

Submission

No 84

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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Submission to Joint Select Committee Enquiry

Royal North Shore Hospital

From the Haematology Department, Royal North Shore Hospital

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Background to this submission and context of comments.

This submission is a representation from the Department of haematology at Royal North Shore Hospital. We care for people with blood and bone marrow cancers such as leukaemia and lymphoma and perform bone marrow transplants. Some members of the Department have worked at Royal North Shore Hospital for over 25 years. We are committed to this hospital and our primary goal is to provide the best care possible for our patients who are often in serious and life-threatening situations. In recent weeks we have received much encouragement and support from our patients who recognize the dedication, skill and commitment of the doctors, nurses and allied health staff. Unfortunately our ability to care for our patients has been compromised over the years through various problems including structural problems, system problems, inadequate resources and management issues. We do not seek to apportion blame to any party since we firmly believe that all of those involved in the health-care system have acted in the best interests of good health care delivery. In our opinion however poor decisions have been made through lack of information or misunderstanding or lack of available resources. It is in this spirit that we make this submission hoping to explain why Royal North Shore Hospital is now subject to a parliamentary enquiry. We offer potential solutions from our viewpoint. We recognize that many submissions have already been made covering several of the issues we will raise; however, by presenting this from the viewpoint of an individual busy specialty Department (haematology) we will demonstrate the effects of the problems at the most basic and functional unit of the hospital, i.e. the specialty Department and the patient wards.

This submission is organised under the relevant headings of the terms of reference.

1.

- a) Clinical management systems at the hospital
- b) Clinical staffing and organisational structures at the hospital
- c) The efficiency, effectiveness and appropriateness of resource allocation and the utilisation within the hospital, in particular the operation of the emergency department.
- d) The effectiveness of complaints handling and incident management at the hospital
- e) Operational management of RNSH in general but in particular, the interaction between area and hospital management as it relates to hospital efficiency, effectiveness and quality of care.

2. That the committee consider any strategies or measures in place or proposed for improving quality of care for patients at the hospital which may also benefit New South Wales' public hospitals.

Clinical management systems at the hospital

a) Issues relating to Departmental Clinical Managers.

The basic functional structure of the hospital is the specialty department, e.g oncology dept, haematology dept, etc. Each department is headed by a clinician, e.g. a medical doctor or allied health professional. The current system of departmental management uses Clinician Managers. These clinicians assume the management role of a department but generally maintaining a full clinical role. This places unrealistic demands on the Clinician Manager and therefore has a fundamental flaw. This dilemma is one issue at the heart of RNSH's problems.

Management responsibilities have become increasingly onerous over several years due to the devolution of responsibilities and tasks from other areas which have been slashed due to budget cuts. For example there is very limited human resources support and limited IT support. Many managers are put into these positions with little management training and little or no additional management support. In particular busy clinicians are expected to continue a heavy clinical load and yet take on the responsibility of managing a department which may have 20-50 staff and a budget exceeding a million dollars. There is no system for giving Clinician Managers backfill to cover clinical duties. Many clinician managers attempt to manage their department in the few moments between heavy clinical commitments but this is impractical and all aspects of their work suffer. Some of the duties required of clinician managers include performance appraisal, performance management, accreditation, policy implementation and planning, leadership, occupational health and safety, departmental finances, budget management and human resources management and recruitment. In recent years the burden of these tasks has increased because support services which previously shared these tasks, such as human resources, have also been victims of budget cuts.

In haematology we have an annual budget of over \$2 million for our Department. About five years ago the hospital stopped sending me printed monthly budget reports (**Appendix 1 - Cost Centre Report - Printed Format - Period Sept-99.pdf**). These were complex and not easy to interpret. However I met at least monthly with the allocated business manager and head of our clinical unit. In this way we could monitor the budget and sometimes make useful decisions. However despite my objections the hospital moved to making budget

reports available only in "online" format. This has been almost useless as the software is very poor. To reach any of the hundreds of individual line items, one must navigate screen by screen drilling down further and further to reach the details of a particular item. Then to get to another item one must start all over again (**Appendix 2 - Cost centre reports - Intranet Version - Screen Shots.pdf**). A detailed analysis of the department's budget would take hours. However, even after identifying all of the line items there is no easy facility for tracking these or graphing them. Then if one did identify a particular item of concern it would be a substantial project in itself to identify the facts surrounding the particular budget problem and then to implement some action. This would need to be done of course in my "spare time" between ward rounds, clinics, meetings etc. Another problem is the loss of a dedicated business manager to help the head of the department. Although the business managers are still present they are spread very thinly and serve multiple departments which is simply not practical.

The major financial problems of Royal North Shore Hospital are the sum of the multiple financial problems of each individual Department.

We suggest that it is at the level of the individual specialty Department and through the department head where the unique local solutions are most likely to be identified.

Clinician Managers remain an essential part of the organisation but they have continuing clinical burdens and in addition take on a full range of local management responsibilities. We believe it is no longer possible to perform both duties adequately without substantially enhanced support of both their clinical duties and management support. The failure to give clinician managers adequate support is a fundamental flaw in the organisational structure. Unfortunately, the history of the organisation has been to appoint committees and other managers to solve problems rather than addressing it at the departmental level which is the effective functional unit of the hospital.

Recommendation: Departmental clinician managers are provided with personnel to give enhanced support for their clinical practices and personnel to support business management activities.

b) Information Technology issues.

The failure to provide an adequate information technology infrastructure is another fundamental issue at the centre of Royal North Shore Hospital's problems.

Lost opportunities and poor decisions in IT planning date back many years. For example, Dr. Arthur was a member of a RNSH clinical committee headed by Dr. David Moore in the late 1980's. We extensively investigated and finally selected a comprehensive electronic medical record that would provide for clinical notes, pathology and radiology requesting/reporting and electronic ordering of investigations and medications. This was an intelligent system that would, for example, alert for drug interactions and duplicate pathology testing. Unfortunately just as we were about to sign the contract, the project was vetoed by the health dept. We were told that the Health dept intended to develop their own electronic health record and we are still waiting 15 years later. This is 15 years of potentially valuable experience in electronic records that has been lost.

Prof James Isbister, now an emeritus consultant, Clinical Professor of Medicine at the Northern Clinical School, was former head of the Haematology Department and was also

chair of the Hospital Clinical Computing Committee. Disillusionment and frustration with inaction ("obstruction") by the RNSH administration and the NSW Health Department of Health resulted in him resigning as chair and turning his efforts to developing the first departmental clinical computer network for clinical records in the Haematology Department. It should also be noted the RNSH Haematology department was the last tertiary referral hospital to have the laboratory services computerised. The requests for implementation were ignored for year after year, until it became so embarrassing to administration, as well as a quality and safety issue, that action was finally achieved.

Despite these setbacks clinicians have continued to explore clinical software systems and several have been identified that would provide comprehensive medical records including quality control functions, ordering and retrieval of pathology and radiology, safe electronic prescribing and even chemotherapy prescribing. Unfortunately we have been discouraged from finding our own solutions because of IT and Health Department policies. There are advanced electronic medical record systems already operating in other parts of Australia but recent advice indicates that implementation of a clinically useful New South Wales electronic medical record at RNSH is still several years away. The failure to implement currently available solutions is having a significant impact on clinical efficiency. Despite the discouragement, some clinicians have sought approval for various clinical systems but the administrative hurdles and the complexity of the business case for these initiatives is time-consuming and therefore very slow to complete.

Another example of the potential efficiency gains from a comprehensive clinical IT system is illustrated by an attempt to minimise high cost drug usage. On the basis of some clinical data the haematology department elected to reduce the usage of a high cost bone marrow stimulant used in leukaemia and bone marrow transplant patients. This medication has been shown to reduce the risk of infection, antibiotic usage and potentially shorten length of stay. Following the change in policy the pharmacy did record a reduction in drug costs in the order of 5-10,000 dollars per month. However in the absence of adequate reporting systems we have no way of knowing whether the financial benefit has been offset by increased antibiotic usage and increased length of stay and potentially increased morbidity. In fact there is data to show that the use of such drugs is cost effective because it minimises other costs. This is only one simple example of how clinicians are operating "in the dark" to some extent. Ultimately the provision of best quality of care requires basic clinical data.

It is particular disappointing that financial reporting systems have been developed to such a high degree and if clinical reporting systems were regarded with the same importance we would be much further advanced in clinical quality.

Comprehensive electronic medical records and electronic clinical information delivery improve safety (e.g. see *Wilcox and Whitman. Reduction of medical error at the point of care using electronic clinical information delivery. Int Med J 2003*). In cancer therapy it is important to have readily available records. We are aware of errors due to inadequacy of paper records and reported these to the hospital administration. We recommended that the solution to this problem was to implement a chemotherapy software prescribing system. So far this recommendation has not been implemented. Dr. Arthur is trying to prepare a business case but has been working on this for over 6 months. It is also interesting that a colleague in IT at another hospital expressed his surprise that the Doctor had to do the business case for an IT solution. In his hospital such projects were done by the IT staff in consultation with the clinicians. Sadly this should be the norm but the RNSH IT department has also been a victim of funding shortages and we understand they have very limited capacity.

Recommendation: clinicians are supported to implement appropriate clinical software systems until the implementation of the fully functional NSW electronic medical record (complete with pharmacy/prescribing modules and other clinically relevant tools).

Clinical staffing and organisational structures

a) Workforce deficiencies.

Our experience with the heavy work load tells us that the current workforce is inadequate. Estimates of the available haematologists and oncologists in our Area health service show that we are below the recommended benchmarks according to the Australian Medical Workforce Advisory Council. Recommendations to appoint additional staff in the past have been rejected by administration because of the budgetary crisis. In response to the crisis in my own Department I prepared a 22 page business case documenting the effective reductions in our workforce over previous years and the increased workload. Based on the figures I requested the appointment of two additional haematologists. After a prolonged delay it was ultimately agreed to appoint one position. In our opinion we are still deficient. The most disappointing aspect of this exercise was that a departmental manager could put many hours into preparation of a case which was acknowledged by the appointments review committee as valid and justified, yet ultimately a good business case was rejected because of the budget crisis once again.

The workforce deficiencies have extensive repercussions which affect our efficiency, the quality of care that we can provide, the supervision for junior medical staff, the development of a cohesive nursing and medical ward team, teaching and research capabilities and many other important aspects. Very importantly however the intensity of the workload, especially in a demanding field such as haematology/oncology, is taking a significant emotional, social and psychological toll on my staff. Many evenings and weekends with family have been hijacked by the demands of the work which cannot be accomplished during a normal day.

An AMA report also has interesting comments concerning the burdens on senior hospital consultants:

"A hospital administrator commented that a major reason hospitals are unable to provide flexible work arrangements is the administrative burden placed on senior consultants. In addition to the clinical and training duties, consultants are required to manage a vast amount of paperwork and data that could readily be managed by an administrative assistant or "data manager". The volume of data provided to consultants has increased with the development of electronic communication. Much of this information is irrelevant to the consultant's immediate practice. It was felt that the provision of data managers to senior consultants with training duties would be of significant benefit to both a senior consultant and the junior doctors under his/her supervision." (Report on consultations with key stakeholders on the flexibility in medical training and work practices. Prepared by the Australian medical Association, March 2003).

The stress on the workforce at RNSH also has repercussions with a major Area partner, i.e. Gosford and Wyong hospitals. A similar crisis in oncology/haematology workforce also exists at Gosford and a recent plea for help could not be supported because of our own

workforce crisis. This is a very important point for the health planners to recognize. With the new Area structure linking larger and smaller centres, then it is more important than ever to have a strong and resilient major centre so that they can assist their brothers in the smaller centres. I am aware of patients with a newly diagnosed cancer who need to wait several weeks for an appointment with an overburdened oncologist at Gosford. In desperation some patients travel to see an oncologist at Royal North Shore Hospital and I am aware of one patient who had to be given a 6:30 a.m. appointment because the RNSH oncologist was already overbooked.

The crisis in the nursing workforce is also well-known. We believe that part of the solution to this problem will require the return to specialty wards and recreation of cohesive specialised teams (see below). However another new role in cancer nursing is the "cancer care coordinator" which has been promoted with seed funding from the cancer Institute of New South Wales. This has been a great success and should be enhanced. The expansion of these positions would substantially enhance the quality of care and is one of the high priorities voiced by cancer consumer groups. Recent attempts to employ more care co-ordinators has been rejected because of budgetary constraints.

Recommendation: ideally the workforce deficiencies should be corrected by appointment of sufficient specialists in line with accepted national and international benchmarks. This is particularly relevant for haematology/oncology. A second-best option is the appointment of an assistant for senior consultants such as a data manager or physician assistant/support person.

b) The loss of specialty wards.

Approximately 5-6 years ago the haematology ward and renal wards were combined into one ward despite advice against this from the medical staff. This was part of cost saving measures that have seen one ward after another closed. The staff were informed by the senior management that we were continually over budget because of excessive "clinical activity" and the best way to reduce budget overruns was to cut clinical activity and this could be achieved by closing wards. Essentially this meant that we were treating too many patients and the hospital could not afford it even though the treatment was appropriate. The contraction of ward space means that a specialty unit's patients can no longer be accommodated in a home or specialty ward because wards are now mixed with multiple specialties. In a typical week the haematology department could have patients spread across 4-6 separate wards. This is very inefficient and the health department's own information shows that patients who are managed outside their own specialty ward have **increased length of stay, increased morbidity and increased mortality**. The haematology department has made recommendations to the hospital managers that we should return to specialty wards and a major submission detailing this proposal has recently been submitted but so far there has been no response to our proposal.

Another adverse consequence of the ward closures and contraction is an increased risk of cross infection. It is recognized that the haematology and renal patients are two groups most vulnerable to infections with resistant bacteria. It seems illogical in our opinion therefore to have these two specialties co-located in a single ward. This concentrates the risk of cross infection. The risk is real since there have been 2 general evacuations of the haematology/renal ward in last 9 months to contain infection outbreaks. Fortunately these have been successful but moving an entire ward of sick people to another induced ward is a difficult task. Interestingly, when Westmead haematology ward faced a similar infection

problem they took prompt action in unity with their CEO by taking the issue to the health department. The health Department acted swiftly by recognising this as a major risk management issue and fast tracked \$5 million for a ward upgrade.

Finally, another adverse consequence from the aggregation of different specialties into one ward is the effect on nursing staff recruitment, retention and job satisfaction. My nursing colleagues have commented that in a teaching hospital such as RNSH much of the joy and satisfaction in nursing comes from participation in a cohesive specialist team such as a specialist haematology or renal unit. Following the amalgamation of renal and haematology wards there was an exodus of many highly skilled nursing staff in each of these fields. Despite our best efforts it has been difficult to recreate the productive and highly effective team of doctors and nurses that previously existed. In our opinion the loss of the specialty team structure increases the difficulty in nursing recruitment and retention. This is supported by the research and for example the publication by Adams et al (*Hospital nurses job satisfaction, individual and organisational characteristics*. J Adv Nurs 2000:536-543) is very interesting. Some extracts from the paper are:

“While hospital level variables are influential, the ward as a physical and social organizational unit probably remains the most significant unit of analysis when examining determinants of nurses' feelings about their work and patient outcomes.”

“The importance of the ward as an organizational unit has also been demonstrated. Ward culture was found to have a pervasive influence over patterns of nurses' behaviour and their views of the work environment.”

“Nurses do not work in isolation and, as well as relationships with nursing peers, their relationships with medical colleagues are important features of the work environment. The quality and quantity of interaction with medical staff is particularly influential in how nurses regard their work.”

It is noteworthy that 6 years ago I wrote to Ms Joanne Fisher (acting executive director RNSH) noting these same problems of losing specialty wards and the potential risk of cross infections. There was no action taken to address my concerns.

Recommendation: the creation of specialty wards is promoted.

c) Concerns about the New Hospital Redevelopment.

There is particular and urgent concern over the apparent inadequacy of the new RNSH redevelopment. We have not been informed of the final bed number for the new hospital and fear that it will be inadequate. We were told that the cancer ward would be a 30 bed ward but we currently run at approximately 35-50 beds. Furthermore there is predicted to be a 30% increase in the incidence of newly diagnosed cancer patients in the next 10 years and an even greater prevalence of cancer patients due to prolongation of survival. It is illogical therefore to plan for less beds than we currently have. In response to questions about the inadequate bed numbers Dr. Arthur was informed that if we needed more beds we would have to argue the case and if successful then we would take beds away from other specialties rather than consider increasing the total bed base to accommodate the predicted increases in number.

The need to preserve a comprehensive multidisciplinary hospital. Another concern is that the limitations on the bed numbers in the new hospital will force out minor specialties.

Already an agenda has been proposed to move certain surgical specialties to other sector or regional hospitals such as Ryde or Hornsby. This should be discouraged. The strength of a tertiary teaching hospital lies in its diversity and multi-disciplinary nature. Fragmentation of services for the sake of utilising unused theatre space in district hospitals is not a good reason to fragment the comprehensive service currently available. Managing cancer patients in particular requires the complete range of colocated services. There is no such thing as a totally independent service and all subspecialties in medicine and surgery synergise with each other at some time.

Recommendation: the proposed bed numbers for the acute inpatient services in the new hospital development is revealed and clinicians are given opportunity to scrutinise the formulas used to derive the bed number. Disagreements about the appropriate bed numbers should be resolved by independent evaluation.

**The efficiency, effectiveness and appropriateness of
resource allocation and the utilisation within the
hospital, in particular the operation of the emergency
department**

a) Capital and infrastructure deficiencies.

RNSH has been substantially underfunded in comparison with other Area Health services (**Appendix 3 - Capital Expenditure of comparative AHS over 10 yrs.pdf**). The attached chart was given to Department Heads about 4 years ago by Mr Peter Lemon (deceased) who was the project manager for the new hospital redevelopment at RNSH. Mr Lemon explained that these figures had been obtained from the health Department and acknowledged that RNSH had been substantially underfunded for capital equipment over the preceding 10 years and this was one of the justifications for proceeding with the new hospital development. The share of capital funding received by RNSH per capita from 1990 to 2000 was approximately 10% of the average given to each other area health service. Northern Sydney AHS received \$70 million yet the expected on an equitable \$/capita basis would have been \$692 million. The magnitude of this discrepancy is potentially even greater because we have heard from various administrators over the years that capital funding was being diverted into the general operating budget because of the perennial shortfall in the allocated budget.

The failure of capital funded building works was felt severely in the haematology and oncology departments. Because of the high risk of cross infection in patients with cancer, particularly those with leukaemia or bone marrow transplant, we urged the administration over several years to refurbish the cancer wards. Despite promises year after year that we were next on the list, the refurbishments would stall because of the annual budget crisis whence all refurbishments were put on hold. After several years of inaction the wards were finally refurbished due to funding from a bequest that was directed specifically to a cancer ward and a fund-raising marathon swim that was directed specifically to a leukaemia ward. If it wasn't for these fortuitous offerings we suspect the wards would still be in their decayed state. Surely this is an unsatisfactory way to run a health system.

The lack of capital funding also extends to essential items of equipment. Throughout our Department many of the pieces of equipment have been from donations. This amounts to

more than \$100,000. One illustrative example of the extent of this problem occurred when attempting to replace a failing bone marrow cryopreservation tank. This is an essential piece of equipment for bone marrow transplantation. My request for replacement was rejected by the business manager because we were "over budget". There was no opportunity for discussion. Yet we had already "saved" the hospital tens of thousands of dollars by purchasing equipment from donations. None of this external funding is ever credited in favour of our budget. Any responsible accounting system should surely record all funding entering the system but it seems convenient to ignore the contribution of donations. In reality the shortfall in capital funding is greater than it appears because the system has been propped up for so long by donations which mask the true deficits.

Another illustrative example concerned the occurrence of fungal infections in the ward several years ago. We suggested that the air-conditioning system could be a contributing factor and recommended replacement with a special filtered air system (HEPA filtering). The story received some media attention. The health Department denied that there was any problem but a colleague at Royal Prince Alfred subsequently thanked Dr Arthur because RPAH recognized the problem and acted upon it by installing HEPA infiltration in their leukaemia ward. Dr. Isbister and Dr. Arthur meanwhile were subjected to an angry retaliation by a previous general manager and informed that this event would severely damage our standing within the health Department and would likely have negative consequences for years to come.

Recommendation: RNSH is provided with an equitable and realistic capital funding program. Capital funding must be protected from use in operational costs and the utilisation of capital funding should be managed in collaboration with clinicians.

b) Funding and Resource issues.

It has been stated that treatment costs at RNSH are higher than treatment costs at other similar hospitals. As far as we know none of this costing has been linked to clinical outcomes. This is a fundamental error that leads to a misleading interpretation of the data. Although health can operate on some broad business principles, health care is intrinsically different to a business operating for profit where maximisation of profit is the primary consideration. However in health, it is self-evident that the community primarily desire optimal outcomes and the cost issues are secondary. Good health management saves lives and returns people to productive lives. In haematology and oncology, sub optimal treatment is likely to result in premature mortality which is actually significantly cheaper because the cost of treatment is proportional to the durations of drug use and supportive care. It is obvious that the public would prefer a more expensive treatment that saves lives compared to a cheaper treatment with increased mortality. Patients who die quickly cost less. Hence until cost data is linked with outcomes it is misleading to make interpretations suggesting that RNSH has poor performance. Indeed, if the haematology department at Royal North Shore Hospital is more expensive than its peers, a very reasonable interpretation is that our patients are surviving and therefore alive to receive further therapy. Another error that we suspect the Health Dept analysts have not seen is the changes in practice whereby procedures once performed as an inpatient are now performed as an outpatient. Since the DRG analyses are performed on in-patients it ignores the outpatient activity. We have pioneered outpatient/ambulatory care bone marrow transplants which reduce a typical 3-4 week Length of Stay down to zero. We also convert a costly procedure as an inpatient into a revenue generating ambulatory procedure. Yet a substantial favourable change in the DRG cost weight would be completely lost because the patient is never admitted. In fact the patients

who are now admitted are the sickest of the sick and so clearly the cost weights will be biased against us because we are selectively changing the good risk patients from inpatient to outpatient treatment.

We suspect that health dept financial analysts working with data in isolation from the new clinical paradigms has resulted in misleading conclusions.

Recommendation: the health Department exercises extreme caution and recognizes the invalidity of cost data for treatments that do not match this against clinical outcomes. Secondly, it is recommended that every effort is made to implement reliable clinical outcome reporting systems. Health analysts are encouraged to work closely with clinicians to check the validity of the assumptions used in data interpretation.

c) Fallacy of the argument for factoring private insurance and private beds into funding of RNSH.

It is understood that funding formulas for RNSH factor in the relatively higher number of private beds and higher private insurance in our Area. We believe this approach could be based on false premises.

The details of the formula need to be revealed. In our experience, rather than relieving the financial pressure on the public hospital, the presence of the private hospitals could have the opposite effect. Firstly, we do not know if the health Department has factored in the proportion of patients in the private hospital who are actually outside the Area Health Service. Many patients come from far away and it's possible that less than 50% of the private beds would otherwise be available for local residents. Did the health Department formula include total numbers of private beds or do they have accurate figures of the private beds used by local residents alone.

A second negative impact of the private hospitals is that they preferentially take privately insured, revenue generating patients away from the public system. So in fact the more private hospitals available then the greater is this negative impact.

Finally, it is common practice for patients who start off in the private system to be transferred to the public system when treatment costs are no longer reimbursed or costs cannot be recovered. For example Dr Arthur was recently referred a patient who was being managed through a private haematology/oncology clinic within the Area. The treatment recommended involved several high cost chemotherapy drugs which were not available through the normal PBS system. It would be unethical to refuse such a patient and so the patient was accepted for treatment at RNSH. Once again the most expensive patients are selectively funnelled into the public hospital system and revenue generating private patients are biased towards the private system in our Area.

Hence, it is possible that the greater number of private hospitals and clinics in our area could, paradoxically, have a negative impact. Since clinicians have not been consulted about potential errors in the formulas, nor have we seen the data that is used, it's possible that the current resource distribution formula is erroneous. We do not know the true answer but offer this explanation, with real life examples, as a logical alternative and challenge the assumptions which we believe should not have been taken for granted.

Recommendation: The assumptions, the actual data and the formulas used to calculate the resource distribution formula for RNSH are made transparent and compared with similar hospitals in other Area Health Services.

The effectiveness of complaints handling and incident management at the hospital

a) Unreliability of Adverse Incident reporting.

It is possible that a review of the incident information management system (IIMS) would suggest there are a few problems in our departments. However this system is flawed because serious incidents are not being entered. Serious incidents are not being reported by doctors because they are so overwhelmed by clinical workload that it is not possible to provide necessary treatment and also spend time filling in incident reports. For example, some oncologists and haematologists have so little time during a busy day that they are compelled to writing up essential chemotherapy prescriptions late in the evenings so that urgent treatment is provided for cancer patients. When the situation is so stressed even a few spare minutes cannot be found to locate a computer and navigate through multiple screens, recall, find and then enter data about an incident. We therefore believe that the IIMS system is not a true reflection of the adverse incidents.

Recommendation: as noted above the appointment of data managers/physician support personnel who work with senior clinicians would solve this problem.

Operational management of RNSH in general but in particular, the interaction between area and hospital management as it relates to hospital efficiency, effectiveness and quality of care

a) The Futility of business planning process.

Over many years the Haematology Department has been involved in repeated planning exercises (See attached for reference only – **Appendix 4 – EQUIP Planning work book, and Appendix 5 – Haematology Business Plan 2006**). Unfortunately these seem to be done for the sake of doing it rather than accomplishing an outcome. It is also disappointing that time and time again the same themes are raised. Inevitably the planning process is paralysed by the perennial lack of resources, the burdens of the day-to-day workload and apparent lack of decision-making from the top to endorse our plans. The main achievements have occurred not because of good planning but because of serendipitous donations of funds. My comments from the summary business plan written to Professor Bruce Robinson, Head of Division of Medicine in 2006 summarises the disillusionment (**Appendix 5 – Haematology Business Plan 2006**):

“Note about previous business plans, development plans, service plans. Over the last 10 years we have participated in many planning activities and as a department spent many hundreds of man hours in these activities which result in the production of lengthy documents which are then submitted to administrators. The EQUIP planning process several years ago was a major effort with at least 20 meetings attended by the majority of clinical staff and many nursing staff and allied health staff. A major document was produced and as far as I can tell this has just gathered dust. There was no feedback from administration and no clear evidence that the process had any positive effects over the next few years. Then in 2004 we had the “Service Planning Review” meetings run by Dr. Tony Penna. Once again I gathered the whole department for meetings and we prepared yet another lengthy document about our departmental activities and business plans. I have never had any feedback about the outcome of this review, nor have I seen any evidence of a positive outcome from this time consuming process. Hence, I trust that this new summary of many self evident issues and solutions will be taken seriously and that we will at least receive some feedback and positive action from our hospital administration. “

It is instructive to note that nearly 10 years ago in the EQUIP planning workbook we noted staff shortages, deficiencies in the IT systems and data collection (**Appendix 4 – EQUIP Planning work book**). Most interesting is a comment under section 2.1 about haematology outliers (patients not in their specialty home ward) being compromised and the need to transfer such patients to the home ward. Our observations have been validated by the latest evidence.

We were encouraged to participate in the time consuming EQUIP program and other planning activities because we were assured that if we wanted the system to change it would be activated through the planning process. Administrators were compelled to listen because it was part of accreditation and so they would “listen and act”. Unfortunately the planning process has been a failure. It is a smokescreen to give the appearance of doing something productive but our recommendations have been ignored whenever funding is required and recommendations dependent on our staff have failed because of the busy workloads.

b) Chief executives and senior managers have a fundamental conflict of interest.

We sympathise with the impossible situation that our hospital and Area managers face. We understand that their contracts have financial performance indicators. We presume that this means they are under contractual obligation for the hospital to come in on budget targets. Certainly there must be an obligation for clinical performance as well however the history of decision-making in recent years suggests that the financial priorities have superseded the clinical priorities. This was evident with the progressive closure of hospital wards in order to reduce clinical activity and thereby reduce expenditure. We can think of few situations where one’s own livelihood and job security conflicts with the interests of providing optimal health care. Such an arrangement may work well in the profit-making business sector but in our opinion is a poor model that puts individuals in such impossible situations. We should consider how we would respond if faced with a decision to close a ward or keep it open at the risk of jeopardising our job. Only an individual of exceptional courage and integrity would risk his livelihood to do the right thing.

Recommendation: many models of decision-making have been tried and all have their failings and benefits. However clinicians would welcome greater participation in a genuine model of shared decision-making as once existed with hospital or Area boards executive management groups.

CONCLUSION

In conclusion the haematology department recognises several problems which in our opinion have inhibited the delivery of quality care to patients. We have solutions to these problems but implementation has not occurred for reasons which include lack of funding, lack of management support, and financial decisions which have been contrary to advice from clinicians but based on financial imperatives rather than quality medical practice considerations.

Solutions to these issues and restoration of high quality care in haematology and cancer medicine would require:

1. Increase in medical staff – haematologists, registrar positions.
2. Increase in nursing staff, particularly cancer care co-ordinators
3. Support for Clinician Managers with backfill for clinical workload and business management support.
4. Implementation of software to solve chemotherapy errors and enhance clinical information.
5. A realistic re-appraisal of the bed numbers required for the service and independent scrutiny of the resource distribution formulas with clinical input.
6. Reconfiguration of current generic wards with a return to specialty wards.
7. Genuine and effective participation in management of our departments.

APPENDICES:

Appendix 1 - Cost Centre Report - Printed Format - Period Sept-99.pdf

Appendix 2 - Cost centre reports - Intranet Version - Screen Shots.pdf

Appendix 3 - Capital Expenditure of comparative AHS over 10 yrs.pdf

Appendix 4 – EQUIP Planning work book

Appendix 5 – Haematology Business Plan 2006

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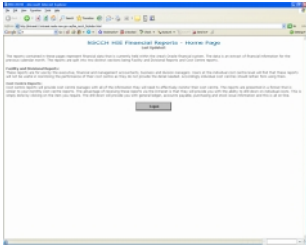
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Cost Centre or T Fund=52056 (52056: Haematology Laboratory - Manly), Facility & Fund Class=201 (RNS:General), Program or T Fund Group=23 (Prog 2.3 Support of Area Health Service s)

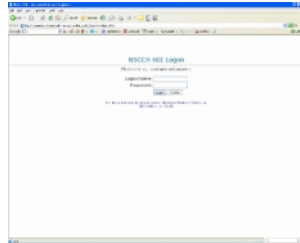
		*****PERIOD*****		*****YEAR TO DATE*****			
Account	Project	ACTUAL	BUDGET	ACTUAL	BUDGET	VARIANCE (# > \$2000)	FULL YEAR BUDGET
<u>SUMMARY INFORMATION</u>							
<u>DIRECTLY CONTROLLABLE ITEMS</u>							
DIRECTLY CONTROLLABLE EXPENSE							
Sal & Wages(excl OT, AL,LSL & REDUNDANCY)		131,190.76	101,841.00	372,795.59	312,309.00	(60,486.59)	1,233,960.00
Overtime		5,097.32	6,486.00	16,079.47	19,892.00	3,812.53	79,130.00
Annual Leave Expense		11,848.71	14,560.00	37,672.02	44,652.00	6,979.98	177,640.00
Long Service Leave Provision		(16,108.72)	1,953.00	14,445.07	5,991.00	(8,454.07)	23,828.00
S/Total Employee Related Exp		132,028.07	124,840.00	440,992.15	382,844.00	(58,148.15)	1,514,558.00
Goods & Services		83,353.68	43,966.00	128,803.86	119,344.00	(9,459.86)	452,484.00
Repair & Maint		30.15	0.00	710.78	0.00	(710.78)	0.00
Internal Trading Entities		0.00	0.00	653.00	0.00	(653.00)	0.00
TOTAL DIRECTLY CONTROL EXPENSE(Excl Asset Acq)		215,411.90	168,806.00	571,159.79		(68,971.79)	1,967,042.00
DIRECTLY CONTROLLABLE REVENUE							
Other User Charges		(150.00)	(195.00)	(610.00)	(599.00)	11.00	(2,381.00)
Other Sources of Revenue		(15,090.52)	(7,845.00)	(21,304.27)	(24,059.00)	(2,754.73)	(95,710.00)
TOTAL DIRECTLY CONTROLLABLE REVENUE		(15,240.52)	(8,040.00)	(21,914.27)	(24,658.00)	(2,743.73)	(98,091.00)
TOTAL CONTROL POSITION TO BUDGET(Excl Asset Acq)							
		200,171.38	160,766.00	549,245.52	477,530.00	(71,715.52)	1,868,951.00

Example of multiple screen navigation to see a single line item of monthly cost centre

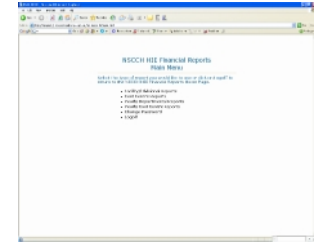
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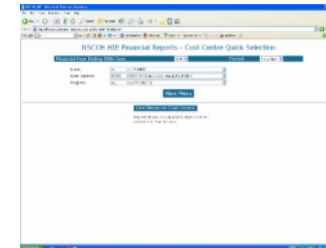
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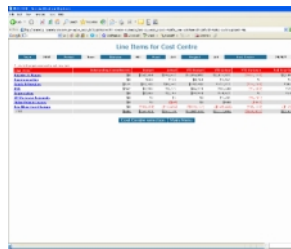
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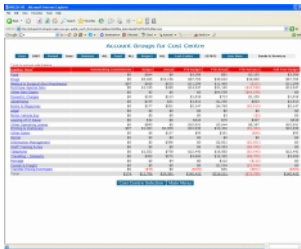
Select month/year
Insert Cost centre codes



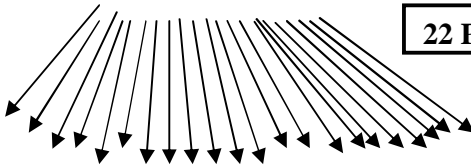
Select first level
line items



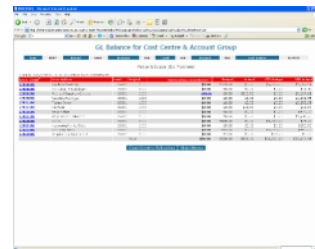
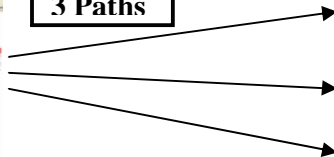
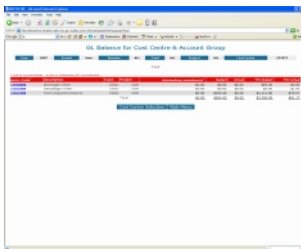
Select first level
line items – 8
pathway choices



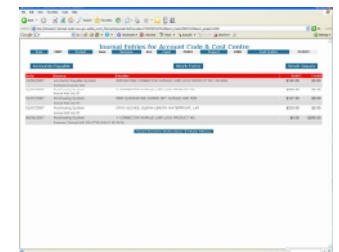
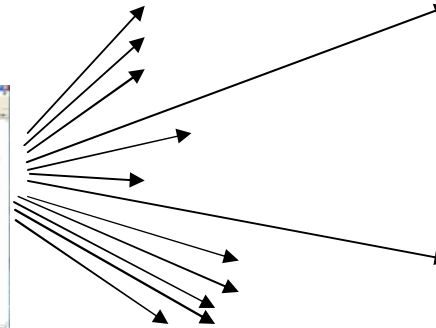
22 Paths



3 Paths



12 Paths



Capital Spending per capita 1989/90 to 2000/01

AHS	\$M*	% \$	Population	% Pop	\$/capita
WSAHS	545.01	14.5%	645,132	13.5%	845
WAHS	264.41	7.0%	301,934	6.3%	876
SWSAHS	630.54	16.7%	731,615	15.3%	862
SESAHS	864.07	22.9%	742,801	15.6%	1,163
NSAHS	70.28	1.9%	752,339	15.8%	93
IAHS	260.17	6.9%	334,904	7.0%	777
HAHS	427.20	11.3%	521,785	10.9%	819
CSAHS	531.50	14.1%	473,062	9.9%	1,124
CCAHS	174.28	4.6%	270,556	5.7%	644
Total	3,767.46	100%	4,774,128	100%	789
Average	3,697.18		4,021,789		919
* CPI adjusted to represent current year dollars					
Expected \$ for NSH on an equitable \$/capita basis				\$692M	

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CONTINUUM OF CARE

CONTINUUM OF CARE						
Std No	Standard	Evidence of Achievements and Improvements	Rating	Action Required and Expected Outcomes	By When	Person Responsible
1.0	STANDARD 1 ACCESS The organisation is accessible to the designated community	Outcomes Achieved for the Standard			June 1998	Chris Arthur
1.12	CRITERIA The community that the organisation serves is defined and information gathered on its requirements is used for the planning and provision of services.	Structure/process: • All patients registered on Haematology database Outcome: • Easier access to patient information	SA	Expected Outcome: • Extend data base to reflect complete clerical record and demographics • Utilise data, improve service provision Action: • A commitment from several HMO's towards clinical base information system (1980's) • To explore options at a later point in time	1999	CA
1.2	The community is made aware of services that the organisation provides.	Structure/process: • As per generic workbook + 12D Outcome:	MA	Expected Outcome: • To promote public education Action: • To develop education initiatives within constraints of resources	1998 A	SB
1.3	The organisation and services within it can be easily located	Structure/process: • Maps sent to % of new outpatients (Dr Isbister) Outcome: • Not all outpatients receive map	SA	Expected Outcome: • Improve access to clinics Action: • Haematology Director to instruct clerical staff to give out maps	1998 B	CA
1.4	Physical access to the organisation is appropriate to the needs of the community	Structure/process: Refer to generic workbook Outcome:		Expected Outcome: Action:		
1.5	Hours of operation of various services of the organisation are appropriate for the community served and for the role of the organisation. The community is made aware of the hours of operation of the organisation.	Structure/process: • 12H is not open after 4.00 pm; not open weekends, public holidays - hours/Pharmacy not adequate • Monday/Friday no CD 34 performed after hours/pnareses Outcome: • Patient care is compromised	SA	Expected Outcome: • Increase resources - human, equipment venue • Autologous blood donation clinic extended Action: • Keep records/statistics. Ward clerk to provide diary for after hours patients • Represent data to appropriate people • Review of pharmacy hours	1998 B	NS CT KG

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1.6	If emergency services are not available, or are restricted, instructions guide access to available services.	Structure/process: • Casualty closes LTO Outcome:	NA	Expected Outcome: • Not to occur Action: • Keep a diary to keep number of problems. • Report to various bureaucrats the problems	1999	KG & other Haematologist
2.0	STANDARD 2 ENTRY The process of entry to the organisation meets patient/client needs and is facilitated through effective systems and a suitable environment.	Outcomes Achieved for the Standard				
2.1	CRITERIA An arrival process for patients / clients and carers addresses their needs and enables efficient and timely entry to the organisation.	Structure/process: • A & E • Elective • Programmed bed • Preadmission clinic • Outlies Outcome: • Working well for programmed beds • Not all get preadmitted. Clinic would improve admission process	MA	Expected Outcome: • To improve pre-admission process. Action: • Set up preadmission clinic to facilitate admission. Would need venue, human resources • Haematology outlies at times are compromised and need transfer in timely fashion • Frequent discussions with Clinical Bed Manager and meeting has been organised with Clinical Bed Manager	1998 A	BMT coordination 12P coordination
2.2	Information necessary for efficient patient/client care is obtained and communicated prior to arrival, when appropriate	Structure/process: • Most as per generic workbook Outcome:	NA	Expected Outcome: Action: • Electronic generation of form - template on RNSH paper and lack person to generate information - ↓ paper waste • Information Workgroup to be notified of the above	1999 C	JPI
2.3	Assessment needed before admission is completed, documented and communicated to relevant persons	Structure/process: • Patient is assessed in VMO's rooms • Residents and registrars will complete forms Outcome: • Works well	MA	Expected Outcome: • Review process Action: • Monitor statistics	1998 A	KG
2.4	Informed consent is obtained by the health professional responsible for the care of the patient/client	Structure/process: • As per generic workbook • Follow hospital policy Outcome: • 100% have signed consent	HA	Expected Outcome: Action:		
2.5	All patients/clients are informed of their rights and responsibilities including providing relevant information for the delivery of care	Structure/process: • There is a Document of Rights (corporate) Outcome: • All new patients are given documentation • Follow Corporate Policy • Elicit and develop guidelines	HA	Expected Outcome: Action: • If non English speaking people are admitted, interpreter service notified	Ongoing	

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2.6	Ongoing communication occurs and information relevant to their care is conveyed in a manner that is understandable by, and readily accessible to, patients/clients, carers and all relevant providers eg Cardiac Surgery, Renal Transplantation	Structure/process: <ul style="list-style-type: none"> Bone marrow patients are kept up-to-date by BMT co-ordinator Review process of transferring patients between locations - 12D Error! Reference source not found. Outcome: <ul style="list-style-type: none"> Works well 	HA	Expected Outcome: <ul style="list-style-type: none"> Continue improvement Action: <ul style="list-style-type: none"> Documentation re transfer 12D à 12H developed. 	Ongoing	
2.7	Throughout the care process care providers document all aspects of care necessary to assist communication	Structure/process: <ul style="list-style-type: none"> Hospital wide charts Nursing care plan Flow chart Outcome: <ul style="list-style-type: none"> Not able to measure compliance of medical notes Variation in quality of standard 	MA	Expected Outcome: <ul style="list-style-type: none"> To improve Action: <ul style="list-style-type: none"> Review of documentation 	1998 B	SK (sub-committee)
2.8	Planning for separation begins at first contact with the organisation and is ongoing throughout the continuum of care	Structure/process: <ul style="list-style-type: none"> BMT is variable time All patients are referred to health professionals As per generic workbook Outcomes: <ul style="list-style-type: none"> Planning for separation begins at first point of contact 	HA	Expected Outcome: Action:		
2.9	Separation planning is interdisciplinary, coordinated and involves patients / clients, carers and all relevant external providers necessary for a coordinated approach to continuing care and separation	Structure/process: <ul style="list-style-type: none"> Interdependency referrals Outcomes: <ul style="list-style-type: none"> Twice weekly meetings to discuss patients NUM refers patients on day of admission 	HA	Expected Outcome: Action:		
3.0	STANDARD 3 ASSESSMENT Patient / client care planning is supported by comprehensive assessment.	Outcomes Achieved for the Standard				
3.1	CRITERIA A comprehensive assessment of the patient/client is performed by professionals with appropriate skills.	<ul style="list-style-type: none"> Structure/process: As per the generic workbook. Pharmaceutical assessment. Outcome: <ul style="list-style-type: none"> As per the generic workbook 	HA	Expected Outcome: <ul style="list-style-type: none"> Comprehensive/integrated assessment process to ensure a co-ordinated approach to care is provided. Action: <ul style="list-style-type: none"> To research other tools in use and review the feasibility of developing a Haematology specific assessment tool. In this review the needs of 12D and 12H are to be considered. Develop an electronic database and clinical record. 	1999	CA/JI
3.2	Assessment is coordinated to reduce unnecessary repetition.	Structure/process/Outcome As above 3.1	HA	Expected Outcome/Action As above 3.1	1999	

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4.0	STANDARD 4 CARE PLANNING A coordinated plan of care, incorporating goals, is developed through collaboration between patients / clients, carers and the health care team to achieve desired outcomes.	Outcomes Achieved for the Standard				
4.1	CRITERIA The plan is developed in consultation with patients / clients and carers and provides for the relevant clinical, social and emotional needs of the patient / client and carers.	Structure/process: <ul style="list-style-type: none"> Transplant clinical pathway. Breast protocols, chemotherapy protocols, mobilisation of stem cells. Outcome: <ul style="list-style-type: none"> Works well 	MA	Expected Outcome: <ul style="list-style-type: none"> Evaluate the clinical pathways that have been developed. Action: <ul style="list-style-type: none"> Develop an evaluation tool. Review planning process and collaborate with other areas within this organisation. 	1999	BMT coordination
4.2	The plan includes the goals to be achieved, services to be provided, time frames to be met, and resources to be utilised.	Structure/process: <ul style="list-style-type: none"> The care plan is currently undergoing a review process. Outcome: <ul style="list-style-type: none"> As per the generic workbook. 	SA	Expected Outcome: <ul style="list-style-type: none"> The new planning tool will improve patient planning. Action: As above.	1999	12D Nurse Education
4.3	The plan of care facilitates a coordinated approach and includes delineation of responsibilities.	Structure/process: <ul style="list-style-type: none"> Team conference twice weekly to plan delineation of responsibilities. Outcome: <ul style="list-style-type: none"> As per generic workbook. 	MA	Expected Outcome: <ul style="list-style-type: none"> Improve case conference documentation. Action: Explore other options to the documentation of case conference planning and outcomes.	1998	NUM (KG)
4.4	The organisation's policies are used as appropriate when planning care, including those which relate to withdrawal of life support, not for cardio-pulmonary resuscitation and organ donation.	Structure/process: <ul style="list-style-type: none"> As per generic workbook. Outcome: <ul style="list-style-type: none"> As per generic workbook. 	MA	Expected Outcome: <ul style="list-style-type: none"> Improve Action: Foster and encourage discussion of patient's NFR status at case conferences. Explore as a team issues relating to patients wanting ongoing treatment.	Ongoing	CA
5.0	STANDARD 5 IMPLEMENTATION OF CARE Care delivery is coordinated and provided according to the needs of the patient / client, and the plan of care.	Outcomes Achieved for the Standard				
5.1	CRITERIA Care is timely and appropriate.	Structure/process. <ul style="list-style-type: none"> Programmed short stay beds in 12P Patients booked into 12H (outpatient area) Outcome. <ul style="list-style-type: none"> Works well Limited access after hours Urgent patients cannot be booked or planned Poor management through casualty 	MA	Expected Outcome <ul style="list-style-type: none"> Improve outpatient services Planning for ambulatory care unit Improve timeliness & effectiveness of care for er Provide better support & backup for apheresis service Action <ul style="list-style-type: none"> Initiate planning process Meet with executive & emergency staff to educate Train additional apheresis staff, Forward planning 	1998	CA & other Haematologist
5.2	Care is delivered according to professional standards and statutory requirements.	Structure/process <ul style="list-style-type: none"> Chemotherapy protocols Transplant protocols Ward protocol and procedure manual Outcome	MA	Expected Outcome <ul style="list-style-type: none"> Ensure standard of clinical management Improve access to protocols Action <ul style="list-style-type: none"> Develop clinical guidelines 	1999	SK/CA

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CONTINUUM OF CARE

		<ul style="list-style-type: none"> Continually updated documents Works well 		<ul style="list-style-type: none"> Put protocols into electronically available forms Review information for agency staff 		
5.3	Care is delivered in a safe and comfortable environment.	<p>Structure/process</p> <ul style="list-style-type: none"> According to hospital guidelines Quiet room for relatives Patient's relatives/friends are educated re special requirements <p>Outcome</p> <ul style="list-style-type: none"> Unsatisfactory due to inadequate space, unsatisfactory sanitary disposal, air conditioning inadequacies (fungal infection risk), inadequate staff resources. Dirty ward areas Hospital policy on placement of patients with infectious disease may increase risk to other patients. 	SA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Reduce risk of poor patient Outcome from nosocomial and environmental hazards. <p>Action</p> <ul style="list-style-type: none"> Discussion and meeting with bed manager re infectious patients. Meet with facilities planner regards ward refurbishment. Write submission for more staff after collecting data of problems relating to staff shortages. (Patient satisfaction surveys) 	1999	KG NS
5.4	Care is delivered in partnership with the patient / client and their carers.	<p>Structure/process</p> <ul style="list-style-type: none"> As per hospital guidelines. Social work education sessions with patients <p>Outcome</p> <ul style="list-style-type: none"> Works well 	MA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Continue to deliver care in partnership with patient and client. <p>Action</p> <ul style="list-style-type: none"> Education sessions being developed by nursing and social work staff for the patients and carers. 	1998 A	RA
5.5	Patients / clients acknowledge their rights and responsibilities in the implementation of care.	<p>Structure/process</p> <ul style="list-style-type: none"> As per hospital guidelines <p>Outcome</p> <ul style="list-style-type: none"> Works well (as per hospital workbook) 	MA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Continue current practice <p>Action</p> <ul style="list-style-type: none"> Nil 		
5.6	Rights and needs of patients / clients are considered and respected by all staff.	<p>Structure/process</p> <ul style="list-style-type: none"> Complete Medical/Nursing/Social Work history is taken Daily review — specific questioning of patients about concerns. Ward 12D information booklets given out According to hospital guidelines <p>Outcome</p> <ul style="list-style-type: none"> Minimal dissatisfaction Clients generally satisfied In outpatient facilities (12H) needs are not adequately met 		<p>Expected Outcome</p> <ul style="list-style-type: none"> 12H has improved ability to satisfy needs of patients. <p>Action</p> <ul style="list-style-type: none"> Develop Ambulatory Care Ward or an interim facility for 12H 	1998	NS
5.7	Care is coordinated in order to ensure continuity of care and follow-up to avoid duplication of the provision of service.	<p>Structure/process</p> <ul style="list-style-type: none"> Case Manager for transplant patients NUM/Doctor to coordinate care of non-transplant patients Clinical Nurse Specialist Programmed Beds Coordinator Team approach - interdisciplinary meetings to make sure no duplication <p>Outcome</p> <ul style="list-style-type: none"> Care is provided without duplication of services Some duplication of drug orders in 12H 	MA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Reduce duplication of drug orders <p>Action</p> <ul style="list-style-type: none"> Obtain fax machine for 12H to reduce drug order duplication 	1998	NS
5.8	The plan of care and goals are revised in response to patient / client progress.	<p>Structure/process</p> <ul style="list-style-type: none"> Case conferences — 2 per week Documentation form at case conference — revised regularly Nursing care plan <p>Outcome</p> <ul style="list-style-type: none"> Up to date care plans in place 	HA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Nil <p>Action</p> <ul style="list-style-type: none"> Nil 		
5.9	Education helps the patient / client and carers to understand the patient's / client's diagnosis, prognosis, treatment, and health promotion and	<p>Structure/process</p> <ul style="list-style-type: none"> Education and support programs by Cansupport and Social Worker 	MA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Develop educational program according to needs analysis 	1998 Ongoing	RA R. Burek

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CONTINUUM OF CARE

	illness prevention strategies. The education is given by appropriate professionals.	<ul style="list-style-type: none"> Medical and Nursing staff give bedside communication/education Brochures/pamphlets given to patients <p>Outcome</p> <ul style="list-style-type: none"> Program helped the patient understand diagrams/prognosis/treatment etc. Needs analysis was conducted 		<p>Action</p> <ul style="list-style-type: none"> Analyse and act upon needs analysis Psychiatry study 		
5.10	Medico-legal issues in relation to care are recognised, addressed, monitored and statutory requirements are met.	<p>Structure/process</p> <ul style="list-style-type: none"> Hospital Policy Incident reporting forms <p>Outcome</p> <ul style="list-style-type: none"> Follow hospital policy for "not for resuscitation" Follow hospital policy for all incidents 	HA	<p>Expected Outcome</p> <p>Action</p>		
6.0	STANDARD 6 EVALUATION Care delivery is evaluated by the health care team to ensure the care continuously meets patient / client needs and assists in the improvement of care provision.	Outcomes Achieved for the Standard				
6.1	CRITERIA Patient / client progress, in relation to achievement of planned goals, is monitored by the health care team.	<p>Structure/process</p> <ul style="list-style-type: none"> Case Conference Review QUARNS participation Ward Management meeting <p>Outcome</p> <ul style="list-style-type: none"> Management information not well distributed Aggregate data on database not available Evaluations by individual disciplines not disseminated 	SA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Results of monitoring activities are more widely distributed <p>Action</p> <ul style="list-style-type: none"> Set in place systems for collection/managing Outcome data Identify Outcome data that is required Notify organisation of needs 	1999	CA
6.2	Patient / client data are analysed to provide information for care improvement.	<p>Structure/process</p> <ul style="list-style-type: none"> Request regularly from QUARNS — death, MRSA, LO5 <p>Outcome</p> <ul style="list-style-type: none"> Some data received 	SA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Comprehensive and reliable patient information/Outcome data is available and regularly reviewed <p>Action</p> <ul style="list-style-type: none"> Identify patient data required Develop systems for collecting/analysing data 	1999	CA
6.3	Indicator data are collected and used for the evaluation of patient / client care and management of services.	<p>Structure/process</p> <p>Ad hoc queries from infection control/QUARNS</p> <p>Anecdotal recording</p> <p>Clinical trial information</p> <p>Specific projects, e.g. Aspergillus infection</p> <p>Outcome</p> <ul style="list-style-type: none"> Act and review policy on basis of outcomes Educate staff with data Sporadic review of patient Outcome data 	SA	<p>Expected Outcome</p> <p>Utilize indications to improve patient care</p> <p>Action taken on results of indicator data collection</p> <p>Action</p> <p>Collect comprehensive data for indications</p> <p>Review what data is to be collected</p>	1999	CA
6.4	Comparative analysis is undertaken and reasons for individual variance are ascertained by the health care team.	<p>Structure/process</p> <p>Indicators in 1996/97 highlighted MRSA problem</p> <p>Outcome</p> <ul style="list-style-type: none"> Education program initiated Recommendations made to bed management Access information from infection control 	SA	<p>Expected Outcome</p> <p>Continue analysis and improve performance</p> <p>Action</p> <p>Await data collection to begin</p>	1999	CA
6.5	Action is taken to address any improvements required.	As above		As above		

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CONTINUUM OF CARE

7.0	STANDARD 7 SEPARATION Patients / clients and carers are prepared for, and are confident about, the continuing management of the patient / client on leaving the organisation.	Outcomes Achieved for the Standard				
7.1	CRITERIA Patients / clients and carers understand instructions for continuing management.	Structure/process <ul style="list-style-type: none"> Ward booklets Specific disease oriented pamphlets Pharmacist educates patient/family + gives medication card Multidisciplinary teams input into continuing patient care Transplant patients instructed by transplant co-ordinator each day while in hospital. Discharge booklet given to patient and family. Draft survey evaluating care process in final preparation Provide pharmaceutical company educational videos and leaflets. Outcome <ul style="list-style-type: none"> Patients give verbal confirmation of understanding Ongoing review of patient understanding after discharge by 12H staff. 		Expected Outcome <ul style="list-style-type: none"> Continue to monitor that patients understand information Action Perform survey of care process to include level of understanding		
7.2	Information, relevant to care and continuing management, is given to the patient / client and carers, and relevant health providers, and is included in the medical record of the patient / client.	Structure/process <ul style="list-style-type: none"> Patient information process as above (7.1) Discharge summary/letters to GP and community nurses. Authority letters sent with patient for drug administration and information Phone call by medical and nursing staff to GP and community nurses and supplemented by written confirmation. Discharge transfer forms from 12D to 12H. Discharge booklet for patients 12 H. checklist social workers discharge planning interviews and literature pharmacists discharge planning interviews, literature, drug documentation allied health discharge correspondence and instructions follow-up post discharge phone calls from transplant coordinator Outcome <ul style="list-style-type: none"> Information flow appears adequate from verbal acknowledgment by clients. Positive feedback from follow-up phone calls 	AA	Expected Outcome <ul style="list-style-type: none"> Formal evaluation of Outcome More effective communication with community services Action <ul style="list-style-type: none"> Pursue patient survey Explore evaluation process of community services Purchase fax machines, facilities for typing and electronic databases Make e-mail more readily available 	1999	CA/SK/CNE
8.0	STANDARD 8 COMMUNITY MANAGEMENT Care is integrated between the organisation and community services to ensure the needs of the patient / client are met.	Outcomes Achieved for the Standard				
8.1	CRITERIA Priority of the patients / client/s needs for community management is indicated to relevant community services.	Structure/process <ul style="list-style-type: none"> Treatment modalities for services prioritized with community services Social work liaison with support services Phone call to GP to indicate priority of review — consultant to ring personally rather than delegate responsibility OT/Palliative Care service notified of priority Outcome <ul style="list-style-type: none"> Patients seen/reviewed in a timely manner 	SA	Expected Outcome As above Action As above	1998 B Ongoing	SB

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8.2	Communication between the organisation and community services is timely.	Structure/process As per 7.2 Outcome Communication is timely	MA	Expected Outcome As the 7.2 Action As per 7.2	1998 B	SB
8.3	The organisation arranges access, and ensures the patient / client is aware of appropriate community services prior to separation.	Structure/process Appropriate multidisciplinary assessment and services arranged as detailed in 7.2 Outcome As per 7.2	MA	Expected Outcome Ensure community liaison is effective Action Evaluate process to ensure effectiveness	1998	SB

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LEADERSHIP AND MANAGEMENT

LEADERSHIP AND MANAGEMENT						
Std No	Survey Item	Evidence of Achievements and Improvements	Rating	Action Required and Expected Outcomes	By When	Person Responsible
1.0	STANDARD 1 The organisation is effectively and efficiently governed and managed, in accordance with its values and goals, to ensure quality of care.	Outcomes Achieved for the Standard				
1.1	CRITERIA Governing Body The governing body, its officers and members of its committees are appointed according to specific requirements and terms of office.	As per Hospital workbook				
1.2	The governing body specifies why the organisation exists (mission) and what it wants to achieve (goals).	Structure/process Nursing mission statement exists Haematology departmental guidelines and five-year plan Outcome Some staff are aware of mission statement and work within its direction and philosophy Mission and goals statements used to support departmental activity and function Apparently poor knowledge of Hospital mission statement	SA	Expected Outcome Communicate mission statement to hospital administration, carers, health professionals and patients Review current mission statement and redefine it Action Nursing staff to review need for a separate mission statement	1998 B	KG
1.3	The governing body provides leadership and has overall responsibility for the organisation's achievements, the quality of care and the organisation's resources.	Structure/process a) <u>governing body</u> - efficient and effective leadership process in laboratory management - existence of a difficult bureaucratic process for nursing and clinical management - change in leadership recently Outcome - await changes due to leadership change - confidence raised in general staff by new leadership - decreased leadership and confidence in the middle management and some nursing issues Structure/process b) <u>haematology department</u> -existence of a cohesive management team with shared responsibility and delegation -recent change of leader and management structure - flexible management structure Outcome - apparent reasonable satisfaction of staff - popular resident term - creation of an effective 12 H and 12 P - effective country clinics - forward plans developed	MA	Expected Outcome Management decisions devoluted to the level where needed but with support of leadership where necessary. Continue to develop leadership/management skills with education and succession planning. Maintain and support flat management structure but with clear leadership and management structure/profile Action Monitor process of change with trust. Identify successes and support them Identify failures and rehabilitate Survey staff regarding satisfaction with management/leadership	1998 A	CA KG

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1.4	The governing body ensures there are effective working relationships within the organisation and with the community, and with other relevant organisations and individuals.	<p>Structure/process</p> <p><u>Governing body</u></p> <p>Ineffective lines of communication between clinical units and departmental members</p> <p><u>Haematology department</u></p> <p>Combined Ward rounds</p> <p>Business meetings and ward management meeting</p> <p>Staff specialists meetings</p> <p>Departmental structure map</p> <p>Outcome</p> <p><u>Governing body</u></p> <p>Ineffective relationships with clinical units</p> <p><u>Haematology department</u></p> <p>Staff have clear understanding of how to achieve results</p>	SA	<p>Expected Outcome</p> <p>Ongoing monitoring of working relationships</p> <p>Formalize project teams for crisis management</p> <p>Action</p> <p>Refer to staff satisfaction survey in 1.3</p> <p>Address problems as they arise</p>	1998 B	CA KG
1.5	The governing body ensures community and staff participation in organisational planning and policy issues.	As per hospital workbook				
1.6	The governing body meets regularly and provides for continuity of governance between meetings so that corporate business is conducted efficiently.	<p>Structure/process</p> <p>Weekly staff specialist meetings</p> <p>Regular Ward management meetings (four monthly)</p> <p>Weekly (Wednesday) Ward meetings where business issues are discussed</p> <p>Free communication between individuals in a receptive environment</p> <p>Outcome</p> <p>Staff satisfied with current structure</p> <p>Efficient governing</p>	MA	<p>Expected Outcome</p> <p>Improvements in communication</p> <p>More ready access via GroupWise</p> <p>Better documentation</p> <p>Action</p> <p>Continue development of electronic/computerized means of communication</p> <p>Review effectiveness/strategies of communication</p>	1998 B	SK CA
1.7	Suitable mechanisms assist the governing body in fulfilling its responsibilities and assessing the organisation's performance.	As per Hospital workbook				
1.8	Terms of reference, membership and procedures are defined for the meetings of the governing body and all committees within the organisation.	As per Hospital workbook				
1.9	Activities of the governing body and all committees are recorded and confirmed.	<p>Structure/process</p> <ul style="list-style-type: none"> minutes taken of ward management meeting minutes kept of weekly staff specialist business meeting nursing meetings and ward monthly forum minuted <p>Outcome</p> <ul style="list-style-type: none"> minutes of meetings documented name of nursing forum changed recently 	HA	<p>Expected Outcome</p> <ul style="list-style-type: none"> to continue <p>Action</p> <ul style="list-style-type: none"> to continue 	1998 A	SK
1.10	Newly appointed members of the governing body are oriented to ensure they understand their responsibilities and duties.	As per Hospital workbook				
1.11	Members of the governing body participate in ongoing education to assist them in fulfilling their role.	As per Hospital workbook				

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1.12	The governing body regularly reviews its own performance to ensure improvement in the quality of care and effective and efficient management of the organisation.	Structure/process <ul style="list-style-type: none"> head of department attended management course and participated the NUM has informal peer review clinical data are collected Outcome <ul style="list-style-type: none"> review assessment sent out for department head 	MA	Expected Outcome <ul style="list-style-type: none"> develop review process for clinical and staff satisfaction Action <ul style="list-style-type: none"> review staff satisfaction review clinical results acquire resources to achieve the review 	1998 B	SK
1.13	Chief Executive and Managers The governing body delegates the necessary authority to the chief executive and managers and ensures their responsibilities are defined to enable the organisation to operate effectively.	As per Hospital workbook				
1.14	The governing body authorises an individual to act for the chief executive when required.	As per Hospital workbook				
1.15	The chief executive and managers provide leadership and act in accordance with corporate policies, delegated authority and instructions of the governing body and are responsible for the management of the organisation and its specific services.	As per Hospital workbook				
1.16	The performance of the chief executive and each manager is reviewed regularly.	As per Hospital workbook				
1.17	Strategic and Operational Plans The organisation's values and goals direct the organisation's actions and behaviour, and are reflected in its culture.	Structure/process <ul style="list-style-type: none"> existence of an intrinsic culture, values, morals as the foundation and ethos of the community of staff. Values and goals voiced frequently at meetings, at the bedside, and in personal interactions. Outcome <ul style="list-style-type: none"> The actions and behaviour of staff reflect its culture. 	MA	Expected Outcome <ul style="list-style-type: none"> Maintained in the culture Action <ul style="list-style-type: none"> Continue current range of activities including: interpersonal interactions, group activities, maintaining a supportive environment, being available to staff, foster of free communication, maintain adequate staff levels and commitment to staff 	1998 B	KG CA
1.18	The organisation's role is responsive to the needs and expectations of its customers and the community it serves.	Structure/process <ul style="list-style-type: none"> Patient representative As per Hospital workbook Patient questionnaire in development Outcome <ul style="list-style-type: none"> We can measure responsiveness 	SA	Expected Outcome <ul style="list-style-type: none"> Improve responsiveness to needs and expectations Action <ul style="list-style-type: none"> Set up an integrated quality control unit 	1999	SB
1.19	The organisation's strategic and operational plans are developed in consultation with, and made known to, management, staff, the community and other relevant health service providers.	Structure/process <ul style="list-style-type: none"> Draft strategic plan in existence and in ongoing development Outcome <ul style="list-style-type: none"> Strategic plans discussed with staff and input encouraged. Strategic plan reflects consultative process with the team 	SA	Expected Outcome <ul style="list-style-type: none"> To make plans known to administration, staff and clients Action <ul style="list-style-type: none"> Disseminate information to major stakeholders and clients. 	1998 A	CA NS
1.20	Operational plans of individual services are consistent with the organisation's strategic plan and other services' operational plans.	Structure/process <ul style="list-style-type: none"> Regular meetings with department head and head of clinical unit and medical administration Outcome	MA	Expected Outcome <ul style="list-style-type: none"> Maintain consistency between the departmental and organisational plans Action	1998 A	CA KG

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		<ul style="list-style-type: none"> Departmental operational plan is consistent with organisational plan. Some uncertainty about hospitals strategic plan members generally work together with some understanding of the broad goals 		<ul style="list-style-type: none"> Continue close relationship between departmental head and organisational administration. 		
1.21	The organisation's strategic and operational plans are implemented and revised as necessary. The achievement of the plans is monitored and Action taken to address any improvements required.	<p>Structure/process</p> <ul style="list-style-type: none"> Ward management meetings Individuals and groups charged with responsibility Some performance indicators <p>Outcome</p> <ul style="list-style-type: none"> Goals are achieved and plans are reviewed as necessary 	MA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Improve implementation and revision of plans. <p>Action</p> <ul style="list-style-type: none"> Develop performance indicators 	1999	KG SK
1.22	Where the organisation is part of an area health service or multi-hospital system, the organisation participates in discussions and decisions on its current and future operations.	<p>Structure/process</p> <ul style="list-style-type: none"> Area haematology service being developed <p>Outcome</p> <ul style="list-style-type: none"> Haematologist actively involved and leading discussions and decision-making 	SA	<p>Expected Outcome</p> <ul style="list-style-type: none"> An effective area haematology service will exist <p>Action</p> <ul style="list-style-type: none"> Continue involvement in the planning process 	2000	CA
1.23	The organisation's services are integrated with others providing health services.	<p>Structure/process</p> <ul style="list-style-type: none"> Multidisciplinary team on the haematology ward Pharmacists and other allied health attend Ward rounds Laboratory staff closely connected and interactive Sometimes unsatisfactory interaction e.g. orthopedic service dissatisfied with consultative haemostasis and thrombosis service. <p>Outcome</p> <ul style="list-style-type: none"> Generally well integrated Sometimes inadequate integration with physiotherapy 	MA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Able to meet needs of other departments Improve patient care by having adequate other services e.g. physiotherapists <p>Action</p> <ul style="list-style-type: none"> Discuss resources with medical administration Discuss problems with physiotherapists 	1999	SK 2nd Haematologist on Committee
1.24	Organisational Structure Service delivery is facilitated by the structure of the organisation.	<p>Structure/process</p> <ul style="list-style-type: none"> Departmental structure exists Effective structure exists Inadequate staff to support the structure <p>Outcome</p> <ul style="list-style-type: none"> Service is delivered but sometimes with difficulty 	SA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Improve staffing levels <p>Action</p> <ul style="list-style-type: none"> Await implementation of activity database to document need for increased staffing levels 	1999	KG
1.25	Established lines of responsibility, authority and communication support leadership, teamwork and the integration of services both within the organisation and with other service providers.	<p>Structure/process</p> <ul style="list-style-type: none"> Established lines exist <p>Outcome</p> <ul style="list-style-type: none"> Existence of a positive attitude, good teamwork and functioning unit internally. Despite established lines external obstructions are unchangeable and stifling E.g. central medical council determining numbers of residents/registrar's and not responsive to local needs 	MA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Not expected to change <p>Action</p> <ul style="list-style-type: none"> No Action, focus attention in more productive areas 		
1.26	The organisational structure is reviewed annually or whenever there is a significant change, such as alteration of the role of the organisation or its services.	<p>Structure/process</p> <ul style="list-style-type: none"> Regular business meetings and environment of free communication between staff <p>Outcome</p> <ul style="list-style-type: none"> Review of organisational structure is a continuous process 	MA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Continue current status <p>Action</p> <ul style="list-style-type: none"> Continue current activity 		
1.27	By-laws, Policies and Procedures The organisation's by-laws, Articles of Association, and each service's policies and	<p>Structure/process</p> <ul style="list-style-type: none"> Nursing protocols Medical treatment protocols Departmental policies and procedures 	MA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Continue current status <p>Action</p> <ul style="list-style-type: none"> Continue current activity 		

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	procedures support the delivery of care and are consistent with the organisation's goals, accepted standards, statutory requirements and the organisation's community and regional responsibilities.	Outcome <ul style="list-style-type: none"> Structure and standards exist which are in concert with the organisation 				
1.28	Compliance with the organisation's policies and procedures occurs throughout the organisation. The policies and procedures are reviewed and revised as necessary.	Structure/process <ul style="list-style-type: none"> Staff required to comply with appropriate policies Policies reviewed regularly Outcome <ul style="list-style-type: none"> Staff comply with policy QUARNS reports received regarding lack of compliance — Action initiated Policies kept up-to-date 	MA	Expected Outcome <ul style="list-style-type: none"> Good compliance will be maintained Action <ul style="list-style-type: none"> continue monitoring compliance 		
1.29	Rights and Responsibilities of Patients / Clients Rights and responsibilities of patients / clients are respected and are addressed through policies and procedures which are in accordance with the values of the organisation, professional codes of ethics and relevant standards and statutory requirements.	Structure/process <ul style="list-style-type: none"> Staff required to comply with hospital policy Outcome <ul style="list-style-type: none"> Staff comply with hospital policy 	MA	Expected Outcome <ul style="list-style-type: none"> Continue current status Action <ul style="list-style-type: none"> Continue current activity Discussion of NFR orders 	1998 B	SK
1.30	Ethics Ethical issues are formally considered and resulting policies are implemented and evaluated.	Structure/process <ul style="list-style-type: none"> Frequent informal and formal debate on Ward rounds regarding ethical issues, often specific patient focused Discussed at regular staff meetings Follow hospital guidelines Outcome <ul style="list-style-type: none"> Policies implemented and evaluated 	MA	Expected Outcome <ul style="list-style-type: none"> Continue current status Action <ul style="list-style-type: none"> Continue current activity 		
1.31	All activities are consistent with recognised ethical requirements of the professions and the organisation.	Structure/process <ul style="list-style-type: none"> Activities performed are consistent with ethical requirements Outcome <ul style="list-style-type: none"> Staff observe ethical requirements 	HA	Expected Outcome <ul style="list-style-type: none"> Continue current status Action <ul style="list-style-type: none"> Continue current activity 		
1.32	Research projects are reviewed and approved by an ethics committee constituted under the National Health and Medical Research Council's guidelines.	Structure/process <ul style="list-style-type: none"> As per hospital guidelines/workbook Outcome <ul style="list-style-type: none"> Unsatisfactory results for urgent ethics committee approvals Research in quality control activities obstructed and stifled by excessively restrictive process 	MA	Expected Outcome <ul style="list-style-type: none"> Improved more efficient and flexible approach to Action <ul style="list-style-type: none"> Review ethics committee approach to urgent approvals Seek review of requirements for quality control type research 	1999	2nd Haematologist on Committee
1.33	Human Resources Management Human resources policies and practices assist with achieving the organisation's goals and are consistent with its values.	Structure/process <ul style="list-style-type: none"> Comply with hospital policy Orientation process in place Outcome <ul style="list-style-type: none"> Staff experience some rigidity and inflexibility in the human resources 	MA	Expected Outcome <ul style="list-style-type: none"> Human resources policy needs to be more flexible and more minimalistic Action <ul style="list-style-type: none"> Inform H. R. department that their policies can be rigid and inflexible 		SK
1.34	The organisation's human resources policies and practices comply with statutory requirements, including industrial relations, equal employment opportunities, occupational	As per hospital workbook				

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	health and safety and contractual arrangements. Also refer to the Human Resources Managements Standards and Guidelines					
1.35	Financial Management Financial Management is used in the achievement of the organisation's goals and strategic plans.					
1.36	The governing body oversees the finances of the organisation. Management processes are established to ensure the financial resources of the organisation are appropriately managed, reported and consistent with accepted standards and statutory requirements.					
1.37	Information Management Relevant information management systems meet the organisation's needs. Also refer to the Information Management Standards and Guidelines					
1.38	Environment The physical environment, including buildings, grounds, plant and equipment is managed and maintained in order to: (a) ensure patient / client, staff and visitor safety, privacy and comfort (b) support efficient organisational performance (c) meet statutory requirements Also refer to the Safe Practice and Environment Standard and Guidelines					
1.39	External Services Documented agreements / contracts cover the appointment of contractors and provision of external services.					

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1.40	Relevant agreements / contracts specify that the quality of services provided is consistent with the appropriate standards of The Australian Council on Healthcare Standards, the organisation's policies and procedures, and other standards, codes of practice and statutory requirements.					
1.41	Agreements / contracts specify that the external service providers will be willing to participate in the accreditation survey by The Australian Council on Healthcare Standards.					
1.42	External services are evaluated by the organisation and Action taken to address any improvements required.					
1.43	<p>Improving Performance</p> <p>The governing body, chief executive and managers create a culture and provide leadership, direction and adequate resources for an integrated approach to improving performance throughout the organisation.</p> <p>Also refer to the Improving Performance Standard and Guidelines</p>					

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HUMAN RESOURCES MANAGEMENT

HUMAN RESOURCES MANAGEMENT

Std No	Survey Item	Evidence of Achievements and Improvements	Rating	Action Required and Expected Outcomes	By When	Person Responsible
1.0	STANDARD 1 HUMAN RESOURCES PLANNING Human resources planning ensures the organisation is staffed to achieve its values and goals.	Outcomes Achieved for the standard				
1.1	CRITERIA Human resources planning is undertaken to support and meet the organisation's strategic plans. Staff are involved in this process.					
1.2	Planning ensures that appropriately trained and / or qualified personnel are available to undertake the type and level of activity performed by the organisation.					
1.3	Workload monitoring is used to ensure appropriate numbers and skill mix of staff are available to achieve desired patient / client and organisational outcomes.					
1.4	Planning ensures that appropriately trained, qualified and, where relevant, credentialed personnel are available and sought for consultation and advice when expertise is not available within the organisation.					
2.0	STANDARD 2 RECRUITMENT, SELECTION AND APPOINTMENT Staff are appointed through a recruitment selection, and appointment procedure that complies with statutory requirements and is consistent with the organisation's human resources policy.	Outcomes Achieved for the standard				
2.1	CRITERIA The recruitment, selection, appointment and re-appointment procedure ensures appropriate competence, training, experience and registration of all appointees.	As per hospital workbook				

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2.2	On appointment, staff receive a written statement of their accountabilities and responsibilities that specifies how their role contributes to achieving the organisational goals. The statements are reviewed and revised as necessary.	As per hospital workbook				
2.3	Accurate and complete personnel records are created and maintained, and are confidential. They are accessible to authorised personnel including the relevant employee.	Structure/process <ul style="list-style-type: none"> • Staff registration • staff assessment placed in locked cabinet • Database (password protected) • N9 completed, sent to nursing administration Outcome <ul style="list-style-type: none"> • Accessible and security maintained 	MA	Expected Outcome <ul style="list-style-type: none"> • Continue to ensure personnel records are maintained and security is maintained Action <ul style="list-style-type: none"> • Review as required 	1998 A	KG
2.4	All services and programs are managed by a person with appropriate qualifications, experience or training.	As per hospital workbook				
2.5	All health professionals are licensed, registered and / or credentialed, as appropriate.	As per 2.3				
Std No	Survey Item	Evidence of Achievements and Improvements	Rating	Action Required and Expected Outcomes	By When	Person Responsible
3.0	STANDARD 3 STAFF RESPONSIBILITIES Responsibilities and accountabilities guide and direct staff to ensure organisational values and goals are achieved and quality care is maintained.	Outcomes Achieved for the standard				
3.1	CRITERIA Staff understand and act in accordance with their responsibilities to ensure organisational values and goals are achieved and quality care is maintained.	Structure/process <ul style="list-style-type: none"> • Rules of 12D Ward Outcome <ul style="list-style-type: none"> • Staff follow guidelines 	MA	Expected Outcome <ul style="list-style-type: none"> • Continue to maintain standard and new staff are Action <ul style="list-style-type: none"> • Review as appropriate 	1998	KG
3.2	Staff are accountable for the care and / or services they give and for their delineated responsibilities.	As per hospital workbook				
Std No	Survey Item	Evidence of Achievements and Improvements	Rating	Action Required and Expected Outcomes	By When	Person Responsible
4.0	STANDARD 4 STAFF TRAINING AND DEVELOPMENT A comprehensive program of staff training and development meets individual and organisational needs.	Outcomes Achieved for the standard				

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	CRITERIA					
4.1	An induction program ensures staff understand their roles, responsibilities and the organisation's values and goals and how these contribute to providing quality care and services.	Structure/process <ul style="list-style-type: none"> • Orientation program a) preceptor checklist b) orientation folder for the unit c) welcome to 12D. All new staff have preceptors in teams d) Onsite educator position in the one of the senior nurses e) Medical staff orientation. Includes orientation written information Outcome <ul style="list-style-type: none"> • Informal feedback from orientation program: chemotherapy packa • Staffing limits have altered the orientation program 	MA	Expected Outcome <ul style="list-style-type: none"> • Continue to improve the orientation program Action <ul style="list-style-type: none"> • Palliative care to be involved in medical staff orientation • Develop a formal evaluation of orientation program • Improve orientation documentation given to medical staff after collaboration with CNCs, nurse educators and HMOs. 	1999	SK and Nurse Educator
4.2	Staff, including trainees, new graduates and external contractors are adequately supervised by qualified staff.	As per hospital workbook				
4.3	Staff achievements and improvement opportunities are assessed through a structured performance evaluation system that also involves the staff member.	Structure/process <ul style="list-style-type: none"> • As per Hospital workbook for awards • Hospital scientists not currently formally appraised Outcome <ul style="list-style-type: none"> • Employee to follow up on award provisions for appraisals and discuss with director 	SA	Expected Outcome <ul style="list-style-type: none"> • Structured performance appraisals are developed for scientific officers Action <ul style="list-style-type: none"> • Develop performance appraisals process. 	1999	CA
4.4	Educational needs of the organisation and all staff are met through a relevant training and development program.	Structure/process <ul style="list-style-type: none"> • Monthly in-service program for nursing staff coordinated by educator • Half-day study days to update staff on haematology. All staff invited to attend • Weekly meeting for all staff to attend multidisciplinary scientific meeting • Weekly multidisciplinary clinical meeting • Hickman catheter workshops • Chemotherapy safety workshops • Management of department encourages staff to attend seminars, conferences. • Sydney wide haematology meetings (medical) • Multiple regular meetings of medical scientists and other subsidiary meetings Outcome <ul style="list-style-type: none"> • Informal evaluation of all programs • Half-day study day altered • Journal club started • Successful exam performance by medical registrars 	MA	Expected Outcome <ul style="list-style-type: none"> • Continue to evaluate and improve programs Action <ul style="list-style-type: none"> • Review usefulness of individual programs • Review pharmaceutical company involvement in education • Purchase computer-based projection facility 	1999	CA SK
4.5	Staff training and development programs are evaluated and improved ensuring they meet organisational and individual needs.	As per 4.4				
5.0	STANDARD 5 INDUSTRIAL RELATIONS Effective workplace relations are facilitated through the implementation of the values and goals of the organisation.	Outcomes Achieved for the standard				

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	CRITERIA					
5.1	Industrial relations policies and practices comply with statutory requirements and Action is taken to address any improvements required.	As per Hospital workbook				
5.2	Management, employees and where applicable their representative associations, are actively involved in human resources issues.	As per Hospital workbook				
6.0	STANDARD 6 EMPLOYEE ASSISTANCE Employee assistance is supported by the organisation and made available to all staff.	Outcomes Achieved for the standard				
6.1	CRITERIA Staff are aware of, and have access to, employee assistance for a range of suitable services.	As per Hospital workbook				
6.2	Managers understand their role in recognising employee needs for assistance and facilitate access to appropriate services.	Structure/process <ul style="list-style-type: none"> • Weekly debriefing program run by psychiatrist • Monthly debriefing program with new nursing graduates with social worker • Debriefing is arranged for sentinel or difficult cases • Support mechanisms informally assessed in staff appraisal process • Registrar and resident workload under review by administration Outcome <ul style="list-style-type: none"> • Staff feel generally well supported • Limited formal support process and awareness for medical staff • Await results from resident workload and staffing review 	MA	Expected Outcome <ul style="list-style-type: none"> • Recognize and provide appropriate employee needs • Oncology/haematology resident medical staff to be supported more effectively Action <ul style="list-style-type: none"> • Key players to review feasibility of a session for resident medical staff • Take appropriate Action once results of registrar and resident workload survey are known • Review weekly debriefing sessions with oncology liaison psychiatry registrar 	1998 B	R Araullo 2nd Haematologist on Committee

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INFORMATION MANAGEMENT

INFORMATION MANAGEMENT						
Std No	Survey Item	Evidence of Achievements and Improvements	Rating	Action Required and Expected Outcomes	By When	Person Responsible
1.0	STANDARD 1 INFORMATION MANAGEMENT PLANNING Planning ensures information management systems meet the organisation's internal and external needs.	Outcomes Achieved for the standard				
1.1	CRITERIA Information is managed to support the organisation's strategic plan.	As per hospital workbook				
1.2	Strategic planning of the management of information enables a coordinated approach and efficient use of information resources for effective delivery of patient / client care and management.	Structure/process <ul style="list-style-type: none"> Strategic plan written including approach to information management Comprehensive departmental clinical information system Existence of bone marrow and cytogenetics databases Outcome <ul style="list-style-type: none"> Continual development of information system Easy access to clinical information Future needs addressed in strategic plan 	MA	Expected Outcome <ul style="list-style-type: none"> Address information management issues through the strategic planning process Action <ul style="list-style-type: none"> Implement current strategic plan 	1999	CA 2nd Haematologist on Committee
1.3	The information management systems are routinely evaluated and improved to ensure internal and external needs are met.	Structure/process <ul style="list-style-type: none"> Information management is evaluated as part of strategic planning Outcome <ul style="list-style-type: none"> Initiatives addressed in strategic plan 	MA	Expected Outcome <ul style="list-style-type: none"> Continue to improve and evaluate information systems Action <ul style="list-style-type: none"> Flowcharts for cytotoxic records need evaluation and improvement Convert flowcharts to computerised format 12H checklist: needs evaluation, evaluate paperwork sent to community nurses update departmental information system to modern software and technology 	1999	CA 2nd Haematologist on Committee
2.0	STANDARD 2 DATA COLLECTION, AGGREGATION AND USE Patient / client care, management of services, education and research are facilitated by collection and aggregation of data and its transformation into information.	Outcomes Achieved for the standard				
2.1	CRITERIA Data Collection Process Relevant, accurate, quantitative and	Structure/process <ul style="list-style-type: none"> as per hospital workbook clinical trial database disease database in the department patient database and clinical record 	SA	Expected Outcome <ul style="list-style-type: none"> evaluate and improve comprehensive data collection for patients service and service management select performance and clinical indicators 	1999	CA SK FC

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	qualitative data are collected in a timely and efficient manner for delivery of patient / client care and management of services.	<ul style="list-style-type: none"> daily collection of patient results <p>Outcome</p> <ul style="list-style-type: none"> moderately efficient and timely access of some patient information for delivery of patient care disease databases are significantly out of date. Collection manipulation and reporting of results is unsatisfactory. 		<p>Action</p> <ul style="list-style-type: none"> continue to evaluate and improve systems so that relevant, accurate, quantitative and qualitative data are collected in a timely and efficient manner for delivery of patient / client care and management of services. 		
2.2	The collection of data complies with professional and statutory requirements.	<p>Structure/process</p> <ul style="list-style-type: none"> as per hospital protocols clinical trial information stored according to good clinical practice guidelines <p>Outcome</p> <ul style="list-style-type: none"> compliance with requirements 	MA	<p>Expected Outcome</p> <ul style="list-style-type: none"> continue to maintain standard <p>Action</p> <ul style="list-style-type: none"> continue current activity 	1998	SK
2.3	Medical Record Data Every patient / client has a unit record which is sufficiently detailed to enable continuity of care, evaluation, education, research and medico-legal integrity.	As per hospital workbook				
2.4	All patients / clients, including newborn infants, are uniquely identified within the organisation.	As the hospital workbook				
2.5	Persons who provide care, document details in the medical record. All entries are legible, dated and signed with designation.	As the hospital workbook				
2.6	All documents associated with care given are filed in the medical record. These should be originals whenever possible.	As the hospital workbook				
2.7	Indexing Indexing of data facilitates information retrieval.	As the hospital workbook				
2.8	Reporting Systems Useful, timely and accurate information is made available to staff in an understandable format for use in delivery of patient / client care and management of services.	As the hospital workbook				
2.9	Knowledge Based Information Clinical, managerial, reference and research information is collected and managed for use by staff in achieving the organisation's goals.	<p>Structure/process</p> <ul style="list-style-type: none"> library facility in department Some performance indicators are collected Clinical trial information is collected Budget reports obtained Human resource database available Ward library exists <p>Outcome</p>	MA	<p>Expected Outcome</p> <ul style="list-style-type: none"> Continue to collect relevant Outcome to achieve departmental goals <p>Action</p> <ul style="list-style-type: none"> Review current data collected end evaluate if it is contributing and worthwhile 	1998	SK FC

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INFORMATION MANAGEMENT

		<ul style="list-style-type: none"> Staff use reference material Information is collected and presented at business meeting and other relevant forums for planning to achieve organisational goals 				
3.0	STANDARD 3 RECORD MANAGEMENT Integrity, safety, access and security of records are maintained and state / territory and national requirements are met.	Outcomes Achieved for the standard				
3.1	CRITERIA Medical records are managed to ensure they are readily accessible for the continuity of patient / client care, that confidentiality is maintained, they are safe, and all statutory requirements and Australian Standards are met.					
3.2	Medical record data are coded to ensure the timely production of quality patient / client care information.					
3.3	All other records are managed to enable rapid retrieval for continuity of care and management of services, education and research.					
4.0	STANDARD 4 MEDICO-LEGAL ISSUES Medico-legal requirements for information are met.	Outcomes Achieved for the standard				
4.1	CRITERIA Confidentiality of patient / client and staff information is preserved.					
4.2	Access to patient / client information adheres to relevant professional and statutory requirements.					
4.3	Statutory notifications are reported to appropriate authorities.					

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INFORMATION MANAGEMENT

5.0	STANDARD 5 INFORMATION TECHNOLOGY Information technology enhances the organisation's ability to meet its information management goals.	Outcomes Achieved for the standard				
5.1	CRITERIA Planning There is an integrated approach for the planning and use of information technology within the organisation.	Structure/process <ul style="list-style-type: none"> Strategic planning document and process in existence Outcome <ul style="list-style-type: none"> Continuous implementation of plan 	MA	Expected Outcome <ul style="list-style-type: none"> Continuous improvement in the use of information technology Action <ul style="list-style-type: none"> Continue implementation of strategic plan 	1998	CA SK
5.2	Information Technology Provision Systems for information technology provision meet appropriate standards and encompass: <ul style="list-style-type: none"> (a) licensing (b) security of systems and information (c) disaster recovery for system failure of any nature (d) standard operating environment enforcement (e) management of ongoing costs (f) mechanism for necessary updates 	Structure/process <ul style="list-style-type: none"> a) Database software FoxPro/Fox base is licensed, licensed kept in department. b) Computers password protected c) Regular backups in place d) Central server, Jupiter, access through normal hospital channel e) RMR allocation in budget, however RMR is frozen. Restrictions placed on management of cost center to buy computer equipment. The purchasing system obstruct development of computing systems. f) Limited availability of funds for updating from staff specialist trust fund. A person exists in the department with technical expertise and regularly updates and reviews possible mechanisms for updates. Outcome <ul style="list-style-type: none"> Meet appropriate standards for a, b, c, d. Unsatisfactory structure and process for management of ongoing costs and necessary updates. 	MA	Expected Outcome <ul style="list-style-type: none"> To continue to meet appropriate standards and improve those that are not currently obtained Action <ul style="list-style-type: none"> Lobby administration for a better mechanism to ensure new equipment and software meets appropriate standards. 	1998	2nd Haematologist on Committee
5.3	Information Technology Use Information technology systems are used effectively and efficiently.	Structure/process <ul style="list-style-type: none"> Staff attend computer training sessions Outcome <ul style="list-style-type: none"> Staff are proficient at computer use Staff accessing training programs effectively 	MA	Expected Outcome <ul style="list-style-type: none"> Continue to ensure effective and efficient use of information technology Action <ul style="list-style-type: none"> Continue ongoing training of staff as required 	1998	SK
5.4	Maintenance Technology and system serviceability is ensured through ongoing maintenance.	As per 5.2				

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SAFE PRACTICE AND ENVIRONMENT

SAFE PRACTICE AND ENVIRONMENT						
Std No	Survey Item	Evidence of Achievements and Improvements	Rating	Action Required and Expected Outcomes	By When	Person Responsible
1.0	STANDARD 1 The safety of all persons within the organisation is protected.	Outcomes Achieved for the standard				
1.1	Safe Practice and Environment Safe practices and facilities are in accordance with relevant statutory requirements, codes of practice and Australian Standards.	Structure/process As per Hospital workbook Outcome As per Hospital workbook				
1.2	Risks are identified, assessed and appropriately controlled. Where substitution is not able to be used or the risks are unable to be eliminated, adequate warning and protection devices are used.	Structure/process Regular Ward assessments for risk are done, assess risk of falls, pressure areas three times per week, environmental hazards one/month PRN Action in the department Outcome Air conditioning system cleaned HEPA filters changed once per year Some risks continue with air conditioning maintenance being inadequate The ice machine is not maintained A lack of hot water in sluices	MA	Expected Outcome Formalize risk assessments Continue to advocate for improvements to risks already identified Action Environmental round on Ward to be formalized Liaise again with occupational health and safety to address issues regarding ice machine and sluices.	1999	KG SK
1.3	Management is responsible for safe practices and facilities throughout the organisation and day-to-day management is delegated to an appropriate person(s).	Structure/process As per Hospital workbook Outcome As per Hospital workbook				
1.4	All staff within the organisation understand and fulfil their role in safe practice.	Structure/process • Fire and safety lectures held regularly, three monthly • Orientation includes a safe practice environment sessions. Manual handling. Outcome • Nursing staff have a good understanding of their role in safe practice. • 100% nursing attendants to fire lectures. • 100% clerical, PSA attendants to fire lectures.	MA	Expected Outcome • Ensure that all staff in haematology understand and fulfill their role in safe practice. Action • some staff in haematology department encouraged to attend fire lectures • transfusion surveillance nurse will be responsible for liaising with department to promote attendance at fire and safety lectures.	1998 A	KG
1.5	Policies, facilities, resources and staff responsibilities are incorporated into a program for the effective safe management of all work practices and all aspects of the environment.	As per 1.4				

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SAFE PRACTICE AND ENVIRONMENT

1.6	Responsibility for coordinating, monitoring, evaluating and reporting on all aspects of safety is delegated by management to a group of relevant staff.	Structure/process <ul style="list-style-type: none"> supervised by NUM on the Ward shared responsibility with laboratory personnel in the department Outcome <ul style="list-style-type: none"> aspects of safety are coordinated 	MA	Expected Outcome Sharing of responsibilities among staff Action Identify individuals and groups to continue this task.	1998 A	KG
1.7	An incident reporting system demonstrates causal and contributing factors enabling corrective and preventative Action to be taken.	As per Hospital workbook				
1.8	Infection Control The prevention and control of infection is achieved with interdisciplinary involvement.	As per Hospital workbook				
1.9	All service operations minimise infection risk in accordance with the infection control program.	As per Hospital workbook				
1.10	To reduce the risk of infection to both patients / clients and staff, cleaning, disinfecting, drying, packaging and sterilising of equipment and maintenance of associated environments, conforms to a system that it in accordance with relevant statutory requirements and Australian Standards.	Structure/process Family/visitors given instructions regarding hand washing routines Food is microwaved are separately Adherence to low microbial diet Reverse barrier nursing HEPA filtered air in single rooms Carpet in single rooms (unsatisfactory) Outcome No obvious change or serious concerns in the infection rate Carpet to be removed from single rooms	MA	Expected Outcome Maintain current standard and system Action Continue to monitor and address issues as they arise	1998	KG SK CA
1.11	Staff Health Issues Staff have access to first aid, medical attention and rehabilitation for work related incidents.	Structure/process Spill protocol followed Comply with Australian standards regards chemotherapy spills Outcome Staff aware of spill protocol	MA	Expected Outcome Continue to ensure staff aware of spill protocol Action Continue current education program	1998	SK
1.12	Security Protection of patients / clients, staff, visitors and the resources of the organisation is achieved by a coordinated approach to security measures.	Structure/process <ul style="list-style-type: none"> system to contact security offices and wardsmen in place as per Hospital workbook Outcome <ul style="list-style-type: none"> delay in attendance of security staff when called 	MA	Expected Outcome <ul style="list-style-type: none"> Ensure protection of patients and staff by security Action <ul style="list-style-type: none"> Document instances of delay Inform fire and safety officer Inform clinical unit head and liaise with other NUM's to determine if it is a widespread problem 	1998	KG
1.13	Patients / clients who are unable to maintain their own safety are monitored but not restricted except where their own safety, or the safety of others, is at risk.	As per Hospital workbook				

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SAFE PRACTICE AND ENVIRONMENT

1.14	<p>Fire Safety</p> <p>Fire risk is minimised by:</p> <ul style="list-style-type: none"> (a) complying with relevant statutory requirements, codes of practice and Australian standards (b) ensuring activities that are a fire risk, are eliminated, minimised or performed in a safe manner (c) inspection from an appropriate fire authority in the past three years or in the event of any major building reconstruction (d) taking Action in response to recommendations made following an inspection by the appropriate fire authority 	As per Hospital workbook				
1.15	<p>Emergency Planning</p> <p>The organisation plans and practices its response to ensure an effective coordinated approach to internal emergencies and, where applicable, external disasters.</p>	As per Hospital workbook				
1.16	<p>Emergency plans comply with relevant statutory requirements, codes of practice, Australian Standards and are coordinated with statutory and civil authorities as appropriate.</p>	As per Hospital workbook				
1.17	<p>Radiation Safety</p> <p>Management is responsible for ensuring that radiation safety measures comply with relevant statutory requirements, codes of practice and Australian Standards.</p>	As per Hospital workbook				
	<p>Planning and Purchasing of Equipment and Supplies</p>	As per Hospital workbook				

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SAFE PRACTICE AND ENVIRONMENT

1.18	Planning of facilities and selection of equipment and supplies involves relevant staff and is in consultation with appropriately qualified personnel.					
1.19	When planning and purchasing equipment and supplies, consideration is given to, at least: (a) infection control (b) occupational health and safety (c) waste creation and disposal (d) cost benefits	As per Hospital workbook				
1.20	Provision of Equipment and Supplies Safe and efficient practice is ensured through the provision of appropriate equipment and supplies that support the organisation's role and level of service.	Structure/process <ul style="list-style-type: none"> Pall blood filters used for all haematology patients Braun needless giving sets used Hospital wide Outcome <ul style="list-style-type: none"> Giving sets are unsatisfactory. A study is in planning to review the problem regarding infections and effectiveness. Policy developed for utilizing and reviewing Braun the system 	MA	Expected Outcome To ensure safe and efficient practice by using appropriate equipment Action <ul style="list-style-type: none"> Get the study underway 	1999	SK
1.21	Specialised equipment is operated only by appropriately trained staff.	Structure/process <ul style="list-style-type: none"> Plasmapheresis machine required to be operated by specially trained personnel Outcome <ul style="list-style-type: none"> Plasmapheresis machine operated by trained personnel 	MA	Expected Outcome <ul style="list-style-type: none"> Maintained the standard Action <ul style="list-style-type: none"> Review number of people to operate machinery 	1998	C. Trilivas
1.22	Items designated by the manufacturer for single use are not re-used unless the organisation has specific policies and guidelines for safe re-use in accordance with the relevant statutory requirements, codes of practice and Australian Standards.	As per Hospital policy				
1.23	Building Requirements, Functional Design and Layout A program for the maintenance, refurbishment and upgrading of buildings and plant ensures a functional, safe and comfortable environment.	Structure/process <ul style="list-style-type: none"> See 1.2 Refurbishment identified in strategic plan Inadequate accommodation for ambulatory care patients Routine maintenance addressed in safety and environmental rounds Carpet in single rooms(unsatisfactory) Outcome <ul style="list-style-type: none"> Multiple small changes to ward area addressing safety and comfort. Awaiting progress of planning meetings Administrators informed of strategic plan Failure to communicate the hospital wide maintenance and refurbishment plans. Perception that there is no co-ordinated Hospital wide maintenance/refurbishment program. 	SA	Expected Outcome <ul style="list-style-type: none"> Improve environment for outpatients Increase awareness of needs to organization Actions <ul style="list-style-type: none"> Encourage patients to lobby for improvements Meet with facilities planners Continue to monitor unsafe situations to outpatient facility Send reports of maintenance activities to administrators Communicate staff dissatisfaction through multiple levels 	1998 to 1999	N Singh KG

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SAFE PRACTICE AND ENVIRONMENT

1.24	To facilitate safe and efficient practices, consideration is given to the functional and geographical layout of the organisation that conforms with relevant statutory requirements, codes of practice and Australian Standards.	As per Hospital guidelines				
1.25	Whatever the design or purpose of the unit, sufficient space is provided for routine and emergency care of the patient / client.	Structure/process <ul style="list-style-type: none"> Insufficient space in 12H and rooms 9 and 10 to provide emergency care Outcome <ul style="list-style-type: none"> Incidents being monitored 	SA	Expected Outcome <ul style="list-style-type: none"> Space issues will be solved by refurbishment Action <ul style="list-style-type: none"> Stimulate and facilitate refurbishment process 	1998	N Singh
1.26	Appropriate storage of equipment and supplies enables safe and efficient work practices.	Structure/process <ul style="list-style-type: none"> Inadequate storage space Outcome <ul style="list-style-type: none"> Equipment stored in inappropriate places 	SA	Expected Outcome As per 1.25 Action As per 1.25	1998	N Singh
1.27	Utilities (Water, Gas, Electricity and Ventilation) When water is obtained from a source other than a public water supply it is periodically microbiologically tested by a National Association of Testing Authorities (NATA) approved laboratory, and treated as necessary.	As per Hospital workbook				
1.28	Water towers, and evaporative condensers associated with air-conditioning systems, are inspected regularly in accordance with relevant statutory requirements, codes of practice and Australian Standards.	As per Hospital workbook				
1.29	Water stored at less than 55°C is checked and treated regularly to ensure it is clean and maintained at a microbiologically accepted standard.	As per Hospital workbook				
1.30	Energy management systems do not compromise the safety and welfare of patients / clients and staff.	As per Hospital workbook				
1.31	Emergency light and / or power supply is provided in accordance with relevant statutory requirements, codes of practice and Australian Standards.	As per Hospital workbook				
1.32	Maintenance The environment within the organisation is clean and safe for patients / clients, visitors and staff.	As per 1.23				

The EQUIP Quality Planning Workbook

SAFE PRACTICE AND ENVIRONMENT

1.33	Registers of clinical and non-clinical equipment are maintained.	Structure/process <ul style="list-style-type: none"> • Ward maintains list of equipment purchased by haematology • Department has list of equipment • New equipment marked with serial numbers Outcome <ul style="list-style-type: none"> • Register maintained on ward 	MA	Expected Outcome <ul style="list-style-type: none"> • Maintain and develop registers further as necessary Action <ul style="list-style-type: none"> • Review adequacy and need for improved registry of equipment 	1998	KG CA
1.34	A clean, safe environment is ensured through regular maintenance of grounds and equipment in accordance with relevant statutory requirements, codes of practice, Australian Standards or manufacturers' specifications.	As per 1.23				
1.35	Equipment is serviced only by people trained in the maintenance of that equipment.	As per Hospital workbook				
1.36	Current information and scientific data from manufacturers concerning their products are available for reference and guidance for the operation and maintenance of plant and equipment.	As per Hospital workbook				
1.37	Equipment is replaced according to a program for upgrading and replacement.	As per Hospital workbook				
1.38	Waste Management The use of appropriate procedures and equipment, that conform to relevant statutory requirements, codes of practice and Australian Standards, ensure the safe and efficient handling, collection and disposal of waste.	As per Hospital workbook				
1.39	Waste disposal is managed through a program of re-use, reduction and recycling.	As per Hospital workbook				

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IMPROVING PERFORMANCE

IMPROVING PERFORMANCE						
Std No	Survey Item	Evidence of Achievements and Improvements	Rating	Action Required and Expected Outcomes	By When	Person Responsible
1.0	STANDARD 1 A culture of improving performance, consistent with the organisational values and goals, exists throughout the organisation, with leadership and direction from the governing body, chief executive and managers.	Outcomes Achieved for the standard				
1.1	CRITERIA Performance Improvement System The governing body is responsible for ensuring there is a system of performance improvement that is consistent with the values and goals of the organisation.	As per hospital workbook				
1.2	The chief executive is responsible for coordinating and evaluating the performance improvement system and its day-to-day management is delegated to an appropriate person(s).	As per hospital workbook				
1.3	The performance improvement system supports a culture of continuous improvement, sets priorities for quality activities and ensures a planned and coordinated organisational approach.	As per hospital workbook				
1.4	All services and staff have responsibility for, are committed to, and demonstrate active involvement in, quality activities to improve performance.	Structure/process <ul style="list-style-type: none"> • Multiple quality activities by clinical nurse specialists. • Active involvement in clinical trials, (ALSG, IDEC, Antifungal trials, Hickman catheter) • Audit of transfusion and blood use • review of low microbial diet • occupational therapy survey of services provided • pharmacy survey: drug charts, G-CSF, weekend leave requirements • residents hand book revised • planning for assessment of psychosocial distress in cancer patients • involvement in maintenance of professional standards programs Outcome	MA	Expected Outcome <ul style="list-style-type: none"> • continue to motivate people to be involved in quality improvement Action <ul style="list-style-type: none"> • identify stumbling blocks to pursuing quality activities • identify unproductive and inefficient work practices that detract from quality activity time • implement the quality workbook (EQUIP) • form a quality steering committee • appoint a quality activity Officer 	1998	SK

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IMPROVING PERFORMANCE

		<ul style="list-style-type: none"> treatment improvement by clinical trial participation nursing patient care improved by nursing quality activities frustration and difficulty experienced because of inability to implement changes from results of quality activities by financial constraints and lack of resources education tools developed by nursing staff educational activities/protocols developed for CMV/transfusion practices clinical trials have helped standardize treatment pharmacy trial validates G-CSF usage final Outcome: all team members participate in quality activities 				
1.5	Managers and staff evaluate the effectiveness of the performance improvement system and take Action to address any improvements required.	Structure/process <ul style="list-style-type: none"> ad hoc evaluation of results of quality activities Outcome <ul style="list-style-type: none"> ad hoc evaluation of activities 	SA	Expected Outcome <ul style="list-style-type: none"> put in place a program for evaluation of quality programs Action <ul style="list-style-type: none"> employ a quality activities Officer form a quality committee for the department 	1999	SK
1.6	Performance Improvement Methodology Quality activities are documented and enable continuous performance improvement and must incorporate the following elements: (a) monitoring, assessing, analysing and evaluating activities (b) taking appropriate and timely Action (c) evaluating the effectiveness of any Action taken (d) feeding back results	Structure/process <ul style="list-style-type: none"> according to nursing quality kit issued to write up activities for clinical trials according to protocol guidelines Outcome <ul style="list-style-type: none"> nursing activities documented clinical trials documented and published 	SA	Expected Outcome <ul style="list-style-type: none"> better and more widespread communication of results and activities Action <ul style="list-style-type: none"> quality coordinator to review feedback mechanisms 	1999	SK
1.7	The organisation demonstrates improvement resulting from quality activities.	Refer to 1.4				
1.8	Confidentiality of patients / clients, staff and other care providers is protected within quality activities.	Structure/process As per hospital workbook Outcome Clinical trials as per protocol				

DOCUMENT ENDS

BUSINESS PLAN FOR HAEMATOLOGY DEPARTMENT 2006

Addressed to Professor Bruce Robinson – Head, Division of Medicine

The Haematology department remains a very active service and we have seen marked increases in clinical activity in the past few years. This is causing serious difficulties in relation to workload and is one of the major issues facing the Department at present. The recent amalgamation with Central Coast has been favourable with positive intentions on both sides for a productive and cooperative future; however significant direct impact on service delivery has not been great. Research activities continue under the leadership of Dr Chris Ward but this is being jeopardised by the workload issues. It was pleasing however to see for the first-time one of our registrars (Dr. Jenny Curnow) progress from the clinical registrar position into a research position within the Department and we hope this will be the first of many. The business plan which follows will highlight and discuss our strategies for solving the various problems and improving the service in the next few years. Unfortunately the negative impact of the budgetary problems of the Area Health Service severely affects the usefulness of any business plan since most of our strategies require investment which is generally blocked at every turn.

Note about previous business plans, development plans, service plans. Over the last 10 years we have participated in many planning activities and as a department spent many hundreds of man hours in these activities which result in the production of lengthy documents which are then submitted to administrators. The EQUIP planning process several years ago was a major effort with at least 20 meetings attended by the majority of clinical staff and many nursing staff and allied health staff. A major document was produced and as far as I can tell this has just gathered dust. There was no feedback from administration and no clear evidence that the process had any positive effects over the next few years. Then in 2004 we had the “Service Planning Review” meetings run by Tony Penna. Once again I gathered the whole department for meetings and we prepared yet another lengthy document about our departmental activities and business plans. I have never had any feedback about the outcome of this review, nor have I seen any evidence of a positive outcome from this time consuming process. Hence, I trust that this new summary of many self evident issues and solutions will be taken seriously and that we will at least receive some feedback and positive action from our hospital administration.

Note that this plan focuses on “clinical activities” in the department. There are a whole range of laboratory planning issues that are being managed through PaLMS under the guidance of Dr. Eva Raik. The haematology department remains functionally an integrated clinical and laboratory unit and there is considerable overlap in the issues and planning processes between the two aspects.

Positive outcomes in the past 1-2 years.

There have been some positive outcomes in the last 1-2 years however much of our efforts have been directed at maintaining the service in a difficult and adverse environment. We have developed or proposed several new initiatives many of which have been rejected or failed to reach completion.

1. There is continuing efficiency of the ambulatory care unit providing the ability to manage the ever-increasing number of patients. There has been improvement in the proportion of privately referred patients with benefits in revenue.
2. We have established a thrombosis management clinic.
3. We were successful in appointment of an exciting new staff specialist, Dr William Stevenson, to the position vacated by James Isbister.
4. We continued and further developed the allogeneic bone marrow transplant programme despite attempts to close the service. We believe that this is a vital service for the Northern Sydney and Central Coast Area Health Service.

Major issues facing the haematology department:

1. Inadequate staffing levels
2. The lack of a comprehensive quality management system to include details of activity and outcomes.
3. Impediments to effective management, in particular lack of useful information from hospital systems. Particularly lack of financial information related to revenue and costing.
4. Inadequate space. Particularly important is the lack of a suitable space for clinical trials activity and clinical trials staff. Office space is also a problem.
5. Clinical management of the thrombosis clinic and thrombosis trials.
6. Information technology issues. This includes the urgent need for an electronic health record, quality management software, chemotherapy prescribing software, remote access and hardware issues.
7. Protocol and clinical guideline development.
8. Lack of financial independence despite increased revenue within the Department. The pervasive negative effects of the Area's budgetary problems stifling local management solutions. This is crippling the usefulness of planning including this business plan.

Details of the individual issues and strategic plans.

1. Inadequate staffing levels.

All of the clinical haematology staff specialists are struggling with the workload which according to figures from various sources has at least doubled in the last five years. There have been no new establishment positions for clinical haematology in the last 15 years and in fact the absolute numbers have decreased by 25% (from seven clinically active haematologists down to five). This has been firstly, due to the transfer of clinical haematologists to laboratory only activities following the

formation of PaLMS (with responsibility for all Northern Sydney Area pathology), and secondly, the effective loss of Dr Bob Ravich who has almost no clinical haematology activity as he moves towards retirement.

Strategic action. A business plan for the appointment of two FTE equivalents in clinical haematology has been completed and will be submitted through the appropriate channels in January 2006.

2. Lack of quality management systems, quality data concerning activity and outcomes.

It is a fundamental point that in order to plan, a department must know its current situation and in particular how it currently performs. In my opinion since this is a fundamental principle and since we do not know in any useful sense our current performance then most business plans are without foundation and lack real value. In fact the first plan should be to build a foundation of information to measure activity and performance. Our core business is to provide optimal health outcomes and in haematology, for example, this will include things like the remission rate for patients with acute leukaemia and lymphoma. We also need to know the survival as well as the side effects of treatment along the way in order to achieve certain levels of survival. We need to have frequent and detailed audits of clinical management, for example to ensure that patients are being managed according to best practice which will be defined in treatment pathways and protocols. This might include, for example, an audit of the types of antibiotic used for febrile neutropenia and the duration of such therapy. What is the rate of antifungal use and what types of antifungal drugs are being used? What is the rate of infections and thrombosis for central venous catheters? These are the real and important health outcomes in our specialty yet we do not know a single one of these.

Strategic action. Systems are available for performing all of these data gathering functions and we have investigated a number of solutions which include particular software packages and employment of a limited number of additional personnel, in particular data managers. I believe we have identified the solutions but now will need to develop the business case and identify funding. I estimate the time taken to develop and promote the business case is likely to take in excess of 20-40 hours which is certainly not possible unless we solve the workforce issue referred to in point 1 above.

There is an impressive software solution that will provide for a quality management and auditing function known as "Software 4 Specialists". The cost of the software is approximately \$50,000 for 6 specialists and 6 registrars. Employment of data management staff to assist with the implementation will also be needed, probably 1 full time would be sufficient as most of the data is entered by the doctor as they see the patients during normal consultations. This is the beauty of this system which is designed to integrate with clinical practice and needs little additional data entry. If the strategy was successful it would provide a comprehensive database with detailed information on patients disease, including disease staging, past therapy, current and progress treatment, co-morbidities etc etc. Outcomes are also entered into the program including response rates according to internationally defined criteria, duration of response, adverse events and survival. All information is in database format and can be searched, queried, tabulated, cross-referenced and reported. One major obstacle will be the IT Department because of the severe limitations and

restrictions on implementing systems that contain clinical data. Nevertheless we believe this is an essential quality management tool that is long overdue and it will be one of our top priorities for this coming year. Another major obstacle is funding for the software and the data manager. I have the possibility of some funding from the pharmaceutical industry who have expressed interest in supporting this project but it will still need some commitment of funding from the hospital.

3. Impediments to effective management, in particular lack of useful information from hospital systems, particularly lack of financial information related to revenue and costing.

Managing a major Department is frustrating because we are expected to manage with minimal information provided to us. The information that does come is often in an incomprehensible format. Managers who perform clinical duties as well as management, are often at a disadvantage because of the unpredictable, time-consuming and sometimes overwhelming nature of clinical responsibilities. This means that time devoted to management must be even more efficient than otherwise it might need to be. I have attempted to analyse the financial reports on the HIE and in fact I even did a course on how to interpret financial reports but the format in which the reports are available on the intranet are next to useless. One must go in and out of different screens, up and down branches and then back up again just to follow one thread. There are no graphing functions or cumulative report functions, at least ones that are available to me. I have occasionally requested information on revenue generation from Joe Philips but getting a single report once every now and again, only when I request it, doesn't allow month-to-month monitoring and management and appreciation of financial activity of the department. I also receive the pharmacy reports with long list of drugs and costing for each item but without a quality management system to identify which patients, which doctors, and which diseases are responsible for this drug usage makes it hopeless to put in place any strategies for modifying drug use. For all we know we may be under using the drugs rather than overusing them as it is often assumed. Reporting of clinical activity is little better. I have obtained reports from the decision support unit and unfortunately the format of these is not helpful. Raw numbers of patients with particular haematological malignancies can be obtained but mostly the reports consist of lists of patient admissions with codes like "lymphoma – with concomitant comorbidities, without major operating room procedure". There is no information about outcome and certainly no easy way to correlate this with parameters like the type of chemotherapy used.

Hence, lack of information about the departmental activity, both clinical and financial is a major deficiency for a departmental manager.

Strategic action. It seems that getting finance & accounting departments and IT departments to provide more user-friendly reporting systems is unlikely to be successful. I have discussed this issue with Colin Murray in previous years and he has apparently raised this issue but nothing has happened. If we can implement a departmental quality management system which will include detailed information on patient numbers with their diseases then this will address some of the issues around the provision of clinical activity. Tackling the financial data is more difficult but it is critical since the ability to enhance services is at least partly dependent on the ability to generate revenue and to control costs. This data is available but it is time-consuming to obtain and also requires time to process it and analyse it with

appropriate software packages. The best solution I can see to gaining this information is to employ a dedicated person who would act like a project officer/quality manager/business manager for the department. This could be an extremely valuable position and if such a person could help manage the finances of the Department they may well pay for their own salary. This is on the business plan for this coming year and it is estimated this proposal will take at least another 10-20 hours to develop, prepare and push it through the various obstacles along the pathway. It therefore has only a slim chance of being done because of my ongoing clinical commitments and lack of staff to whom such activities can be delegated.

4. Clinical trials and other departmental space limitation. The haematology department is critically short on space. Partly this relates to the fact that we have both a laboratory and a clinical component to our practice. In the past couple of years the laboratory space has contracted as we needed to give up space to microbiology with movement of microbiology laboratories from the district hospitals. This has affected the clinical trials and the research sections of the department. Clinical trial activity has increased in the past few years. Also the demands for improved efficiency in running clinical trials has increased. The space we have now is no longer adequate. The clinical trials data managers and research nurses are packed into a small section that is actually part of the laboratory and so never designed as a clinical trials office. At the same time the research programme under Dr Ward has enlarged but space for the scientists has become critical. This would be partly solved if the research scientists could use the laboratory space currently occupied by the clinical trial staff. Ideally a purpose designed clinical trials area should be built so that all aspects of clinical trials could be performed in the one area. This would include office space for the data managers and research nurses, storage space for case report forms and trial related documents, a small laboratory bench space for basic processing of specimens (e.g. centrifuging samples), two or three examination rooms where patients could be seen by the investigator or research nurse and where patients could be consented. Also there would need to be an area for trial monitors to come for auditing.

The haematology general office is also in desperate need of refurbishment and modifications that would make the available space more efficient. We currently conduct daily clinics in the department and perform about 30 bone marrow biopsies each week in a side room in the main departmental office area. Two secretaries work here, there is photocopier and fax machine and constant traffic and phone calls. We also have a "waiting area" for patients and another corner for the bone marrow nurse to sit and manage the bone marrow biopsy bookings and reports. The whole area is often chaos and not designed for the multiple functions we have tried to squeeze in.

Strategic action. A business case with an actual floor plan design for a haematology clinical trials unit was submitted to the facilities planning group in November 2005. The haematology department also offered to fund the proposal, i.e. for the refurbishment which would be required, using departmental trust funds. The proposal has been presented to Colin Murray and Andrew Bott who agreed with the merits of the proposal. Unfortunately the proposal was rejected by the facilities planning on the grounds that other uses of available space in the hospital were higher priority. Our intention is to try again in early 2006. We believe this proposal is also a very high priority. Increasingly in haematology the optimal management of patients consist of participation in clinical trials where they can access the latest therapy. Clinical trials are just as much "core business" and "essential clinical work" as anything else that we do. In many instances such trial therapies are the only treatment

that might be effective in some haematological malignancies. As such I believe that providing for clinical trials should receive the same top priority as any other necessary clinical activity.

Clinical trials also generate revenue and in the case of trials with high cost drugs they avoid the expense of these drugs that might otherwise be used off-trial. Some of these drugs cost in excess of \$10-20,000 dollars for a single patient. Hence the potential savings are significant.

Regarding office space improvements one of our secretaries put a lot of effort into planning a reconfiguration of the office and designed a more space and work efficient area. The secretary also drew up plans and investigated solutions and even obtained quotes (e.g. for a compactor to store documents). However when this proposal was submitted for approval we were reprimanded. This was because planning is the role of “facilities planning” and we had no right to do our own planning! Despite the damaging effects of this event on staff morale we still believe in the plan and will resubmit proposals for office refurbishment through the “facilities planning” process. This is disappointing since we are aware of the long delays through this process and the potential for many projects to be shelved or put on hold because it doesn't fit in with someone else's priorities.

5. Running of the thrombosis clinic and thrombosis trials. The thrombosis clinic (known as the “Clot Clinic”) has been a very successful new service initiated in the past 12 months. It addressed a serious deficiency since anti-coagulation and thrombotic problems remain major causes of morbidity and mortality yet we did not have a specialised clinic where patients could be referred for diagnostic assessment and management advice. A clinic devoted to the diagnostic assessment and management of patients with thrombotic and haemostatic disorders now exists and is supervised by Dr Chris Ward. This provides pre-operative assessment of patients who are thought to be at risk of thrombotic complications post surgery. The clinic is also closely integrated with the management of patients presenting through emergency with a thrombotic event. The clinic facilitates the transition management of these patients in the difficult hiatus between the initial presentation to emergency and then the longer term management by their general practitioner. In some ways the clinic has been too successful and soon after its inception it needed to be expanded to two days per week. In the past six months 1050 patients have been reviewed at the clinic and this has generated \$17,800 in clinical billings and there is probably at least this much again generated in pathology revenue. The success of the clinic has added significantly to the clinical workload of Dr Chris Ward even though he is assisted by one of the registrars and Dr Jenny Curnow (Research Fellow). The clinic is also an ideal focus for the running of clinical trials in thrombosis. We believe that the productivity of the clinic both from a therapeutic and a research viewpoint would be markedly enhanced if we had a nurse assistant who would assist with the thrombosis management of patients and at the same time assist with the clinical trial management. These roles would synchronise very well. A thrombosis clinic nurse is essential since a lot of the management of these patients requires checking of results and phone calls as many of them are managed with a combination of direct contact and phone contact. This is time-consuming but would be most suitably done by a specialised thrombosis clinic nurse. There is also great potential for running clinical trials in thrombosis which is a very active area of research into new therapeutic agents. Recently Dr Ward has turned away offers to participate in clinical trials because we have had insufficient trial support staff as well as the demands on his own

time. The appointment of a research nurse who also assists with the running of the clinic would help to solve this problem.

Strategic action. A business case will be prepared to make a new position of “thrombosis clinic and research nurse”. Since at least 50% of the work would be devoted to routine management of patients it will be proposed to have a sharing arrangement to fund this position with 50% coming from hospital funding, perhaps funding already generated by the clinic, and 50% coming from clinical trials income. Preparation of the business case is estimated to take at least 15-20 hours and so once again will be affected by the workload of the staff specialists and the limitations on time to write the Business Case and follow it through.

6. Information technology issues. This includes the urgent need for an electronic health record, quality management software, chemotherapy prescribing software, remote access, hardware. Access to timely information concerning patient care remains a top priority. It has been disappointing that despite the availability of excellent technical solutions, we do not have a functioning electronic health record. There have been some advances this year but the progress is painfully slow. For example, we identified a software package known as Plexus IBA Spectrum that could provide for an electronic health record, prescription writing, retrieval and storage of the patient’s pathology and radiology results, and electronically generate requests for pathology, radiology and chemotherapy. After many months of negotiation with the IT Department and hospital administration it was agreed to trial this in the newly formed thrombosis management clinic run by Dr Ward in 12A. The software has been installed for several months now but is not yet functioning because Dr Ward has had insufficient time to implement the programme in his clinics. This is therefore one example of how these business plans are interconnected. Failure to solve the workload issue will adversely impact on the success of every other part of the business plan.

Chemotherapy prescribing is one of the most serious issues in the therapeutic area of the department. A medication error for chemotherapy was partly responsible for initiating a “root cause analysis” and health department investigation last year. Chemotherapy prescribing errors can lead to life threatening complications either because the patient’s disease does not respond from underdosing or dose omissions or because of serious toxicity from overdosing. Transcription errors are also a significant problem since chemotherapy protocols need to be handwritten on to the prescribing charts and a single chemotherapy protocol can be very complex. There is great potential for transcribing errors and something as simple as putting the decimal point in the wrong place can be fatal. There are safeguards to prevent this such as the pharmacist checking but there are limits to failsafe mechanisms which is why we saw the medication error last year. Chemotherapy prescribing software is at a very advanced stage and is widely used for example in the United States and Canada. Implementation of such software would avoid many transcribing errors and would provide a much more secure and accessible record of patients treatment. Currently it is difficult to actually retrieve the record of chemotherapy for a patient and if it happens to be after-hours and the paper records are filed away then there is no way that we can track down what chemotherapy a patient has had in recent weeks.

Remote access to clinical information and our departmental files would be a significant benefit to the clinicians. We are frequently contacted about patients while at home or otherwise outside the hospital. In some circumstances access to detailed pathology and radiology results could be critical when giving appropriate advice

about a patient. It is unfortunately a fact of life that much of our hospital work is done while at home. This is made more difficult by the limits to or absence of on-line remote access from home or while away on leave. It appears that access to Groupwise has just become available on broadband internet access but we still have limits on broadband access to the many other functions of the intranet including radiology. This is possible through VPN clients but it took me over 6 months to get this approved and operating. I understand there is still a reluctance to allow this more generally to clinicians. Access to shared files via broadband would be the next advance since we could use a single master file rather than having multiple copies both inside and outside the hospital. A further advance would be wireless access since this would give even greater freedom to get connected both within and without the hospital environs. A wireless access connection currently operates for the Palliative Care Clinicians at Gosford hospital and so there is a model already in operation to be followed.

Strategic action. Although the hospital and health Department are pursuing electronic health records it still is likely that a useful EHR is more than 1-2 years away. We will continue to pursue the trial of the Plexus IBA Spectrum software. We have been in discussions with Margaret Duguid from the pharmacy, since Margaret has seen some excellent chemotherapy prescribing software that she would like us to consider. A meeting with the software company has been planned early in 2006. Funding will again be a major issue as the software is expensive (approx \$80,000). Another somewhat promising possibility is a parallel plan by Dr Campbell Tiley (Director of Haematology, Gosford hospital) who is developing an electronic health record using the Cerner Power Chart application. Dr Tiley has been working with a team of clinicians including nurses and allied health practitioners in Gosford to develop the screens and lay out for a haematology/oncology application. Dr Tiley has also received a large grant from the health Department to develop his plan. Chris Arthur has been involved in the planning and signalled his desire to be part of the implementation. Since this project has been sanctioned by the Area IT Department it may be easier to take this program forward. The Cerner Power Chart is unlikely to fulfil the auditing and quality management functions that the "software 4 specialists" performs. Interestingly Dr Tiley was so impressed with "software 4 specialists" that I understand he is in the process of purchasing this program for implementation for Gosford haematology. It may therefore be possible to link with him in this project.

Remote access and greater utilisation of modern IT solutions is on our agenda but we have been disappointed by the poor links with the IT department and the failure to have a really functional and co-operative working relationship with the IT department. We hope to improve this but have no good ideas on how to do this at the moment. Participation in clinical computing committees in the past has been disappointing.

7. Protocol and clinical guideline development. A considerable amount of the diagnostic and therapeutic work in haematology can be performed according to clear protocols and treatment pathways. Although as a group of haematologists we more or less practice in the same way, nevertheless, we also recognise that there would be substantial benefits for the staff specialists and junior staff if we had very clear protocols and therapeutic pathways to follow. Having an identical treatment pathway has a number of benefits including: greater familiarity with the treatment by the doctors and the nursing staff, the ability to analyse results because patients are treated the same way, and as an aid to clinicians who may be less familiar with a particular disease. Treatment of haematological malignancies is becoming increasingly

specialised. For example, one member of the department has special expertise in chronic myeloid leukaemia, another has special expertise in amyloidosis, another one has special expertise in hypereosinophilic syndrome etc. It's not easy to seek out the local expert every time you have a patient needing treatment but if these are documented in protocols and treatment pathways then it makes management much more efficient. We currently have a book of protocols which have been put into electronic format and are available on some computers but they are several years out of date. They do not have treatment or management pathways incorporated. We have been trying to update the protocols for the last two years but attempts to form even a brief working group have been regularly overwhelmed by the sheer volume of day-to-day clinical and administrative business.

Strategic action. We do have a clear idea of the sorts of protocols and treatment pathways that we want to document and in fact we have even borrowed or purchased detailed documents from other hospitals. Such documents extend to several hundred pages if they are done properly with enough detail to be useful. The preparation of such documents, even with the help of a template from elsewhere, is a major undertaking and probably in excess of 100 - 200 hours work. This is because each disease needs to be researched and then the data synthesised, agreement reached and the protocol and clinical pathway written. This needs to be performed for each of at least 20 different diseases. Changes in optimal treatment have tended to change even at 12 monthly intervals over the past few years in a number of haematological malignancies and so it is not a simple matter of copying someone else's documents. Furthermore the documents need to be modified for the local idiosyncrasies. Once the documents are completed it is necessary to update them otherwise they rapidly become not only out of date but potentially damaging if someone applies an outdated therapy to a particular patient.

Although this is a momentous task it is a high priority. We have agreed to appoint an additional registrar funded from departmental trust funds for the first eight months of this year and one of the tasks of this registrar will be to assist with the development of protocols and therapeutic guidelines. We don't expect this task will be anywhere near completed but we hope it will be a start.

8. Lack of financial independence. Many if not most new initiatives and enhancements require financial investment. For example most of the projects noted above require either personnel, software, hardware or refurbishments. The current budgetary crisis in the area health service is not new but does seem to be worse than 10 years ago. Unfortunately the flow on effects of this crisis have been stifling. For example, it was recently difficult just to get a broken Dictaphone replaced even though this was used for seeing patients who generated income! As if it wasn't self-evident, it was necessary to put forward a justification for why the Dictaphone should be replaced. When the clinicians' time is so limited it shows a gross misunderstanding of the priorities that force a specialist to use valuable time to justify a Dictaphone! In the light of difficulties with small things it makes managers totally despair and lose hope when considering large projects such as those considered above. The only solution I see to this is if departments can be given access to a limited amount of discretionary funding. In the case of the haematology department we do have the ability to generate revenue through services provided. We are aware that there are some holes in the revenue capture; much of this is due to inefficient billing systems. We suggested about eight years ago that if departments could identify a new initiative to generate revenue that the facility fee could be returned to the Department and used

at the discretion of the departmental managers. This would be a win-win solution because the revenue is still being spent on essential hospital functions but according to the local department priorities, which we believe can only be appropriately determined by the individual department. Furthermore, with this system there was an incentive to increase billing since a proportion of the revenue came back to the Department. When Professor Norbert Berend was the hospital CEO this plan was activated and worked well for a couple of years. At least to a limited extent it gave our Department part of the financial independence we needed to develop our priorities and plans. I believe that if the individual departments are strong then the whole hospital is strong, like the analogy of a house and the quality of the bricks that support it. Unfortunately in recent years and presumably because of the severe budgetary restraints the agreement for use of new initiative revenue has not been honoured. I understand that some senior managers are philosophically against the concept of incentive, however I think this ignores basic understanding of human nature and the nature of enterprise in business psychology.

Another important reason for financial independence is to overcome the inefficiencies that layers of bureaucracy create when trying to get something approved. For example, I am trying to replace a computer in a clinic that is used for patient management but Colin Murray tells me that there will be at least 3-4 layers of committees or individuals that need to sign off and approve this. Even if it is successful this will take many weeks to proceed through the layers. This makes it impossible to improve efficiency when the weakest links are beyond our control. We would like to see the same sort of urgency applied to the administrative decisions as applies to our clinical management.

Strategic action. We plan to once again explore mechanisms to gain at least some partial financial independence for the department. If we cannot do this then we are vulnerable to the vagaries of political and high-level financial decisions. It is intended to pursue negotiations with administration to explore mechanisms for some limited financial independence. The departmental requirements are in fact quite small in comparison to the overall budget and our ability to capture just a small percentage of total revenue would make an overwhelming difference to the productivity of the department.

CONCLUSION

This is a brief summary of some of the major issues affecting the haematology department at present and our strategies to solve the problems and enhance the service. Our main fear is that these good ideas will be stifled either by lack of time to implement them or bureaucratic obstacles that weaken our resolve.

Prepared by Chris Arthur, 1/02/2006

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02/02/2006

Prof Bruce Robinson  
Division of Medicine  
Royal North Shore Hospital  
St. Leonards 2065

Dear Bruce,

RE: Departmental Business Plan

As requested please find attached our departmental plans for this year. I am happy for this to be given to any senior management you think may benefit from this.

Regards,

Chris Arthur