AUSTRALIAN MEDICAL ASSOCIATION QUEENSLAND
ABN 17 009 660 280
T | +61 7 3872 2222
E | amaq@amaq.com.au
88 L'Estrange Terrace
Kelvin Grove QLD 4059
PO Box 123, Red Hill QLD 4059
ama.com.au/qld

21 October 2024

Adjunct Professor Jackie Hanson
Chief Executive
Metro North Hospital and Health Service

By email: [redacted]

Subject: Caboolture Hospital ED meeting outcomes

Dear Adjunct Professor Hanson

Thank you for meeting with us and doctors from Caboolture Hospital's emergency department on Monday, 14 October 2024, to discuss ongoing clinician concerns about patient and staff safety in the ED. Please find enclosed a copy of the minutes, including the ED registrars' statement delivered at the start of the meeting.

We appreciate the time you and your senior executives and staff allocated to air the issues as a group and to commence discussions towards resolution.

Many matters remain outstanding and these are set out in the second document enclosed ('Caboolture Emergency Department Meeting Outcomes'), including the ED registrar concerns (Table 1) and SMO concerns (Table 2) with:

- requested actions;
- agreed/proposed actions; and
- completed date or MNHHS explanation why the action can't be completed and alternative proposed actions.

The aim of this document is to identify actions that are supported by both the ED clinicians and MNHHS executive and specify timelines and details for their implementation. As agreed by all parties during the meeting, it is imperative the matters are resolved collaboratively, effectively and promptly to ensure the safety of Caboolture Hospital's patients and staff.

We respectfully seek your input where indicated in the document with a response by **31 October 2024**.

In addition, we note non-ED clinicians also raised concerns that the Hospital does not require recruitment panels to include appropriately qualified medical practitioners from the department to which relevant roles are being filled. Clinicians state this is hindering recruitment efforts and lowering morale given the chronic staff shortages across the hospital.

The inclusion of appropriately qualified medical practitioners on recruitment panels is an important requirement for both patient safety and staff attraction and retention and we ask you to implement such a requirement as a priority.

As always, we are open to meet to discuss these matters with you and look forward to receiving your response.

Yours sincerely

[redacted]

Dr Nick Yim
President
AMA Queensland

Dr Brett Dale
Chief Executive Officer
AMA Queensland

Copied to:
Mr Michael Walsh, Director-General, Queensland Health, [redacted]
Ms Karlene Willcocks, Executive Director, Caboolture, Kilcoy and Woodford Clinical Directorate, Metro North Hospital and Health Service, [redacted]
Mr Bernard Curran, Board Chair, Metro North Hospital and Health Service, [redacted]

21 October 2024

Caboolture Emergency Department Meeting Outcomes

Table 1 – ED Registrar concerns

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
1. Nationally competitive locum rates	Insert text	Insert text
2.a) Optimisation of recruitment processes and attraction	DMS will meet with SMOs group every 4 weeks, to oversee improvements in recruitment system. Attraction incentives can be advertised to potential recruits. Streamline medical workforce processes to focus on optimising recruitment and retention of good doctors.	Insert text
2.b) The maintenance of adequate ED staffing should be a proactive process. Department is designed for staffing of: • Day shift – four registrars, • Evening shift – four registrars, • Night shift – Two registrars. This requires 120 clinical shifts per fortnight to cover. To staff three registrars on day + evening shifts + two on night shifts requires 112 clinical shifts per fortnight. To staff two registrars on day, evening and night shifts requires 84 clinical shifts.	Insert text	Insert text

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Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
We request that rosters be provided to executive on a fortnightly basis, with a projection of filled clinical shifts. We request that a staffing crisis response procedure be generated – eg. Nationally competitive locum rates, rotating registrars from other sites, any other possible assistance possible, and implemented automatically when recognised that projected clinical shifts in any given fortnight fall below 112, with a further escalation if the number falls below 84 – eg. Further increase in locum incentives. We also request that when these triggers are activated, that a communication of measures taken be sent to the SMO and registrar groups.		
2.c) We would appreciate a commitment to staffing our department such that registrars do not exceed the current industry standard of 25% night shifts – one week in four. Doing more than this encourages burnout and discourages learning and professional development.	Insert text	Insert text
2.d) ED staff with numbers comparable to other EDs with presentation numbers (all roles and levels)	Form an agreed path and timeline to fund then recruit to average workforce levels, seen at other MN EDs and QH EDs of similar size.	Insert text
2.e) Re: recruitment – we ask that that job ads be accurate, timely and that ads submitted via locum agencies be reviewed prior to publication. We humbly submit that an attraction bonus that is not	Insert text	Insert text

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
advertised does not serve as an attraction bonus, and should be advertised. The possibility of being in charge overnight cannot be ruled out at present, and this should be clearly stated.		
2.f) There was time in our meeting dedicated to explaining the barriers prohibiting publication of timely and accurate job ads. We ask that these barriers be dissolved, overcome or circumvented. Lives depend on this.	Insert text	Insert text
2.g) We ask that same-position pay inequalities be avoided. We would appreciate commitment to ensuring that attraction/retention bonuses implemented for new staff are applied to existing staff also - at time of implementation.	Insert text	Insert text
2.h) Plan for registrar night cover that **does not** require any of the following due to patient safety risks: • one of the evening SMOs working through both shifts; • assigning an SHO to the resus role; or • single registrar night shifts.	Insert text	Insert text
3.a) Clear strategy to attract and retain senior nursing staff- Specifically those with ED experience. We need those with a well honed sense for impending decompensation.	Insert text	Insert text
3.b) Retention bonus for senior nursing staff	Insert text	Insert text
3.c) Executives to speak with staff and address frequency of occupational	Insert text	Insert text

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
violence against triage staff. We ask for a streamlined and accessible escalation pathway for occupational violence, with assistance from senior management to ensure guaranteed and consistent enforcement of consequences. 'zero tolerance for violence or aggression' currently feels like fiction. Discussion of engineering solutions to triage staff occupational violence would also be appreciated.		
3.d) Executives to speak with nursing staff and provide better supports to triage staff facing patient complaints every shift.	Insert text	Insert text
4.a) RE: Demand surge plans, ie. Tier 3 – We acknowledge that this procedure exists, however escalating concerns re: clinical workload does not seem to affect number of ambulance arrivals, based on lived experience. If the existing plan is effective, we would appreciate data that demonstrates such. If not effective, we would appreciate the formulation and formal testing of a surge plan that is effective.	Insert text	Insert text
5.a) Re: complaints management – A complaints process should be used to identify systemic shortfalls and patterns that contribute to patient dissatisfaction. We would appreciate affirmation that the complaints process will not be used to target individuals. Triage staff in particular report being issued with a 'please explain' following a complaint.	Insert text	Insert text

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
5.b) Re: complaints process - in times of resource shortfall, complaints will increase, this is as it should be. The community is right to be angry. We respectfully submit that asking clinicians to devote time to averting budding complaints is both a corruption of the purpose of the complaints process, and any time spent on this is time taken from acting on clinical priorities. We ask that you commit to the complaints process proceeding naturally, without interference.	Insert text	Insert text
6.a) If we are to continue to practice with a resource shortfall, we ask for support from our upper management in the face of increasing complaints, while we practice as best we can.	Insert text	Insert text
6.b) When complaints are raised via the media – owe are rendered mute by respect for patient confidentiality. We have absolutely no avenue for response. We ask that before senior management speak to the media in such cases, that our own input be sought. Doing otherwise undermines us further in the public eye. If our community does not trust us, our advice is not followed. This renders us ineffective, and puts our patients at risk. We ask for commitment from senior management to seek a collaborative approach with us during such events.	Insert text	Insert text
7.a) Re: Executive interference with clinical priorities – we acknowledge that making suggestions is within your	Insert text	Insert text

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
purview. We submit that, regardless of intent, recent input has been interpreted as straying well beyond suggestion. We ask in future for commitment to special care being taken re language + persistence employed when making such suggestions.		
8.a) Re: interference with patient locations – There has been a recent uptick in presentations of young people with behavioural disturbance to the ED. Pressure has been applied to prevent us from treating these young people in areas other than our paediatric ED. When the person in question is screaming expletives at the top of their lungs, damaging property and attempting self harm with nearby objects, it makes the entire paediatric ED unsafe for other patients and families. When verbal de-escalation fails, we are left with no good options. The preferred method would be a low stimulus environment, set up to minimise risk of self harm, allow time to self regulate. We are barred from this at present. We would like to be able to move young people to the mental health area when we deem it the least of available evils.	Insert text	Insert text
9.a) Re: QAS offloading – We acknowledge that it's vitally important that ambulances be able to attend unwell people in the community. We would also like it recognised that there is zero point in an ambulance bringing someone to us if we	Insert text	Insert text

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
are not equipped to treat them in a timely fashion.		

Table 2 – ED SMO concerns

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
Lack of crisis support		
1.a) Commitment to develop a Caboolture Hospital emergency arrival surge protocol, within 3 months.	• MNHHS execs offered to: ▪ Provide a link to ED clinicians for the capacity protocol, including criteria and triggers for tiered responses. ▪ Review and update the framework in collaboration with ED staff. ▪ Provide clarity on how ED overload can trigger a tier 3 response. • MNHHS CMO offered staff to shadow her to see how they manage the issues in the hospital. • ED staff to advise what information they wish executives to share with them about the various issues covered above (e.g. actions when ED overloaded/Tier 3/ramped ambulances needing release; recruitment efforts and status).	Insert text
1.b) Commitment to develop a MNHS emergency surge response plan, within 3 months. Designed for situations where emergency arrivals overload 1-2 emergency departments, to enable equity of patient access to emergency care.		
2.a) Written clarification of the principles for when a code yellow can be triggered, 24/7, not person or role dependent.	Hospital executives offered to: • Produce information to table at the ED Green Meetings and via the ED Director and Nursing Directors/team leaders and logistics nurses to show ED staff what's happened in the past week/fortnight including: ▪ Number of Tier 3s called	Insert text

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
	▪ How long the hospital was at each Tier 3 ▪ Number of ambulances diverted ▪ Number of procedures stopped • Include in those communications so SMOs can see what's been happening.	
2.b) When requests for code yellow are declined, a concrete risk assessment and mitigation plan needs to be made, to ensure the provision of safe healthcare.	Awaiting review of tiered capacity response protocol.	Insert text
Interference with patient locations		
3.a) Agreement that the location of clinical care is a clinical responsibility, within the available clinical resources.	**Agreed**: 3.a): Executives confirmed that the order in which patients are treated and where they are treated is a clinical decision.	Insert text
Interference with staff locations		
4.a) Agreement that the real-time distribution of clinical staff within ED, is the responsibility of the clinical leads on-duty. In order to meet the emergency care needs of patients, in a fair manner.	**Agreed**: 4.a) Executives agreed that frontline clinical leads decide where staff are distributed. When a satellite facility requests redeployment of staff, the Service Line Medical Director and Nursing Director and Allied Health Director will communicate, to make a coordinated response, aware of the need to provide safe staffing levels in the ED.	Insert text
4.a) ED performance measures will include 'equity of access to care' for known patient cohorts; paediatric, older people, mental health. The aim to ensure that all people can access emergency care in an equitable manner, reflective of the seriousness of their condition.	Insert text	Insert text

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
Access to ward care		
5.a) Agreement that **all** admitted patients get equitable access to ward beds, based on clinical need.	Executives agreed that patients awaiting ward beds will be prioritised with equity, regardless of their location in ED and EDSTTA. If patients in STTA wait more than 4hrs for a ward bed or an IHT, Executives want to be informed of this delay, in order to help facilitate access to a definitive care location.	Insert text
5.b) ED performance measures will include ward access measures for short stay unit and acute areas, aiming to ensure equitable access to ward care.	Insert text	Insert text
Prescriptive staffing, removing flexibility		
6.a) See 4.a	Insert text	Insert text
6.b) Agreement that changes to models of care and 'solution design' will involve codesign with local staff groups, who provide the healthcare. Acknowledging that defining the problems may benefit from objective external assessment.	Insert text	Insert text
Disabling recruitment efforts		
7.a) DMS visit to ED SMO meeting each month, to help oversee the interface between ED and Medical Workforce process improvements.	Exec Director, DMS and SMOs to meet to maximise opportunities for recruitment and retention. Exec Director offered staff resourcing to help this improvement. DMS agreed to attend ED SMO meeting every 4 weeks, to help oversee recruitment and retention of ED medical workforce.	Insert text

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
8.a) Agreement to apply the B1 'Recruitment and Selection policy' in the same manner as other MN Emergency Departments.	MN CMO requested that recruitment and retention processes be reviewed, to focus on outcomes, removing unnecessary bureaucratic steps.	Insert text
8.b) Agreement that any recruitment incentives can be openly communicated with potential recruits.	Executives to confirm with ED staff that the registrar incentive payment has been formally approved for 2025 by end of the week (COB 18 October). Executives agreed that recruitment and retention incentives can be communicated and marketed to potential recruits.	Insert text
8.c) Decisions on recruitment levels will be made before recruitment cycles occur. If delays are unavoidable, then these will be communicated openly with the SMO group, along with collective plans on how to manage these risks and clear written responsibilities, with timelines for subsequent decisions.	Agreement that recruitment processes, including authorisation, need to align with known recruitment cycles. It is healthy to escalate any impending failures, in order to provide staffing staff levels, to meet the emergency needs of our community. MN CE requested that MN CMO provide MN-wide ED Registrar recruitment for 2026 onwards. MN CE requested that CKW work with other MN facilities to optimise voluntary distribution of ED Registrars each term, with urgency. Acknowledging the impact on incentive payments and travel costs.	Insert text
8.d) Formation of a standing delegation for locum contracts and extensions, to enable quick turnarounds. This can be modified over time to reflect changing needs.	MN CE stated that there is currently no limit on locum funding, to get ED Registrar levels up to full funded level. Acknowledging the skillset of locums is frequently lower than permanent Registrars.	Insert text
8.e) Formation of a new 'provisional offer recruitment & selection form', to enable speedy provisional offers	Insert text	Insert text

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
and safe compliant full recruitment processes.		
Diverting ED staff to work elsewhere		
9.a) Agreement that satellite hospitals manage their workforce, without short-notice redeployment from ED.	Executives agreed that staffing of ED and satellite facilities is separate. See 4.a	Insert text
10.a) Staff are not redeployed away from ED, unless it has adequate resourcing to provide an acceptable level of emergency care.	Executives agreed that the safe provision of emergency care is an essential service. Agreement that the primary purpose of ED is to provide resuscitation and stabilisation of critically unwell people.	Insert text
11.a) Agreement that on occasions when CKW cannot provide adequate levels of service provision at both the ED and satellite hospitals, then either a whole of CKW or MNHS response will occur.	Multiple executives stated they want to be called whenever the ED cannot provide a safe level of emergency care for the community. They will coordinate a response.	Insert text
Interfering in clinical prioritisation		
12.a) Agreement that movement of individual patients within the ED is the responsibility of clinical leads. These clinical leads may seek management assistance when unacceptable clinical or system delays occur.	Agreement that it is the responsibility of clinical leads to determine the best location for providing emergency care.	Insert text
12.b) ED performance measures will include access to care measures, regardless of the method of arrival in ED. With the aim of equal access to care, for triage cohorts. Eg. Abdominal pain, chest pain, fevers.	Insert text	Insert text

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
Eg. Arrival to treatment. Eg. Arrival to primary treating clinician.		
12.c) See 5.b	Insert text	Insert text
13.a) Agreement that the purpose of the ED is primarily to provide emergency care for all the community.	Broadly agreed	Insert text
13.b) Agreement that integrity needs to be reflected in all our performance KPIs.	Insert text	Insert text
Providing incorrect clinical diagnoses		
15.a) Agreement that all staff need to act within their scope of clinical practice.	[redacted] Agreement that all staff need to act within their scope of clinical practice.	Insert text
15.b) Agreement that individual healthcare management plans are the responsibility of clinicians; formed with multi-disciplinary and multi-specialty input. Managers can contribute to the formation of these plans, where they contribute specific knowledge.	[redacted] An ED management plan process already exists, with approximately 150 active plans. This process was recently placed on hold. The DMS will review the process in the next few weeks, in order that this important aspect of ED care can be resumed. [redacted]	Insert text

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
Interfering with patient triage		
16.a) Agreement that triage is a clinical tool, to be used by frontline ED clinicians.	• Agreement that triage is a clinical tool, for use by clinical staff, in prioritising access to care. • Trauma informed care requires a consideration of known history, when assessing triage and care location.	Insert text
Level of care not accessible to other patients		
17.a) See 15.a & 15.b	See 15.a & 15.b	
17.b) CKW senior management education on duality of roles, partiality and managing conflicts of interest.	Insert text	Insert text
18.a) See 13.a	See 13.a	
Directed care for an individual family		
19.a) See 15.a & 15.b & 17.b	See 15.a & 15.b & 17.b	
Lack of collaboration and codesign		
20.a) Agree that staff involved in implementation, need to be involved in the solution design process.	Insert text	Insert text
21.a) Apply IHT processes consistent with all other MN EDs. Ie. Stop requiring 'online IHT forms' for patient transfers to Caboolture Private Hospital.	Insert text	Insert text
21.b) Agree that ED models of care will be designed by staff who work in the ED.	Insert text	Insert text
21.c) Acknowledge that ED SMOs have a deep understanding and	Insert text	Insert text

Requested action	Agreed/proposed action	Completed date or MNHHS explanation why can't be completed and any alternative proposed action
learning about how emergency care can be provided; that they will be included in ED redesign and improvement processes.		
Complaints system mismanagement		
22.a) See 24.a	See 24.a	
23.a) Agreement that system managers will respond to complaints which primarily relate to system issues.	Insert text	Insert text
24.a) Commit to form a more mature CKW complaints management process, which includes prioritisation of severity, graded response options and allocation to the role which has the responsibility for the primary complaint.	Insert text	Insert text