with the reviewers will resolve as clinicians become more familiar with the environment and practices, these include: a lack of familiarity with policies and procedures; the general loss of productivity as new staff learn their roles and become familiar with other staff; and lack of knowledge of the DMR.

The FSH Director of Nursing and Midwifery has implemented ‘Care Rounding’ (otherwise known as ‘Intentional Rounding’) for inpatient wards. Care Rounding was developed in the United States of America by the Studer Group and has been implemented across the United Kingdom (including Queen Elizabeth Hospital, Musgrove Park Hospital, Northumbria Healthcare Foundation Trust) and within other hospitals in Australia including Royal North Shore Hospital Sydney, St Vincent’s Hospital, Epworth Hospital Victoria, Repatriation General Hospital Adelaide and Concord Repatriation General Hospital.

‘Care Rounding’ is an evidence-based structured process where nurses on wards undertake regular checks of their patients at set intervals (usually hourly). During these checks the nurses carry out scheduled or required tasks as well as ask their patients a series of questions designed to address frequently reported issues that patients have with their care. ‘Care Rounding’ aims to ensure that all patients receive attention on a regular basis; that there is a reduction in patient falls and pressure ulcers; and that there is an increase in patient and staff satisfaction.

The review team’s understanding of ‘Care Rounding’ at FSH is that it has been successful in some wards more than others. To understand whether it has a positive effect on patients and staff at FSH, it needs to be reviewed and evaluated.

Emergency surgery

At the time of the review FSH was continuing to work through a number of issues relating to emergency surgery, including:

It was reported that patients who were considered semi-urgent (for example, acute appendicitis and paracholic abscess) had been left waiting for surgery for several days and some patients chose to have their care transferred to St John of God Hospital, Murdoch. Surgeons stated that urgent cases were not appropriately escalated over routine cases and the clinical services plan to transfer elective surgery to Fremantle Hospital was not yet working as envisaged.

The Country Health Service had expected that FSH would provide significant surgical capacity to care for urgent and semi-urgent patients from regional and remote areas. Due to emergency capacity limitations at FSH, improved access for rural and remote patients has not yet occurred. Surgeons expressed concern that urgent cases were not triaged and operated upon in clinical appropriate times despite elective surgery continuing.

Elective surgery

The hospital had inherited significant numbers of elective patients onto its waitlist. These patients were transferred for surgery at FSH and both the waitlist and general efficiency of the process may have been improved had this patient cohort been better triaged or audited prior to transfer.

The current wait list method should be reviewed to ensure patients are triaged to the most appropriate setting, waits are minimised and workloads centrally coordinated. The hospital's clerical staff are not always sure of which individual surgeon is credentialed to undertake the specific surgery at the hospital, leading again to patients being placed inappropriately on waitlists and later relisted under the appropriate surgeon. Clerical staff performance would be improved with enhanced clinical input or supervision.

Prioritisation of surgical of elective and emergency load at FSH needs to be the responsibility of a senior surgeon who should review and prioritise all cases for the day to ensure that emergency and semi-urgent cases are dealt within appropriate time frames. One patient was of the understanding that they had been booked to have their surgery while in fact the booking did not appear at either at FSH or Fremantle Hospital resulting in their being placed back on the waiting list.

Specialist surgery

In a city with a population the size of Perth it is inefficient to have multiple, separate sub-speciality surgical services on-call at night where networking sub-speciality surgeons would allow more appropriate cover. This has been achieved in vascular surgery with a unified on-call arrangement. Similar networking arrangements in other speciality areas would offer benefits to both patients and surgeons. While this may not be resolved by FSH alone it is an issue that would assist the hospital in the management of its costs and should

be further considered by those with statewide system management responsibilities.

Maternity services

FSH Maternity Services, a new Level 5 maternity service (Level 6 being the maximum), provides care for women with low risk pregnancies through to the care of women with high risk pregnancies such as gestational diabetes, pregnancy induced hypertension, complex medical problems such as cardiac disease; and for women with high Body Mass Index (BMI). The service was projected to have 3300 births per annum; however current activity indicates a higher demand. In addition to women booked into the service there are a number of unbooked women presenting in late pregnancy or in labour; creating demand issues.

Systems are in place to manage different level emergencies within the FSH Maternity Services:

- Category 1 Caesarean Sections – Emergency drills are conducted weekly. The maternity service has an obstetric emergency call system with an anaesthetic consultant always available with Operating Theatre team support.
- Obstetric Emergency – Rapid response (time critical) from anaesthetic and obstetric teams.
- Medical Emergency Team (MET call) response for the hospital.
- Obstetric registrar escalation – registrar will respond, assess and escalate to anaesthetics, intensive care and neonatology as requested.
- Category 2 Caesarean Sections – designated response team contacted via paging group Theatre, Anaesthetics, Obstetric and Neonatology team.
- New born early warning tool is being rolled out. This will be helpful to neonatal intensive care and postnatal areas.

FSH Maternity Services has adopted the WA tertiary maternity hospital, King Edward Maternity Hospital (KEMH) policies across the antenatal, fetal maternal medicine and intrapartum periods and adapted to FSH work flows and services.

The adoption of KEMH polices is appropriate and provides an evidence-base for the care of women including those with complex pregnancies during antenatal, intrapartum and postnatal care. It also provides continuity for obstetrics and gynaecology registrars who rotate from KEMH to FSH. The move to a higher acuity service has resulted in the model of care being predominately obstetric with limited midwifery continuity of care provided.

Polices are available to midwifery and obstetric staff on the FSH Information Technology ‘Hub’. Staff are notified of any changes to policies via email, a communication book and through weekly meetings.

It is understood that there was initially a proposal to develop a Midwifery Group Practice (midwifery led continuity of care model of care for FSH) but this model has not been implemented.

Efforts to improve continuity have been made with the establishment of midwifery teams in the antenatal clinics and in the postnatal period. There is no midwifery continuity in the intrapartum period. The lack of continuity models is perceived by some as a limiting factor for both women and midwives.

There is a low threshold for bypass of the unit. The current reported criteria is if there are 4 women in labour at any one time or a risk of not being able to provide 'one to one' care; and/or if the Maternal and Fetal Assessment Unit is at capacity. The risk mitigation strategy introduced is to assess all women individually who contact the maternity service in early labour when the criteria for bypass is met. This allows for individual assessment of the capacity for the service to manage care or the need to request the woman go to another service.

There are a number of staffing and recruitment issues involving both medical and nursing staff that need to be addressed in this service.

Midwifery:
Resolution of recruitment issues will be an important step for the FSH Maternity Services. There are 22 postnatal and antenatal beds plus 4 birthing suites currently open, with capacity for the other 12 postnatal and antenatal beds, and 2 additional birthing suites, to open as activity and staffing allows. There is currently a shortage of 40 FTE midwifery positions. The current vacancy rate is limiting the capacity of the service to deliver a safe, quality service and any increase in activity will further exacerbate this situation. Skills mix of the midwifery team is also of concern with the increased acuity some unbooked and complex pregnant women presenting to FSH.

There is a lack of senior midwifery supervision after hours. This role is needed to ensure that accountability, responsibility and decision-making occurs to influence and manage patient flow, and to ensure management of clinical issues.

Neonatal Unit:
There are currently 13.5 FTE nursing positions vacant within the Neonatal Unit.

Obstetrics and gynaecology registrars and junior medical officers:
Recruitment of junior medical officers (JMO) and registrars was reported as a major and ongoing issue. As gynaecology services expand to provide more complex care to women and as activity increases within FSH the obstetrics and gynaecology registrars are experiencing difficulties appropriately covering the maternity intrapartum services.

Consultant Obstetricians and the Director Obstetrics and Gynaecology have agreed to provide onsite supervision after hours for junior medical staff. There is also an agreement that should midwifery staff be concerned, they are able to escalate directly to the Consultant rather than through JMO and registrars. This strategy provides a short-term solution but the service must address recruitment issues to ensure long-term safety and sustainability.

6. Review of hospital-wide services

External providers

Serco

Serco were awarded the State Government Facilities Management contract for non-clinical and support services at Fiona Stanley Hospital. Under this contract Serco provides:

- 'Hard' facilities management services, including estates, maintenance, energy and utilities, grounds and pest control
- 'Soft' facilities management services, including patient catering, internal logistics, cleaning and reception
- Helpdesk and communications
- Central sterile supply services
- Maintenance of wired and Wi-Fi data network
- HR, recruitment, non-clinical training and education, occupational safety and health
- Procurement, management and maintenance of all hospital assets
- Procurement and distribution of consumables.

Serco works with FSH clinical services to provide integrated services to patients. The contract is an outcomes-based arrangement with contracted service levels set against more than 450 Key Performance Indicators (KPIs). The KPIs are tailored to monitor each service and where Serco does not meet the standard identified in a KPI, failure points accrue each month which can lead to financial abatements to offset the performance failure.

The contract with Serco has proved challenging at a number of levels. Many of the potential money saving initiatives envisaged by employing a Facility Manager are yet to achieve savings. Significant FSH Executive time has been spent understanding the limitations of the contracted services and managing the interface between the organisations. Both Serco and FSH have executives dedicated to managing this important relationship.

Consumables and equipment management:
Stores management was designed to be transparent to clinical staff at ward level with an agreed imprest of stores maintained. Early in the commissioning of FSH, this system failed such that Nursing Unit Managers took on the role of counting and ordering stores. This resulted in significant over-ordering and stock loss whilst imposing an unplanned burden on senior medical and nursing staff. It is understood that many of these issues have now been corrected, however, staff described feeling uncertain about stock provision and levels and this has definitely lead to both over-stocking and deficiencies of imprest and non-imprest goods.

Similarly, the centrally controlled inventory of equipment purchased and maintained by Serco, on behalf of hospital, has not yet produced any savings. Equipment is tracked throughout the hospital and should be easily available to

staff. Early experience has been disappointing with equipment not located as designated on the system, and at times being difficult to find at all. Staff also reported early damage to expensive equipment through mishandling, inappropriate cleaning and movement.

A major area of additional expense for the hospital has been the intermittent failure of the cardiac telemetry system, which has necessitated the allocation of senior nursing staff to monitor cardiac patients. The facility manager sub-contracted IT network services (to British Telecom), electronic equipment installation and maintenance (to Siemens) and has purchased a Philips telemetry system. Currently, the system fails intermittently and the source of failure remains obscure. To mitigate patient risk, senior cardiac trained nurses are rostered to monitor patients in the cardiac wards, necessitating extra expense by the hospital to ensure patient safety.

Portering:
The contract with Serco did not allow for porters to physically touch patients. Given that a significant part of a porter's role is transferring patients to and from beds, chairs, wheelchairs, operating theatre tables and so on, this created a major difficulty for the hospital to overcome. FSH has subsequently employed 120 Assistants-in-Nursing and Serco has added 70 additional porters to meet the hospital needs. This is both inefficient and costly. Clinical staff reported instances where 3 individuals were each required to perform a task such as moving a patient from theatre and cleaning the theatre floors that in other jurisdictions would be performed by only 1 person.

Helpdesk:
The establishment an all-encompassing Helpdesk combining telephony with numerous support services including IT support, equipment finding, maintenance management and patient and relative enquiries continues to be challenging. The number of calls exceeded expectation and the complexity of the tasks required of a person unfamiliar with the hospital setting proved distressing for families, carers, staff and others trying to navigate the system.

The load on the Helpdesk has been diminished by better internal hospital use of the hospital intranet, and internal 'paging' (Wi-Fi and phone calling). Staff expressed concerns that the Helpdesk was continuing to have difficulty triaging calls to the appropriate service within FSH. There was also a perception from both staff and patient's relatives that the Helpdesk is overly concerned about patient confidentiality and privacy, hindering legitimate attempts to contact patients and relatives. A careful review of the confidentiality policies within FSH is suggested.

Food services:
As outlined elsewhere in this report patients had an inability to use, or lack of familiarity with using, the PES meal ordering system and this frequently resulted with incorrect meals being provided to patients or none at all. To overcome this issue, the nursing staff have been managing meal ordering, a service that was intended to be managed by others. This has reduced the time many Nursing Unit Managers might otherwise have had available to work with their staff and/or improve patient experiences. It has also proved anxiety

provoking in patients and given the importance of nutrition in relation to wound healing, deconditioning was and may continue to be, a patient safety issue.

Bed linen:
There were issues of soiled linen not being automatically changed and not being changed when requested. The contract with Serco stated that bed linen would only be changed when requested by clinical staff. This led to numerous patient complaints and unnecessary tension between patients and their clinical carers. A system needs to be put in place which provides patients with clean linen when required whilst appropriately minimising linen utilisation. Patients should not experience lying in soiled linen which also exposes them to a potential infection risk.

Central Sterilisation Supply Department:
A major concern for the hospital, albeit now corrected, was the failure of Serco to provide the centralised sterile supply needs of the hospital. Serco purchased 'state of the art' sterilisation equipment and employed an experienced sterilisation manager and staff who had completed a TAFE sterilisation course. Theatre staff discovered 'dirty' instruments and surgical trays as well as trays with vital equipment missing, necessitating returns to the Central Sterilisation Supply Department (CSSD) resulting delay in surgery and concern regarding cleanliness and sterility of equipment. This issue led to a number of significant adverse articles in the local media, impacting on both FSH and Serco.

FSH attempted to mitigate the problems by redeploying senior nursing staff from theatres with sterilisation qualifications and experience to supervise Serco's service. Management of sterilisation services have now become to be the responsibility of FSH. The failure of the CSSD was both operationally significant and damaging to the reputation of the hospital. Whilst there have been no reported adverse clinical outcomes reported for patients; both patients and staff did experience considerable distress.

The cancellation of this element of the Serco contract was the culmination of months of reported staff concerns, and focus by the FSH Executive.

The majority of hospitals engage with external providers at varying levels. In the main external providers increase the resources available to staff and patients, particularly within public hospitals. However, when this engagement directly threatens the safety of patients cared for within the hospital, it is the responsibility of the hospital to manage and if necessary terminate the service provided by the external provider. The lessons learned by both Serco and FSH need to be a reminder to inform and better prepare future similar relationships between health services and external providers.

State Information Communication Technology

FSH is the first WA public hospital to implement a Digital Medical Record (DMR). The DMR (BOSSnet) is a digitised version of the traditional integrated paper-based medical record.

The DMR initially comprises of:

- Direct data entry eForms completed by clinicians that can be viewed in the DMR in real time. Currently these include an admission form, integrated progress notes, team conference/ multidisciplinary team notes, nursing risk screening tools and assessment forms.
- Electronic documents received from other clinical systems used across FSH such as Cardiobase, NaCS, TEDS, CGMS, STORK, eCONSULT, PROCREP and eReferrals viewable in real time.
- Critical alerts from the patient administration systems (webPAS and TOPAS) and anaesthetic alerts.
- Allergies sourced from NaCS and the FSH eDiet application.

A major change for many clinicians working at FSH relates to the introduction of the new bedside information technology. As yet, the multiple applications that form the DMR are not fully integrated so clinicians cannot easily move from one application to the next.

Problems were also reported with the DMR's inability to put an alert on the system (warning about an impending potential issue e.g. a reaction to a type of drug or the need for the patient to be seen urgently); this was seen as a safety and quality issue.

The introduction of the DMR has allowed the start of efficiencies in the care of patients and communication between team members. Each patient's clinical notes are available to multiple staff members at the same time. This allows for instance, the surgical team to access the patients' notes on a ward round at the same time as the social worker is accessing the notes to facilitate the patient's transfer to a rehabilitation facility.

Currently, to open all applications within the DMR to admit and manage a patient takes approximately 15 minutes due to the integration issue. Staff at FSH have expressed concerns that as the new children's hospital progresses to opening, Information and Communication Technology (ICT) enhancements and fixes will be further delayed as the same ICT staff involved in developing the programs become overextended.

Technology changes are also an issue within the outpatients department where it can also take in excess of 15 minutes to open all the software to manage the patient's notes. Furthermore, clinicians with less computer experience find it difficult to type with sufficient speed and/or accuracy which further reduces patient throughput. It was noted that there was a good dictation service (transcription) in place which was appreciated by many clinicians.

Administration

Patient records

Planning for the transfer of patient records from both Royal Perth Hospital and Fremantle Hospital to FSH appears to have been thorough. However, in numerous cases, these patients' records were unavailable or misplaced at the

time of the patient's first clinical presentation at FSH outpatients department. This has meant that a large part of treatment histories for some oncology and haematology patients has, at best, been reconstructed from the patient history. Other outpatient clinics have been similarly affected by the failure to have some patients' records available at the time of consultation.

Outpatient booking system

One of the significant improvements for patients moving to FSH is the allocation of a specific appointment time for their outpatient treatment rather than being seen within a 4 hour session. This change has been well received by the patients and the clinicians**.** However, there appears to be no alert or triage system within the outpatient booking system to allow urgent patients to fill consultations over routine or less urgent patients. This has meant that general practitioners and specialists have had difficulty scheduling timely and appropriate consultations for the sicker more urgent patients.

A concern for cancer patients treated at FSH is the number of occasions they are required to attend the hospital for each chemotherapy cycle. Delays in the preparation of chemotherapy has meant that whilst, in the past, patients could have their blood tests, specialist consultation and chemotherapy in one visit, this now takes 2 to 3 presentations over several days at FSH. Despite these issues, the vast majority of patients are treated appropriately and without clinical incident.

Patient entertainment system

Each patient bed has a bedside computer - Patient Entertainment System (PES) with inbuilt facility for: food ordering, television, internet, games and hospital functions. These computers are also used by clinicians to enter clinical notes into the Digital Medical Record (DMR). While cutting-edge, the system has initially proved difficult for clinicians and patients to navigate, and most clinicians stated that they preferred to enter clinical data on the computer on wheels (COWS).

Elderly patients and patients with disabilities including those who are semi-conscious or delirious find the PES difficult to use and, as previously identified, were unable to order food. Patients and staff noted that in a number of cases, late food orders could not be processed or patients received inappropriate food or the food received was not as ordered. In the initial commissioning of the hospital, it appeared that staff were unaware these issues existed.

'Care Rounding' has been initiated which requires nursing staff to check with patients and, if required, to enter information into PES. This latter aspect was not planned for and is an issue for nursing staff and patients. A number of patients interviewed stated that using PES had been a problem for them during their admission to FSH.

7. Recommendations following the review of operational clinical and patient care at Fiona Stanley Hospital

These recommendations are based on the experiences of patients, their families and/or carers and FSH staff as told to the reviewers and in a number of instances from written complaints made to the Minister for Health, the Acting Director General and/or FSH about the care patients received.

The recommendations are also based on the observations of the independent review team and the discussions held with clinicians and the staff of the hospital. It is acknowledged that some of the issues behind these recommendations may no longer be matters of concern; however, they were evident or reported during the review and are here for completeness.

It is also appreciated that large and complex institutions need time to ensure that the policies and procedures which govern their activities have time to be embedded while ensuring good governance and integrated risk management and system improvements.

Recommendations Scope A

Review all of the complaints received by the hospital since commissioning, interview selected patients (and families) to gain additional detail and review the hospital's strategies to address the relevant issues.

The reviewers recommend that:

A1. Consideration be given to placing within the Emergency Department a mechanism for advising patients and their families/carers of current waiting times.

A2. Systems be put in place for the routine and as required change of bed linen not solely reliant on nursing staff to request these changes.

A3. A review of the cleaning of patient areas be undertaken with a view to initiating a program which least disrupts patients.

A4. Where appropriate, the needs of children in waiting areas be addressed.

A5. Systems be implemented which ensure that as far as possible discharge medications are waiting for patients to collect on discharge or that waits for pharmacy are kept to a minimum.

A6. Patients be provided with advice of changes to their medication pre-discharge so that should prescriptions be received post-discharge the patient understands the revised medication regime.

A7. A review be undertaken of the current outpatient booking system with the aim of ensuring that patients and their families/carers are provided with adequate notice of upcoming appointments and minimising 'no shows'.

A8. The FSH *Customer Liaison Service* changes its name to the *Patient and Family Liaison Service* to reflect the focus on patients and their families/carers.

A9. The Consumer and Community Advisory Council at FSH commence work with the Safety, Quality and Risk Unit to develop and implement key 'Patient Experience' performance indicators to improve the patient journey.

Recommendations Scope B

Evaluate the delivery of operational clinical care, including the impact on patients and clinicians, highlighting examples of what has worked, what needs improvement, and any risks and opportunities.

The reviewers recommend that:

B1. Externally provided IT services need continued enhancement and the development of 'deep links' within the various applications.

B2. A review be undertaken of the current structure with the aim of better distributing workload and responsibility across the streams during which consideration is given to the establishment of a separate fifth stream for midwifery, obstetric, neonatal and paediatric services and that a sixth stream be created to reduce the size and complexity of Stream 4.

B3. Senior management engage with a broader cross-section of clinical leads to hear first-hand of front line problems with consideration given to the establishment of a clinical council.

B4. A review be undertaken of the systems in place to transfer patient records between the relevant hospitals and that systems are put in place to ensure that records are available when clinicians consult with patients.

B5. An 'alert system' be implemented within the Outpatients booking system to allow clinicians to bring forward urgent patients over less urgent patients.

B6. Regular reviews be undertaken of the hospital's waiting lists for surgery to ensure that bookings have been made for the right surgeon at the right hospital and further that the initial review determine if there is a need for clinical supervision for the staff working on the surgical wait lists.

B7. South Metropolitan Health Service and the North Metropolitan Health Service look at establishing area-wide or metropolitan-wide coordination for various surgical subspecialties as already occurs for vascular surgery.

B8. A planning study be undertaken to inform FSH of its current and future demand for maternity and neonatal services so that human resources strategies can be better informed with the aim of ensuring access to adequate numbers of appropriately skilled personnel.

B9. FSH investigates the possibility of establishing its own casual pool of midwives.

B10. Should demand for gynaecological services within the hospital continue to expand, strategies be developed and implemented to ensure that this service is appropriately and separately staffed so as not to compromise obstetrics services.

B11. FSH gives consideration to the immediate appointment of a Quality and Safety Coordinator for Maternity Services.

B12. FSH considers the benefits of implementing a Midwifery Group Practice model of care.

B13. That the 'Care Rounding' model be reviewed in relation to where it is working well and where it is not; that the Care Rounding model be evaluated and an analysis occurs in relation to its impact on falls, pressure ulcers and complaints in the areas where it has been implemented; and that that these results are tabled at the Nursing Executive Council, partnering with Consumer and Community Advisory Council and the Clinical Governance Committee.

Recommendations Scope C

Evaluate the patient's experience of their care and make recommendations for improvement.

The reviewers recommend that:

See Recommendations Scope A.

Recommendations Scope D

Outline where the hospital is operationally performing well and efficiencies are being made; and assess where there are particular inefficiencies in the delivery of care and make recommendations for improvement.

The reviewers recommend that:

D1. Ongoing review of policies and procedures be undertaken to ensure compliance with the model of care and the patient-centred aims of the hospital.

D2. FSH Executive reviews the transparency of its decision-making and considers introducing general staff meetings where issues and decisions of interest to staff can be discussed.

D3. A benchmark review, against large Victorian or New South Wales Hospitals be undertaken, once FSH is bedded down, to assist realigning staffing levels to ensure efficiency levels are maintained, whilst not compromising patient safety.

D4. Service activity within Maternity Services be re-scoped to take account referral patterns and population growth within the catchment of FSH.

D5. Skill mix and staffing levels within the Maternity Services be reviewed to reflect the increased acuity and demand needs.

D6. As the gynecology services expand placing additional workload on registrars that resources are matched to workload to ensure that obstetric services are not compromised.

D7. Maternity Services should establish a safety and quality review process including morbidity and mortality review meetings and safety audits to review, track and action incidents and increasing caseloads.

D8. The development of a midwifery-led continuity of care model for low-risk pregnant women should be further considered.

Recommendations Scope E

Examine the resources currently provided and highlight areas of clear deficiency.

The reviewers recommend that:

E1. Continued efforts be made to emphasise with all staff regardless of their employment status that they are responsible to FSH and employed to serve the needs of FSH patients.

E2. Safety and quality issues arising with contracting services need to be managed judiciously by the FSH Executive team through its contract management process.

Recommendations Scope F

Examine the role, responsibilities and working relationships of the various staff groups.

The reviewers recommend that:

See all of the above Recommendations.