

## Background

In October 2015, the Office of the Health Ombudsman (the office) made the decision to investigate a notification from the Chief Executive of Metro South Hospital and Health Service (MSHHS). The notification concerned serious clinical and operational issues found to have impacted on the performance of the Logan Hospital audiology department (Logan audiology).

The office was advised of a series of ongoing issues dating back to 2011 regarding the clinical competency of audiologists providing diagnostic testing and assessment services. The office's investigation sought to determine if MSHHS had implemented appropriate strategies and governance processes to ensure children attending Logan audiology receive a quality audiology service that meets contemporary practice standards.

## Overview of Logan audiology

All babies born in Queensland's public and private hospitals receive free hearing screening through Queensland Health's Healthy Hearing (HH) program. The HH program aims to ensure every child reaches optimum speech and language development, through early detection of permanent childhood hearing loss and early intervention. The HH program has developed statewide key performance indicators (KPIs) designed to support and maximise linguistic competence and literacy development for children who are deaf or hard of hearing.

Logan audiology is one of 12 paediatric audiology clinics in Queensland that receives referrals from the HH program to provide specialised support services, including diagnostic services for newborns and babies. Audiologists assess babies referred by the program, recording all test results and audiological outcomes for every child assessed.

The HH program works collaboratively with audiology services to support the delivery of standardised evidence-based treatment. This is done through a range of quality control and performance monitoring activities, including data reporting against KPIs and auditing of audiological practice.

MSHHS provides audiology outpatient services from both the Logan and Princess Alexandra Hospitals. The audiology team at Logan provides diagnostic audiology services for both adults and children which includes:

- babies referred from the newborn hearing screening program
- children with multiple health concerns and developmental delays
- comprehensive hearing assessment for adults

- a walk-in clinic for clients referred through the ear nose and throat (ENT) clinic.

In 2015, MSHHS initiated a restructure of Logan audiology, with key changes comprising:

- merging the audiology and speech pathology departments
- creating and commencing additional audiology positions within the newly formed department
- relocating audiology services to refurbished facilities and co-locating with the Integrated Specialist ENT Service
- ceasing the provision of paediatric diagnostic services at the Gold Coast University Hospital.

The restructure has seen the introduction of a combined Director of Speech Pathology and Audiology role which provides strategic direction and professional leadership and operational management to a larger multidisciplinary team, including audiologist and speech pathologist. Within the team there are currently six permanent audiologist positions, with four audiologists qualified to provide paediatric diagnostic audiology services under the auspice of the HH program. Advanced audiologists based within the Speech Pathology and Audiology Department are clinical specialists with clinical supervisory responsibilities for their audiology colleagues.

## The investigation

The office identified three areas of concern and sought to determine if MSHHS had identified and implemented processes and measures to adequately address these issues. During the investigation, the office reviewed extensive documentary evidence and information provided by MSHHS and met with clinical and operational staff from Logan audiology.

### Issue 1—Inadequate clinical expertise of Logan audiology’s paediatric audiologists

The HH program conducted its first audit of audiological practice at Logan audiology in July 2011; this included a sample of 10 case files and revealed significant shortcomings in diagnostic case management. The HH program provided training and supervision to the audiologists identified through the audit process, in an effort to improve clinical practice and the department’s performance outcomes.

In 2014, a larger sample audit was repeated and again revealed significant shortcomings in audiological practice at Logan audiology. Consequently, all paediatric audiologists at Logan audiology managing cases referred by the HH program commenced an individualised supervision program and undertook further training.

In response to further investigations into the performance and management of Logan audiology, MSHHS identified two audiologists considered to have practised below accepted clinical standards; the practitioners were suspended while disciplinary action commenced. The two practitioners were referred to the office in December 2015 and the then Health Ombudsman took immediate action to prohibit the audiologists from providing any health services.

## Findings

The office recognises that neonatal and infant diagnostic audiology is a complex speciality area requiring significant specialised training and clinical supervision. As Health Ombudsman, I find the poor performance outcomes of Logan audiology were, in part, systemic and sustained due to the absence of a professional learning culture and commitment to high quality service provision.

The HH program provided audiologists with professional development support following the 2011 audit findings, however this had minimal impact on improving Logan audiology's performance outcomes—as demonstrated by the 2014 audit findings. There were a number of factors contributing to the continued poor performance of the service including workload of the director; isolation of the service; and the fact that the director, whose performance was a known issue, was responsible for implementation of the recommendations following the audit.

I acknowledge that, following the 2015 restructure of Logan audiology, a substantial amount of work has been undertaken to improve performance and patient outcomes, significantly reduce waitlist timeframes, and improve staff workplace satisfaction. Critical to this has been:

- recruitment of highly skilled and experienced professional staff, including paediatric diagnostic audiologists
- introduction of a comprehensive clinical supervision framework within the department, incorporating peer-to-peer review and a competency-based training program
- participation in professional advisory and advocacy working groups, including the HH program's Audiology Working Group and Queensland Health's Audiology Governance Group
- merging the audiology and speech pathology director roles into one position with operational management responsibility of the department.

## Issue 2—Inadequate response to issues identified

Logan audiology underwent three external quality assurance activities from 2011 to mid-2014, including the two HH audits and an external review commissioned in November 2013. Multiple items were identified for follow-up, including urgent action to address inaccurate infant testing, interpretation of results, and replacement and calibration equipment; recommendations relating to staff training; and the revision or introduction of protocols and guidelines.

At the time of these activities, the director position was responsible for managing the findings and determining when appropriate action had been taken to adequately address the item or recommendation. This process did not involve higher level clinical or corporate oversight of the quality or adequacy of improvements implemented.

In late 2014, the Executive Director, Allied Health, MSHHS, was formally notified of a case involving a child with delayed diagnosis of moderate-severe permanent hearing loss as a result of inaccurate reporting and failure to follow up by Logan audiology. MSHHS responded by immediately commencing a clinical audit of all diagnostic referrals sent to Logan audiology from the HH program of children born in 2011 to 2014; every appointment was examined and a total of 228 cases were identified.

A detailed report was prepared in July 2015 with further follow-up of patients undertaken, resulting in a small number of children identified with hearing issues that had not been appropriately diagnosed or followed up by the service. MSHHS recorded and managed these cases through the hospital's incident management system, Riskman, and commenced a formal open disclosure process with each of the affected families.

## Findings

The 2014 notification highlighted the seriousness and extent of the issues affecting the quality of the paediatric audiology services at Logan Hospital. MSHHS initiated an urgent and appropriate risk response with a thorough audit of all case files and transparency for the affected families. This included follow-up of a number of cases by MSHHS staff to ensure appropriate care and management.

This office's investigation has involved meeting with operational and clinical staff from the newly amalgamated Speech Pathology and Audiology Department. I am satisfied that, since the restructure of the department, significant changes have occurred that demonstrate a robust approach to quality improvement and that reporting of clinical incidents is now in place.

Importantly, the restructuring of the department has ensured audiology services are now assessed for accreditation under the National Safety and Quality Health Service Standards. This process requires the department to have systems in place to actively manage patient safety and quality risks. The department's quality activity reports demonstrate this, with reports regularly generated from the integrated electronic medical record system to investigate data accuracy, escalate issues or concerns, and analyse information.

Additionally, the HH program has introduced a quarterly monitoring program to monitor diagnostic outcomes for babies referred to the department. This information is collected and reported on from the QChild database used by all HH program sites and is able to identify any issues or concerns relating to outstanding clinical and operational KPIs.

I am satisfied MSHHS has demonstrated an ongoing commitment to continuous quality improvement of audiology services and that suitable mechanisms are now in place to monitor, identify, and respond in a timely and appropriate manner to areas of risk.

## Issue 3—Inadequate governance processes and systems

Prior to the 2015 department restructure and relocation, Logan audiology comprised a small team of audiologists with limited training and competency in critical areas of service delivery, particularly paediatric diagnostic testing. The team was physically and professionally isolated, with minimal corporate oversight, or professional collaboration or development. Additionally, the team was operating without appropriate child-specific protocols and guidelines, and were providing services to children inconsistent with best practice.

The newly formed department brought audiology services under a governance structure that provided oversight of clinical and corporate systems and processes, ensuring it connected with the broader hospital and health service framework.

MSHHS's commitment to improved governance of audiology services is illustrated by the focus areas identified in the speech pathology and audiology department's 2016–17 operational plan, one of which was the development and implementation of protocols and work instructions to standardise service delivery. This work was prioritised during 2016 in recognition of the critical relationship between documented processes and patient safety and quality improvement systems.

## Findings

MSHHS's decision to restructure the department has been essential to the success of improving the performance outcomes for paediatric audiology at Logan Hospital. The department has demonstrated the effectiveness of the governance changes through significantly improved patient outcomes reported by the HH program. The new governance framework provides transparency and accountability which will considerably mitigate the risk of repeated adverse outcomes.

## Conclusion

The office was made aware of the issues affecting the quality of audiology services at Logan Hospital following the completion of a comprehensive clinical audit. The audit report made specific recommendations to address systemic issues impacting on staff performance and patient outcomes, including inadequate staff training and supervision, and administrative and governance processes.

It is evident the governance changes implemented by MSHHS have ensured the recommendations have had appropriate oversight and have been effectively implemented; this has significantly improved the quality of the service audiology patients—in particular babies referred by the HH program—received at Logan Hospital. In July 2011, Logan audiology was described as one of the poorest performing services in the state, however in March 2018 the HH program confirmed Logan's diagnostic reporting rates are among the best in Queensland.

The office is satisfied children receiving audiology services at Logan Hospital are receiving high quality professional healthcare services and encourages MSHHS to continue to review its clinical and corporate governance processes to ensure the service remains of a high standard.