Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program

West Moreton Hospital and Health Service

Ipswich, QLD

Organisation Code: 71 51 30

Survey Date: 20 – 24 August 2012

ACHS Accreditation Status: ACCREDITED

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About The Australian Council on Healthcare Standards

The Australian Council on Healthcare Standards (ACHS) is an independent, not-for-profit organisation, dedicated to improving the quality of health care in Australia through the continual review of performance, assessment and accreditation. The ACHS was established in 1974 and is the leading independent authority on the measurement and implementation of quality improvement systems for Australian health care organisations.

The ACHS mission is to 'improve the quality and safety of health care' and its vision is 'to be recognised nationally and internationally as the leading Australian organisation that independently assesses performance and promotes and improves the quality and safety of health care.'

The principles upon which all ACHS programs are developed and the characteristics displayed by an improving organisation are:
• a customer focus
• strong leadership
• a culture of improving
• evidence of outcomes
• striving for best practice.
These principles can be applied to every aspect of service within an organisation.

What is Accreditation?

Accreditation is a formal process to assist in the delivery of safe, high quality health care based on standards and processes devised and developed by health care professionals for health care services. It is public recognition of achievement of accreditation standards by a health care organisation, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards.

How to Use this Survey Report

The ACHS survey report provides an overview of quality and performance and should be used to:

- provide feedback to staff
- identify where improvements are needed
- compare the organisation's performance over time
- evaluate existing quality management procedures
- assist risk management monitoring
- highlight strengths and opportunities for improvement
- demonstrate evidence of achievement to stakeholders.

This report provides guidance for ACHS members for future quality improvement initiatives by documenting the findings from the organisations accreditation survey. This report is divided into four main sections.

1 Surveyor Team Summary Report
2 Ratings Summary Report

1 Surveyor Team Summary Report

Consists of the following:

Function Summary or Periodic Review Overview- A Function Summary/Overview provides a critical analysis for organisations to understand how they are performing and what is needed to improve. It provides an overview of performance for that Function and comments are made on activities that are performed well and indicating areas for improvement.

Criterion ratings

Each criterion is rated by the organisation and the surveyor team with one of the following ratings.

- LA
- SA
- MA
- EA
- OA

The rating levels are:

LA – Little Achievement - Organisations that achieve an LA rating will have an awareness or knowledge of responsibilities and systems that should be implemented but may have only basic systems in place. At this level compliance with legislation and policy that relates to the criterion would be expected.

SA – Some Achievement - An organisation that achieves an SA rating will have achieved all the elements of LA and will have implemented systems for the organisation's activities. At this level there is little or no monitoring of outcomes, and so efforts at continuous improvement may be limited by a lack of understanding about the effectiveness of existing systems.

MA – Marked Achievement - The label for MA has changed from "Moderate Achievement to "Marked Achievement" as the term "Moderate" did not reflect the high standard of achievement that organisations reach within the MA award level. An MA rating requires that achievement against the elements of LA and SA has been demonstrated and that efficient systems have been established for collecting relevant outcome data on processes and preferably outcomes, monitoring this information, evaluating current procedures and planning improvement in response.

EA – Extensive Achievement - To Achieve a rating of EA in EQuIP5, demonstrated achievement against the elements in LA, SA and MA must be met. In addition, response to EA elements will be reviewed and extensive achievement against the criterion statement and/or its elements is required. Organisations will be able to demonstrate extensive achievement in a criterion if they satisfy one and preferably more, of the following requirements:

- internal or external benchmarking and subsequent system improvement, and / or
- the conduct of research that relates to the particular criterion, and subsequent system improvement, and/ or
- proven, excellent outcomes in that particular criterion.

OA - Outstanding Achievement - All elements of LA, SA, MA and EA must be achieved as well as a demonstration of leadership in this criterion. Leadership in a criterion does not necessarily mean that the organisation is a peer leader of performance and excellence in Australia. However, it does require an organisation to use concentrate evidence to demonstrate that it is one of the best and, more importantly, that it has taken a leadership stance in communicating its outcomes to other professionals, other organisations and/or consumers/patients, or that the organisation is being recognised and sought out for its knowledge by other professionals and organisations.

Criterion Comments -

Surveyor comments regarding individual criterion detailing issues and surveyor findings and opportunities for improvement. Comments are available for all mandatory criteria giving an indication of why the organisation is achieving at the given rating level.

Criterion Recommendations -

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular criterion. Surveyors are required to make a recommendation where an LA or SA rating has been assigned in a criterion to provide guidance and to provide an organisation with the maximum opportunity to improve. Recommendations in the survey report need to be reviewed and prioritised for prompt action and will be reviewed by the surveyor team at the next on site survey.

Risk ratings and risk comments will be included where applicable- Risk ratings are applied to recommendations especially where the criterion rating is an SA or an LA to show the level of risk associated with the particular criterion.
Risk ratings could be:

- E: - extreme risk; immediate action required.
- H: - high risk; senior management attention needed.
- M: - moderate risk; management responsibility must be specified.
- L: - low risk; manage by routine procedures

High Priority Recommendations (HPR) -

A High Priority Recommendation (HPR) is given to an organisation when:

- consumer / patient care is compromised and / or
- the safety of consumers / patients and / or staff is jeopardised.

Surveyors complete a risk assessment to validate their decision to allocate a HPR, which should be addressed by the organisation in the shortest time possible.

2 Ratings Summary Report-

This section summarises the ratings for each criterion allocated by an organisation and also by the survey team.

3 Summary of Recommendations from the Current Survey-

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular criterion.
Recommendations are structured as follows:

The criterion numbering relates to the month and year of survey and the criterion number. For example recommendation number OWS 0811.2.1.1 is a recommendation from an OWS conducted in August 2011 with a criterion number of 2.1.1

4 Recommendations from Previous Survey-

This section details the recommendations from the previous onsite survey. The actions taken by the organisation and comments from the surveyor team regarding progress in relation to those recommendations are also recorded.

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Survey Report

FUNCTION SUMMARY: CLINICAL

West Moreton Hospital and Health Service (WMHHS) undertakes comprehensive assessment of patients for admission through pre-admission and within specialty units and the Emergency Department (ED). The Community Health Services Central Intake also has comprehensive assessment strategies. Guidelines for the deteriorating patient are in place and linked to the Adult Deterioration Detection System (ADDS).

Care management plans are evident in the medical records and form a foundation for care delivery. Care planning in Child and Family Health has a multidisciplinary team approach and clinical pathways have been introduced where they can add value to high cost high resource illness pathways by looking at variances and predicting outcomes. Consent forms for numerous procedures are varied across the Health Service and are used in conjunction with surgical consent forms.

There is need to review the consent forms throughout WMHHS with an outcome such that there is one consent form for all invasive procedures. The No Consent No Booking policy has resolved the issue of patients on elective lists having no written consent.

It was evident that clinical care is evaluated throughout WMHHS. Mortality and morbidity meetings occur through the various departments within Ipswich Hospital; however there is variability in feedback and it is recommended that more robustness be put into this important area of health care outcomes.

Discharge processes are in place and commence at pre-admission or admission. The journey boards enhance the patient journey and advance the patient in a more systematic way through the work expertise of the health professionals they require. Clinical handover at the bedside is implemented in some wards and units and not in others. There is a recommendation around this area.

WMHHS has a strong foundation for the provision of ongoing care due to the quality and commitment of the community based services which use a proactive model to provide assessment management and referral, aiming for the most appropriate setting in which to meet the needs of the client.

Evaluation has occurred across the majority of these services, and there is evidence of change to ensure improved practice. Qualitative and quantitatively validated assessment tools are used to measure clinical outcomes and the impact of specific exercise and education programs for people with chronic conditions.

Decision making at the end of life is performed exceptionally well in all areas across the organisation.

Information is available to the community on the services available through a variety of strategies and the current redevelopment has involved ongoing consultation with the community. Collaboration occurs between the organisation and consumers and carers through relevant support groups and Rural Reference Groups.

The Oral Health Service has reviewed access to treatment and is trialling a process to appoint all patients to the service to minimise waiting time at the clinics.

Access: An organisation-wide redesign project is currently underway to address demand management, patient flow and access. This involves work to meet State and National Targets for access in the areas, Emergency access and Triage targets, elective surgery targets and Outpatient Specialist Clinic access. Although this initiative is in the early stages of implementation, there has already been some improvement in the key indicators identified.

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Appropriateness: WMHHS provides impressive integrated inpatient, ambulatory and community services that are responsive and adaptive to the needs of clients/patients/consumers and the changing demographics within the population it serves. Innovative models ensure that the right care is available and delivered in the right place at the right time. Opportunistic service delivery reaches the most vulnerable consumers who traditionally have high rates of non-attendance and has resulted in impressive key performance outcome data. There are rigorous inclusion and exclusion criteria. Strong collaborative arrangements exist with major referral centres for transfer of care, or where appropriate, ongoing management at WMHHS.

Effectiveness: Evidence drives practice improvement in both clinical care and service planning and configuration. Data are collected from relevant internal and external sources to allow evaluation locally and across the system.

WMHHS have an organisation wide medication safety system with associated policies and procedures in regard to medication prescribing, dispensing, administration and storage. There is good clinical pharmacist input into ward activity at Ipswich Hospital but improvement in this service at all the outlying hospitals would strengthen the medication safety system. Operational efficiency KPIs measure performance against targets and overall are very good.

The monitoring of temperatures of drug refrigerators is less than optimal and systems need to be implemented to improve this area. A formal system for reporting of adverse drug reactions to ADRAC is also required.

WMHHS has very good surveillance systems for both community acquired and nosocomial infections. The staff immunisation program has produced exceptional results and the CSD units at both Ipswich Hospital and the Ipswich Community Dental Clinic have excellent processes which ensure that the AS/NZ Standard for sterilisation of reusable instruments is met at all times.

Cleaning standards in both the dental clinics and the hospital are very high, however there were some issues identified in the Mental Health Unit related to washing of client clothes and the transportation of food and mops that need to be addressed. Hand hygiene is generally high but there is opportunity for improvement in a couple of areas.

WMHHS has a commendable system for the assessment, identification and management of pressure injuries and those patients who are at risk of developing such injuries. Data is continually monitored and benchmarked at the State level. Two wound consultants manage not only the inpatients throughout the service but also provide assistance to community service providers and outpatients without being specifically funded to do so. This service, the resultant reduction in occupied bed days and patient satisfaction with the service has helped to improve the organisation’s rating for this criterion.

Across the organisation there are good systems and processes in place to manage the prevention of falls and minimise harm from falls. Falls incident data is regularly reviewed at the Unit level, is on display for staff and analysed through the Falls Working Party and Patient Safety and Quality committee at an organisation level.

WMHHS has a well-developed, evidence based blood and blood product transfusion service, based on NH&MRC guidelines. This service is closely monitored and has identified and addressed the issue of inappropriate requests for blood and blood products. There is a zero tolerance for the acceptance of blood samples and requests that are not perfectly completed. This approach has reduced the potential for errors. Blood wastage has also reduced as a result of strategies implemented to address this issue. Blood refrigerators are alarmed and closely monitored. Transportation of blood is carried out in line with best practice as determined by the ARCBS.

WMHHS has an organisation-wide patient identification and procedure matching system but this is not fully implemented throughout all areas of the organisation. It has been well implemented in key areas

such as Pathology, Radiology and Oral Health. Unfortunately, not all staff in the operating theatre at Ipswich Hospital follow the best practice “time out” procedure which includes completing the World Health Organisation’s checklist for the correct patient, correct site and correct procedure.

The organisation is in the initial stages of addressing the criterion for Nutrition. Initiatives such as the Red Tray Alert system and menu and meal review have been implemented at some of the smaller rural facilities and are aimed at improving nutrition for patients. Results have been shared with the other rural hospitals within WMHHS.

The recently established Nutrition Working Party has completed a detailed self-assessment against the Nutrition criterion and developed an action plan to address areas for improvement.

Providing high quality nutrition care to patients is a complex task requiring a multidisciplinary approach with the roles and responsibilities of staff clearly defined, agreed and regularly reviewed. Strong clinical governance with Executive sponsorship will facilitate the implementation of the Nutrition Management Strategy currently being implemented by the Nutrition Working Party.

Consumers are involved in many ways within the WMHHS. A consumer sits on the Board’s Quality and Safety Committee bringing a community perspective and community knowledge. Consumer groups are engaged in many activities across the health service and a consumer feedback form "Tell us what you think" has been introduced. Complaints to the media have decreased, largely due to the consumer involvement with the wider community. The Ipswich Foundation is a Statutory Body that supports the WMHHS in many ways with particular interest in healthy lifestyle activities and fund raising.

Gatton and Laidley
Both Gatton and Laidley rural services provide exceptional quality of care, evidenced by the consumer feedback that is received at both facilities. Members of the survey team had the opportunity to meet with representatives of the Hospital Auxiliaries, who play an integral part to sustaining the running of these small health services. The involvement, support and role of the local Hospital Auxiliaries is evidence of true community engagement and commitment. Those present spoke very highly of the services being provided and the contributions made through the monies raised that assist in providing improved patient care and patient journeys, an example being the palliative care bed at Laidley.

The multi skilling of staff at both facilities is impressive, especially the up skilling of wards persons at Gatton to perform X-rays. Implementation of the Red Tray Alert system for the serving of patient meals at Gatton which aims to assist in the prevention of malnutrition in the elderly is an excellent initiative and there was already some evidence of improved clinical outcomes since the system was implemented.

Learnings from the unfortunate floods in the Lockyer Valley in early 2011 have resulted in updates being made to the external disaster management plans which, in conjunction with the interagency emergency services, are excellent.

The survey team acknowledges the fire and other associated risks related to the building structures at Laidley and the risk mitigation strategies and controls that are in place for evacuation, two of which are conducted at night and include an exercise with the QLD Fire and Rescue and the Ambulance Service.

Mindful of the building risks, the organisation has placed two recliner chairs into the ward area for the monitoring of non – admitted patients over night. With only two staff members on at night this has reduced the need to be in the ED to observe the patient, leaving the second staff member alone on the ward area.

A recommendation regarding the risk management process has been made highlighting the need for more efficient risk profiling and use of risk registers so that extreme risks are entered into local risk registers e.g. the fire risks associated with the building structure at Laidley are not being escalated through the risk management system to the District Risk Register and Executive team for appropriate action.

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Boonah and Esk
Each of these small rural services are managed by enthusiastic acting managers. Despite the uncertainty of the future of these leaders, both teams comprise dedicated staff. Having such highly skilled, multi-skilled (including radiology) nurses, particularly in emergency departments is a significant asset to these small communities.

A nurse practitioner at Boonah will be an additional asset and enhance emergency coverage already provided by several RIPERN trained nurses and General Practitioners. The embracing of the 'Productive' model at Esk and Fish model at Boonah is to be commended.

Both sites are well equipped, often due to the generosity of local auxiliary or community groups, who have provided, for example, bariatric equipment at Boonah. Activities designed to enhance staff morale e.g. monthly BBQs at Esk, are commended at both sites. Staff education is often provided locally at these rural services e.g. Esk Study Day with a Health Barrister to address medico-legal issues, as well as Journal clubs and onsite mandatory competency days.

Like those employed at Esk, members of the survey team were also concerned about the fire risk for the facility. The building is elevated, being a "Queenslander" style, constructed largely of wood and quite close to a natural bush area. It was pleasing to note that staff are focused on mitigating this risk; including having two fire officers and regular evacuation exercises, and 100% completion by staff of fire training, but the risk still remains a concern.

There are challenges to meet infection control standards at both sites, but particularly at Esk where the one dirty utility room is some distance from main patient area. The number and location of bathrooms and hand washing sinks also creates difficulties. There are often a number of patients being managed within these facilities, none of which are designed for patient isolation.

Despite the age of both the facilities they are well maintained though Esk is in need of some paint work and the emergency signage needs to be completed.

The recent commencement of a Rehabilitation Service at Boonah is proving positive with additional allied health resources being introduced.

There was also concern from the survey team that at both Boonah and Esk there is ambiguity around the medical superintendent's positions in terms of role, responsibility and authority. There needs to be more formal medical governance at each facility as well as improved timeliness of endorsement of medications ordered by telephone, review of pathology results and medical assessment prior to transfer. This forms a recommendation to be addressed.

The survey team was particularly impressed by the engagement of the auxiliaries at both facilities and the way in which the health service at Esk, together with the whole community managed the external flood disaster in early 2011.

Community and Primary Care Services
The Community and Primary Care Services are centrally located in central Ipswich adjacent to the railway station and major bus interchange. Community Health Services are also available at Goodna and the four Rural Hospitals with an outreach capacity for specialist services provided from the Ipswich Centre.

A broad range of services is provided by the larger team based in Ipswich, and there is a commitment to providing services to the most vulnerable populations, with flexible service delivery to meet the needs of clients.

All referrals to Community Health are managed through the Central Intake service, including the registration of clients in the patient information system.

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Community Health services are well integrated into the inpatient setting with services such as Hand 2 Home, based in the Emergency Department, providing a rapid response, multidisciplinary assessment and management of complex clients. This team is also able to coordinate care for the complex client to facilitate early discharge and follow up in the community if required.

There is evidence of a strong culture of ongoing evaluation and improvement within the Community and Primary Care Services.

Aged Care Assessment Program and Chronic Conditions Services also provide an in-reach service to facilitate early assessment and referral of inpatients to an appropriate setting for on-going care. These strategies provide significant support to the inpatient services in the management of patient flow and access.

Oral Health Service
The Oral Health Service of WMHHS is a well-coordinated clinical group. All the facilities visited were well maintained and clean. Staff engagement in infection control is strong and the infection control processes in place, including sterilising services, comply with AS/NZS Standards and State policy.

There is good clinician compliance with patient identification processes including the 3Cs.

The inclusion of the Oral Health Service in the multidisciplinary Head, Neck and Mouth Cancer clinic is to be congratulated. The Oral Health Service is able to provide useful pre-, peri- and post-operative dental treatment and support to patients during often complex, painful and sometimes disfiguring treatment e.g. treatment of problematic teeth prior to treatment, assistance with the management of mucositis and other oral complications associated with treatment, prosthetic restoration of missing teeth to assist eating and speech and social function by restoring some aesthetics.

It is noted that the initial multidisciplinary consultation with all groups involved in the treatment of the patient may be intimidating to the patient and some consideration should be given to support of these consumers. It is also noted that transport, using the "CODI van", is available for patients who are required to receive some of their treatment in Brisbane.

A program of systematic audit is conducted across the service that incorporates:

a clinical record audit that monitors compliance with policy and standards; a review of patient satisfaction with the processes for treatment that is a face to face interview with the consumer; a clinical examination of the patient's oral cavity to evaluate the effectiveness and appropriateness of the treatment; an audit of the sterilising processes including checks of the sterilising records to ensure compliance with requirements; and use of check lists to standardise the operation and maintenance of equipment including the start-up and shut down of the clinic.

The service has reviewed the entry process of emergency and acute need patients to its service and found that there is need for change. It was considered unacceptable that patients who required emergency or acute services were required to attend in person at a clinic and wait for a dental clinician to become available to provide pain relief treatment. A trial process has been developed that proposes using telephone triage of patients and making appointments for these patients. The telephone questionnaire is already in place in the ISOH software and will support this process, thus easing the stress for both patients and reception staff.

Mental Health
It is evident that referral systems involve strong relationships with a variety of referral partners and there are agreed referral protocols in place (1.1.1). Policies and procedures exist for care delivery across the service and these are evaluated (1.1.2). Consumers and carers are well informed of the consent process and there is a good understanding across the service regarding consent processes and the legislative requirements of mental health service delivery (1.1.3). The systems for entry and retrieval of clinical

documentation (discharge and transfer 1.1.5) are well managed within the Consumer Integrated Mental Health Application (CIMHA) which is utilised across inpatient and community settings. Access to computer terminals is variable across the Integrated Mental Health Service (IMHS) and this variability needs to be addressed.

Considerable effort is required to ensure patients'/clients' discharge planning and communication regarding their ongoing care is appropriately transferred between service providers particularly the Non-Government Organisation (NGOs).

There was evidence of developing partnerships with general practitioners and external providers. This was evidenced by the work being done regarding Psychiatry clinics in General Practices and Super Clinics with the IMHS.

Ongoing care processes are evaluated and improvements were evidenced across the service. There are multiple sources of education for consumers and carers regarding ongoing care with strong consumer involvement in care delivery and planning processes.

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Function: Clinical **Standard: 1.1**

Criterion: 1.1.1

Assessment ensures current and ongoing needs of the consumer / patient are identified.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.1.1

Within the WMHHS pregnant women are assessed for the level of care required when they present for care during their pregnancy and are screened into appropriate models of care. There are inclusion and exclusion criteria for levels of pregnancy care provided. Close links exist between WMHHS and referral centres including referral and transport processes for patients requiring higher levels of care. This is commended.

WMHHS Community Health Services Central Intake has comprehensive assessment strategies to facilitate prompt early referral to appropriate services.

The Region-wide Patient Risk Assessment form has been developed to screen for high risks. This is just being rolled out across the organisation. The Medical Business Unit (MBU) has improved patient flow, consumer involvement and Emergency Department Engagement in care, through the introduction of the Ripple effect project.

The Region has instituted guidelines for the deteriorating patient with the introduction of the Adult Deterioration Detection System (ADDS) and the Child Early Warning System (CEWT).This would be further enhanced by a MET type system, with ongoing review of the effectiveness of such a system. This is the subject of a recommendation.

Electronic journey boards have enhanced the patient stay and improved allied health referrals for discharge home.

The Pre Admission clinic provides preoperative assessment of patients, however this clinic fluctuates in the times it operates which is both inefficient and confusing to staff and patients. This is the subject of a recommendation.

A protocol and guidelines have been developed that better utilise telemetry beds and include specific safety rounds. A rapid assessment asthma clinic has been established, with a dedicated asthma team and the outpatient department has been redesigned to better engage consumers and allow better time and space utilisation.

A "drop in "Diabetes Clinic has been introduced to address consumer needs.

Mental Health

There is a well-documented process for assessment across all sites within the WMHHS. Utilisation of the State-wide Information System (CIMHA) ensures a standardised suite of assessment tools are completed for every consumer, particularly around risk assessment. Access to CIMHA at the point of assessment is variable across the Mental Health Service and this is largely due to access to computer terminals in interview areas. If it is the intention of the service to utilise electronic health care records for entry and retrieval of clinical information at the point of assessment and care this access requires improvement. A recommendation regarding this area is raised under Criterion 1.3.1.

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The implementation of the High Security Inpatient Nursing Pre-Admission Assessment Form to assess consumers prior to admission to The Park Mental Health Centre is a positive initiative to ensure appropriate assessment of consumers who may require admission to this specialised service. Similarly, the Seclusion Flow Chart for consumers detained under the Mental Health Act and Involuntary consumers gives a well-documented process for supporting, reducing and even eliminating restraint and seclusion.

The Reconciliation and Recovery Team, Evolve Teams and the Acute and Continuing Care teams provide good examples of where the assessment system is ensuring that the current needs of the clients are appropriately identified.

Recommendations

Criterion 1.1.1 #1

Surveyor's Comments:

The survey team noted the introduction of a comprehensive assessment of the deteriorating patient. However it was noted there was no formal MET type process.

Surveyor's Recommendation: **HPR:No**

The Ipswich Hospital introduce a formal MET System or similar process to respond to the deteriorating patient.

Criterion 1.1.1 #2

Surveyor's Comments:

There is a Pre Admission clinic available, however the infrastructure is such that the numbers of patients assessed at this clinic are well below benchmark numbers for comparable health services in accordance with the operating hours of the clinic. This clinic could be used more effectively on a daily basis.

Surveyor's Recommendation: **HPR:No**

The Pre Admission clinic be reviewed so that the resources can be used more effectively allowing for more patients to be seen through this clinic.

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Function: Clinical **Standard: 1.1**

Criterion: 1.1.2

Care is planned and delivered in collaboration with the consumer / patient, and when relevant the carer, to achieve the best possible outcomes.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.1.2

Policies, procedures and guidelines are available from the Queensland Health (QH) website which provide direction for patient planning and care evaluation. It was noted that not all staff were able to navigate rapidly through the system.

Clinical Programs across Child and Family Health Services (CAFHS) demonstrate a multidisciplinary team approach to care planning, in collaboration with patients/families/guardians.

Care management plans are evident in the medical records and form the foundation of clinical care delivery. Multidisciplinary clinical review facilitates the evaluation of care, with care management plans amended as necessary. Cohorts of patient outcomes are considered at multidisciplinary meetings and areas of concern are able to be recognised and acted upon.

Improvements have been implemented in wards with the introduction of the productive ward and the increased time for care projects. Key achievements are the improved work environment and more time to respond to patient calls.

A new clinical pathway has improved the care of gastroenteritis patients in Paediatrics.

Hourly ward rounds have been introduced in the rural hospitals (Gatton and Esk) to improve patient care and subsequently the incidence of falls has reduced.

The Patient Risk and Assessment Monitor (PRAM) has been recently introduced. Its effectiveness will need to be assessed, monitored and evaluated by the next survey.

The CIMIS system identifies cases that require review of clinical incidents

Mental Health

The utilisation of CIMHA, a consumer-centric clinical information system designed to support mental health clinicians in the provision of safer quality mental health services, ensures that there is an electronic copy of individual management plans, Individual Care Plans (ICPs), risk assessment and discharge plans available. This ensures clinical information is available to all services utilising CIMHA either as end users or in ‘read only’ format.

In terms of consumer involvement in assessment and care planning, there may be opportunities to better involve some consumers in the care planning process and provide evidence of this. It is acknowledged that not all consumers are able to be involved in these processes and this will be dependent on their illness acuity however those that can be involved should be.

The Care Co-ordination model used at The Park indicates flexibility and responsiveness to the needs of the consumers and carers. It utilises a joint planning process between consumers, carers and care co-ordinators in the development of ICPs.

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Weekly reviews of consumer care from an ICP perspective is documented in the clinical record either directly into CIMHA or uploaded as a Word document. The Care Planning Package Checklist provides Care Co-ordinators and clinical team members with a quick reference to the tools that require completion for care planning review. A new checklist is completed at each care plan review date.

The ICP and Recovery and Crisis Prevention Plan (RCPP) are the documents that combine all the assessments and information together and outline the goals for the consumer to work towards recovery.

The ICP has a strengths focus and aims to highlight the consumer's goals as well as clinical issues. These are living documents that are utilised in direct care and clinical decision making.

Recommendations

Criterion 1.1.2 #1

Surveyor's Comments:

Mental Health
Opportunities exist for consumers to be involved in their care planning process where possible. Some documented evidence should be provided of this.

Surveyor's Recommendation: **HPR:No**

Develop a system to monitor compliance with care planning, and document consumer involvement in the process.

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Function: Clinical **Standard: 1.1**

Criterion: 1.1.3

Consumers / patients are informed of the consent process, and they understand and provide consent for their health care.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.1.3

There are a variety of consent forms and information forms available for an array of procedures. These are used in conjunction with surgical consent forms. A review of consent forms is required so that one consent form is available for all invasive procedures. This is the subject of a recommendation.

Consent processes are evident in CAFHS. Notes within the medical record documenting minor procedure or examinations include notation that verbal explanation and consent occurred e.g. for blood collection and abdominal palpation.

The Medical Records Department has audited the consent to release medical information forms with a good result.

The previous deficiency related to obtaining consent from patients placed on elective lists has largely been resolved with the implementation of the No Consent No Booking policy, however, continued diligence in this area is required.

WHO guidelines have been implemented in the operating theatre, however, the survey team noted incomplete uptake in certain disciplines. This is the subject of a recommendation in another criterion (Refer 1.5.6).

There is evidence that patients from different cultures and language groups are considered with respect to the consent process, as are the needs of the patient with an intellectual disability.

An audit of the consent process forms/documentation has identified some areas for improvement around adequate patient identification on each page of the relevant consent form and the identification of the medical officer. This will require ongoing work to ensure better compliance.

Issues were identified by the survey team around photographs being taken and stored digitally without adequate patient consent or a process being followed. This is the subject of a recommendation.

Mental Health

There is good understanding across the service regarding processes and documentation associated with consent. Medical records (both paper based and electronic) are well-structured and appropriately maintained. There is an appropriate awareness of legislative requirements and relevant guidelines and a process is in place to review current practices.

The referral processes to the service include communication to the referral source that every referral occurs with the knowledge and consent of the client or the client’s guardian. Compliance with the consent process is evaluated utilising an audit tool which has identified improving compliance.

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Recommendations

Criterion 1.1.3 #1

Surveyor's Comments:

There was evidence of photographic recording of patients occurring together with digital storage, often on private devices. This is contrary to hospital policy and protocol.

Surveyor's Recommendation: **HPR:No**

Review the consent process for photographing and digital recording to ensure staff understand how and when photographs and digital images may be obtained and stored and how to gain adequate patient consent for this.

Criterion 1.1.3 #2

Surveyor's Comments:

A variety of consent forms and information forms are available for an array of procedures. These are used in conjunction with surgical consent forms.

Surveyor's Recommendation: **HPR:No**

Review all consent forms and develop a single consent form for all invasive procedures except blood. Monitor the use of the new consent form for compliance and evaluate the outcome.

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Function: Clinical **Standard: 1.1**

Criterion: 1.1.4

Outcomes of clinical care are evaluated by healthcare providers and where appropriate are communicated to the consumer / patient and carer.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.1.4

A Mortality and Morbidity meeting schedule is evident throughout CAFHS. Visiting specialist medical officers from referral centres attend the meetings to provide expert opinion. Lessons are disseminated back to the clinical workforce and these drive evidence based improvements to clinical care.

Mortality and Morbidity meetings also occur in other departments of the Ipswich Hospital, however interdisciplinary variability was noted across Ipswich Hospital and West Moreton Health Service. The nature, extent of case review, robustness, feedback and uniformity of this process across the Hospital and Health Service in all disciplines is recommended.

Recent Acute Coronary Syndrome Snapshot survey and audits for stroke via the Queensland Stroke Network have been completed.

A multidisciplinary approach has been implemented to manage head and neck cancer treatment, resulting in improved access to dental care.

The MBU has implemented a quality improvement activity for patients presenting with COPD; as a result the length of stay has been improved from 5.8 days to 4.8 days.

Health Roundtable data has been reviewed so that strategies for the top 5 DRGs can be implemented. This has commenced with the COPD program.

The productive series of patient care has been reviewed using both patient and staff surveys.

Other departments (MBU, ED) have conducted satisfaction surveys. The Renal Unit has conducted a patient survey and has used the HDU to measure consumer perception of care.

Respecting patient choices has been introduced in the palliative care outpatient program together with bereavement risk screening.

Mental Health

There was some evidence that the care delivered by WMHHS, is evaluated by the health care providers. The results for seven day follow-up, discharge summary completion and 28 day readmission rates generally indicate improvement in the quartiles from 2010-11 to 2011-12 as evidenced by the data presented in the Mental Health Performance Management Framework. The establishment of annual review processes at the Continuing Care Team (CCT) ensure that all the outcomes of clinical care including intervention requirements and risk assessments are evaluated.

Clinical record documentation audits are conducted across the service in all Community and Inpatient Teams. This clinical record review includes demographic information, legibility, evidence of sequential filing of clinical records and the presence of consumer identification labels on all documentation.

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Other areas captured include intake, assessment, recovery/treatment plans, relapse management plans, discharge summaries and case review. Results reviewed during the survey show variable results across the service and there should be a continued improvement in these results with the work being undertaken in this area.

Recommendations

Criterion 1.1.4 #1

Surveyor's Comments:

Interdisciplinary variability was noted across the Hospital and Health Service in relation to Mortality and Morbidity meetings. A consistent process for all medical disciplines and departments is recommended.

Surveyor's Recommendation: **HPR:No**

Introduce Mortality and Morbidity meetings for all medical disciplines covering all departments within Ipswich Hospital and the West Moreton HHS.

Function: Clinical **Standard: 1.1**

Criterion: 1.1.5

Processes for clinical handover, transfer of care and discharge address the needs of the consumer / patient for ongoing care.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.1.5

The HHS has a wide range of policies and guidelines which inform staff about the process for discharge and transfer of patients across the health service. Journey boards are continuing to be introduced into wards these may be electronic boards or flip boards. They provide a visual aid to the patient journey and referral to allied health. They also identify patients at risk regarding discharge and barriers to early discharge. The estimated date of discharge is recorded. These boards meet the specific needs of each ward.

The use of multidisciplinary rounds and meetings, conferences and simple innovations such as the Breakfast Club in rehabilitation facilitate transfer home and back to the community.

The Surgical Business Unit performs follow up telephone calls to discharged patients. This captures almost all patients and provides effective feedback on care. Continued use of discharge information sheets and fact sheets, which have had patient and staff input, enhance the process of discharge home.

Electronic discharge summaries aid return to the community and transfer of patients.

The Ripple Project has improved transfer of care from the ED and enhanced patient involvement. Daily bed management has reduced exit block. This project has also increased the estimated date of discharge (3%-28%) and medical note (70%). Continued improvement of this is encouraged.

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The interhospital transfer within the HHS has been improved with a clear policy.

Nursing clinical handover occurs at the bedside in the majority of wards although taped handover still occurs on some wards. Clinical handover will be subject to a recommendation.

Formal handover processes exist in all medical areas which are specific to the area. This seems better evolved in certain areas than others and needs to be reviewed across the Ipswich Hospital and West Moreton HHS. The MBU is reviewing the process regularly, and buddy systems reduce the chance of errors occurring on the weekend.

Mental Health
Every effort is made by staff to ensure safe and appropriate care is provided at both The Park facility and within the Integrated Mental Health Services (IMHS). The senior experience and expertise of the community clinicians across the service under the guidance of the Team Leaders for the age-specific services ensures risks are identified, clinical needs of clients are addressed and information is shared at the point of transfer or discharge. Handover meetings occur across the service. There are policies and guidelines that address the requirements for clinical handover, as well as a system for implementing the policy/guidelines.

Information for consumers regarding care and discharge processes is readily available via a variety of documents. Examples of this information are the Orientation Information for Consumers (High Security Inpatient Service), the Care Planning Package Toolkit and the Mental Health Service Handbook for carers, families and friends of a person with mental illness.

There are opportunities to review the transfer of health information to other service providers with particular focus on health information provided to both Non-Government Organisations at the point of discharge. This will be of benefit to the consumer and ensure that there is a smooth and safe transition when an episode of care is completed or when there is a change in clinical/care personnel.

It appears that this is not always done in collaboration with the other service providers and relevant information is not always shared with key service providers. This will have implications for transfer of care, client management and outcomes and, as such, is the subject of a recommendation.

Recommendations

Criterion 1.1.5 #1

Surveyor's Comments:

The survey team found evidence of taped recording for the purposes of clinical handover in certain wards and areas of the Ipswich Hospital and Health Service.

Surveyor's Recommendation: **HPR:No**

Cease the use of taped recorded handover and introduce clinical handover at the bedside throughout the Ipswich Hospital and West Moreton HHS.

Criterion 1.1.5 #2

Surveyor's Comments:

Medical handover exists in many wards and departments of Ipswich Hospital, however this is an evolving process and needs to be reviewed and progressed so that it covers all medical areas.

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Surveyor's Recommendation: **HPR:No**

Review and progress medical handover, across the Ipswich Hospital and Health Service so that all medical areas are involved.

Criterion 1.1.5 #3

Surveyor's Comments:

Transfer of health information to other health providers does not always occur at point of discharge. To ensure a smooth and safe transition when a patient is discharged, transfer of all clinical information needs to occur.

Surveyor's Recommendation: **HPR:No**

WMHHS develop a handover template (example ISBAR) that will capture all aspects of the patient's care at point of discharge.

Function: Clinical **Standard: 1.1**

Criterion: 1.1.6

Systems for ongoing care of the consumer / patient are coordinated and effective.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.1.6
Policies and procedures support the coordination of care for people with chronic and complex conditions throughout the patient journey. Systems are in place to identify the patient early, on presentation to the ED, and to commence multidisciplinary assessment and care coordination.

The Hospital to Home service, after identifying the complex patient in the ED provides ongoing care coordination and assists in the discharge planning process to ensure referral and follow up by the most appropriate service. Care coordination of complex patients requiring input from multidisciplinary teams is also facilitated by the use of journey boards in the inpatient units to ensure all staff have access to timely information relevant to planning the patients' safe discharge to the community.

The Older Persons Programs, Aged Care Team, Geriatric Evaluation and Management Service and the Early Discharge Service facilitate early referral and multidisciplinary assessment of the older person. This team works closely with the local Residential Aged Care Facilities (RACF) with the aim of avoiding unnecessary admission of the older person to an acute facility and enabling access to ongoing care in the RACF.

In addition to the range of services offered in the Older Persons Program, there are a number of services under the Health Maintenance Program which focus on strategies to reduce acute presentation and avoidable admission through promoting self management and a healthy lifestyle approach. These include Heart Health Service, Diabetes and Respiratory Service, Community Based Rehabilitation, Home Care and Transition Care Program.

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Evaluation has occurred across the majority of these services and there is evidence of changes having been made to ensure improved practice. Qualitative and quantitative validated assessment tools are used to measure clinical outcomes and the impact of specific exercise and education programs for people with chronic conditions.

Mental Health
The organisation has policies and procedures in place which reflect and direct ongoing care process. There are systems in place for prioritising patients with high acuity mental illness and all admissions to the Acute Adult Mental Health Unit are managed through Ipswich Hospital ED. Access and referral criteria exist for each service and these appear well understood by all clinicians and referrers. Ongoing care is facilitated through appropriate referrals and care co-ordination arrangements particularly in the CCT in consultation with the consumer's primary health care provider.

There are clear arrangements for liaison and referral between services and organisations. Roles and responsibilities reflect a multi-disciplinary, integrated care approach. There is some involvement of some consumers however opportunities exist to further involve the consumer in their ongoing care planning.

Every effort is made to manage consumer care in the community and systems exist to transfer care when appropriate. CIMHA assists in integrating the clinical record to facilitate secure and reliable information exchange.

Recommendations

No Recommendation

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Function: Clinical **Standard: 1.1**

Criterion: 1.1.7

The care of dying and deceased consumers / patients is managed with dignity and comfort, and family and carers are supported.

Organisation's self-rating: MA **Surveyor rating:EA**

Overall Comment

Overall Comment 1.1.7

End of life decision-making processes are well developed across all disciplines. WMHHS has undertaken extensive consultation and communication to promote discussion with patients about end of life choices, and relevant documentation is contained within the medical record. Extensive evaluation and benchmarking has occurred, facilitating improved processes to increase the uptake of advanced care planning for those with serious conditions.

Care of the dying, managing death, respectful processes to ensure culturally appropriate and sensitive care after death and bereavement support are evident for the whole of life cycle. There are good working relationships with local funeral parlours at sites where there are no morgues.

Maternity services provide exceptional bereavement support for parents suffering perinatal losses at all gestations, supported by appropriate ongoing community services.

Paediatric palliative care is provided in collaboration with relevant services. Advanced Care Directives sensitive to the needs of bereaved families of children are regularly discussed at clinical meetings to ensure inappropriate prolongation of life is avoided in this cohort where clinicians may be reluctant to allow a child to die despite documented plans. Organisational support is available to staff involved in the unexpected death of a patient, in addition to clinical review processes.

Heart failure and respiratory failure clinicians work with palliative care staff to develop pathways for non-cancer related palliative care, both for inpatients and, increasingly, in the community. This close working relationship has seen a dramatic increase in the numbers of patients and consumers with advanced care directives.

Processes are in place across the organisation in acute, subacute and community settings, to ensure that relevant clinical staff are aware of advanced care directives where they exist (on patient boards, handover sheets, in addition to completed documentation within the medical record).

Recommendations

No Recommendation

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Function: Clinical **Standard: 1.1**

Criterion: 1.1.8

The health record ensures comprehensive and accurate information is collaboratively gathered, recorded and used in care delivery.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.1.8

There has been a concerted effort to ensure that the health record is accurate and complete. Audit processes are in place at both the State and Health Service levels that validate content of the records and monitor compliance with documentation standards and policy.

Key actions by the WMHHS have improved the timeliness of access to the health record at outpatient clinics including redesign of folders, reorganisation of the records' store to archive and cull for destruction and rationalise the space for current records at Ipswich Hospital.

Recommendations

No Recommendation

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Function: Clinical **Standard: 1.2**

Criterion: 1.2.1

The community has information on health services appropriate to its needs.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.2.1

WMHHS is currently undergoing a major redevelopment and clinical services planning associated with the redevelopment has involved information gathering on the current and projected demographics of the population within their service catchment and planning for the future needs of this population.

A number of strategies are used to provide information to the community on available health services. These include use of the local print and television media to promote good news stories, advice of the implementation of new services and keeping the public informed of changes associated with the redevelopment of major building work.

The Communications and Engagement team facilitate information exchange through the media and also provide support to staff in the development of client information or in the promotion of specific activities or groups. Information is provided in a culturally appropriate format with input from relevant Aboriginal and Torres Strait Islander Elders.

Collaboration occurs between the organisation and consumers and carers through relevant support groups and Rural Reference Groups. Recent evaluation of the process for engaging with consumers and stakeholders has led to the development of stakeholder maps to identify the range of informal and formal processes in place to engage consumers and other stakeholders and ensure that information is available on the organisation.

External service providers are informed of the process for referral to specific services in the organisation. Of particular note is the work associated with improving the referral to outpatients department. This has involved regular communication and feedback to the General Practitioners which has led to improvement in the quality of referral information and resulted in significant improvement in the time taken to triage these referrals.

Mental Health
Information on the service and how to access services is widely available to the community and other health care providers. Mental health clinicians are able to undertake mental health assessments in the Emergency Department 24/7. The service has been able to develop specialised mental health teams to meet specific needs of the population e.g. Evolve Therapeutic Service, Recovery and Resilience Team.

Information about the process of referral and intake criteria is available to referrers. Consumers and carers are also given adequate information about available services. The service has embarked on an exercise to consult with staff, consumers and carers to ascertain information about perceived barriers to access to information (e.g. psychiatry clinics in General Practices and Superclinics).

Recommendations

No Recommendation

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Function: Clinical **Standard: 1.2**

Criterion: 1.2.2

Access and admission / entry to the system of care is prioritised according to health care needs.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.2.2

Policies and procedures (QH and local) provide a framework for prioritising access to services and, where relevant, there are documented inclusion or exclusion criteria. Systems to prioritise care are regularly monitored and evaluated and changes made to improve access where possible.

There was evidence of a range of initiatives to improve access across the organisation, particularly within community health services. Examples included the establishment of Drop-in Clinics for Diabetes to address the high number of clients who did not attend their booked appointment. In response to the high incidence of diabetes among the Pacific Islander population a Pacific Islander registered nurse has been employed to work within the Diabetes team and this person has been supported to become an accredited Diabetes Educator.

The WMHHS is currently undergoing a major redesign project which primarily aims to address demand management, patient flow and access. The main areas of focus are the Emergency access and Triage targets, elective surgery targets and Outpatient Specialist Clinic access. Although this initiative is in the early stages of implementation, there has already been improvement in the key indicators identified. As these are State and national targets for access, there is capacity for the organisation to benchmark their performance against peer organisations in the near future.

Mental Health
Access to services is prioritised according to need. Mental health consumers who need inpatient admission are assessed in the Emergency Department. Some consumers who are known to the service are admitted directly to the Inpatient Unit.

Access to State-wide Forensic Inpatient beds at The Park is managed well. Admissions are prioritised to meet demand. A waiting list is maintained when there are no available beds and the list is re-prioritised on a regular basis to accommodate consumers with more urgent needs.

Recommendations

Criterion 1.2.2 #1

Surveyor's Comments:

The Oral Health Service is trialling a process to streamline emergency patient intake at the Limestone Street Clinic. The trial will require telephone contact with all patients who require treatment to make an appointment. This is a significant change from the current process that asks emergency patients to attend the clinic early and wait until a dental clinician is available to treat them.

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At present there are only limited facilities for the Oral Health Service to support this level of telephone contact and it is expected that, following a successful trial of the process, a call centre will be needed to roll out the process across the WMHHS.

Surveyor's Recommendation: **HPR:No**

WMHHS explore opportunities to establish a call centre to assist the Oral Health Service to improve access to the service by using the full functionality of the Information System for Oral Health (ISOH) program including the telephone questionnaire triage system.

Function: Clinical **Standard: 1.3**

Criterion: 1.3.1

Health care and services are appropriate and delivered in the most appropriate setting.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.3.1
Acute, subacute, community
WMHHS is commended on the integrated service planning processes evident across the organisation. Internal and external factors are considered in service configuration.

Innovative approaches were evident at the local level to ensure appropriate service models and environment within the confines of budget/geography. Such innovation was evident whether as a component of a service wide improvement initiative, or as a local improvement initiative, particularly to improve access during times of peak demand.

Various homecare services and collaboration with other service providers minimise hospital presentations.

Considerable service improvements and/or modifications to service models were evident across the organisation to maximise the uptake by vulnerable groups with high rates of non-attendance. Examples of innovative service redesign include the various “drop-in” clinics across the service profile of chronic and acute health. Service provision is audited regularly using tools to measure clinical and operational outputs that inform improvement/refinement.

The Diabetes Drop in Clinic has decreased failure to attend rates.

The Lactation Drop in Clinic is well attended.

Strategies to increase uptake of pregnancy care to women who are unlikely to attend include:

- satellite maternity clinics at Laidley and Boonah;
- after-hours pregnancy care clinics;
- successful roll-out of “closing the gap” maternity initiative including indigenous healthcare workers resulting in impressive outcomes on key performance indicators (KPIs) (attendance at key pregnancy care visits, breast-feeding rates, birth weight > 2500g);
- and strong collaborative arrangements between sites to facilitate local maternity care by early

transfer post-partum to smaller services closer to women's homes and communities, which also maximises capacity at Ipswich and enhances strategies to manage the increasing birth rate (from 2000 to 2800).

Ipswich may further improve access potential by reconfiguring birthing services to ensure that women not in labour do not take up birth rooms for assessment and are encouraged to go home (where clinically appropriate).

Mental Health
The service at The Park appears well resourced. With development of new facilities and services, the service's capacity to deliver appropriate care will further increase. The service has already undertaken considerable redesign work to re-configure services and ensure facilities are more appropriate to meet consumer needs. There are plans to undertake further redesign work in the future.

Many services within the Integrated Mental Health Service lack adequate space to enable delivery of appropriate care. The Community Mental Health Facility is congested for the number of staff that occupy this facility.

The High Dependency Unit at Ipswich has a very small courtyard with restricted space for consumers.

Seclusion room walls are made of material that is frequently and easily damaged. Damaged walls have now been covered with plywood, which creates an inappropriate environment for treatment of consumers. Public telephones in this Inpatient Unit are in a very public area and the ability to have private conversations is reduced.

Mental health care is delivered by appropriately trained staff. Staff at The Park are well supported with education and training resources. Education and training programs for Transition as well as Masters-level nursing training are well developed. Staff also have access to a Peer Support Program which provides excellent peer support by staff to staff who may be in need of pastoral care.

The service obtains feedback via consumer satisfaction surveys; however, it needs to develop a plan to formally consult with referrers and the wider community with regard to appropriateness of services it delivers. Currently this occurs informally but feedback is not necessarily captured in a formal or consistent manner.

The service is moving to an electronic environment and critical clinical information has to be accessed electronically, however, the number of computer terminals available limits the ability of staff to both enter as well as retrieve important clinical information. This can also compromise access to appropriate care.

Recommendations

Criterion 1.3.1 #1

Surveyor's Comments:

The service obtains feedback via consumer satisfaction surveys; however, it needs to develop a plan to formally consult with referrers and the wider community with regard to appropriateness of services it delivers. Currently this occurs informally but feedback is not necessarily captured in a formal or consistent manner.

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Surveyor's Recommendation: **HPR:No**

Mental Health
Develop methods to obtain feedback from referrers and the wider community about appropriateness of mental health services delivered generally and to specific populations.

Criterion 1.3.1 #2

Surveyor's Comments:

Seclusion room walls are made of material that is frequently and easily damaged. Damaged walls have now been covered with plywood, which creates an inappropriate environment for treatment of consumers.

Surveyor's Recommendation: **HPR:No**

Review the material used to make Seclusion Room walls in the High Dependency Unit at Ipswich Hospital and ensure a more durable material is used to reduce the likelihood of damage.

Criterion 1.3.1 #3

Surveyor's Comments:

The High Dependency Unit at Ipswich has a very small courtyard with restricted space for consumers.

Surveyor's Recommendation: **HPR:No**

Explore alternate options to ensure the external environment is more appropriate to meet needs of the consumers in the Mental Health High Dependency Unit at Ipswich Hospital.

Criterion 1.3.1 #4

Surveyor's Comments:

The mental health service is moving to an electronic environment and critical clinical information has to be accessed electronically. The number of computer terminals available limits the ability of staff to both enter as well as retrieve important clinical information. This can also compromise access to appropriate care.

Surveyor's Recommendation: **HPR:No**

Progress the Business Case regarding increased computer facilities across the mental health service to ensure that there are sufficient computers available to staff to enable full utilisation of CIMHA and other data systems.

Criterion 1.3.1 #5

Surveyor's Comments:

Paediatric inpatient services at smaller sites: The survey team appreciates the complexity in acute care delivery, particularly of specialist services, at small hospitals, where there may be few and infrequent admissions in any given specialty.

Paediatrics is an example that was highlighted during the survey. WMHHS provides comprehensive and integrated paediatric services, catering to the needs of the most complex medical/surgical/psychosocial

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needs, and is to be commended. However, there are only a small number of inpatient paediatric admissions to the smaller sites, limiting clinical expertise in this specialty. Additionally, inpatient paediatric areas should be environmentally appropriate to the needs of children and their families.

Surveyor's Recommendation: **HPR:No**

Develop processes across the HHS to ensure paediatric inpatient services are provided in a physical setting appropriate to the needs of children, and that care is provided by clinical staff with minimum core competencies in paediatric care.

Function: Clinical **Standard: 1.4**

Criterion: 1.4.1

Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.4.1

Evidence drives practice improvement in both clinical service delivery and service planning and configuration. Data is collected from relevant internal and external sources to evaluate locally and across the WMHHS

Evidence informs clinical practice, systems and processes across the organisation.

There are processes in place to alert the need for review, develop action plans to mitigate risk, implement improvement strategies and evaluate, thus completing the quality cycle.

Case reviews, case conferencing, and Mortality and Morbidity meetings are conducted in clinical areas, at local and organisational levels, where clinical care is evaluated with consideration of the effectiveness of this care according to evidence based principals. Expertise is sought externally where required. Lessons are shared and disseminated to clinicians for local uptake.

Recommendations

No Recommendation

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Function: Clinical **Standard: 1.5**

Criterion: 1.5.1

Medications are managed to ensure safe and effective consumer / patient outcomes.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.5.1

WMHHS has an organisation wide medication safety system with associated policies and procedures in regard to medication prescribing, dispensing, administration and storage. These policies and procedures are current, easy to read for clinical staff and are appropriate to the level of service provided. There is a Drug and Therapeutic Committee that monitors and reviews medication-related:

- risks;
- policies, procedures and protocols;
- medication related adverse incidents; and
- medication safety related KPIs.

A large proportion of the medication-related incidents are captured by the clinical pharmacist (at Ipswich Hospital) as part of their role in the Unit.

Each patient has a Medicines Management Plan developed by the treating doctor in association with the clinical pharmacist. The Pharmacy Systems operational efficiency KPIs demonstrate a high rate of pharmacist review for both medical and surgical patients (>96%) and over 40% of medication charts were identified as requiring intervention at Ipswich Hospital.

Over 70% of both inpatient and outpatient prescriptions at Ipswich Hospital are filled within 30 minutes. Known medication allergies are well documented in the medical history. However, the HHS does not have a set process for reporting adverse drug reactions that occur within the patient stay episode to the Therapeutic Goods Administration (TGA).

The National Inpatient Medication Chart (NIMC) is used across the HHS with the exception of the Offender Health Program which uses a 42 week drug chart and the Intensive Care Unit (ICU) which uses a dedicated drug chart. The Aged Care Mental Health Unit uses the longer stay version of the NIMC. WMHHS also has an electronic List of Medications (eLMS) which forms part of the medical record, is exported to the discharge summary and can be printed out for patients. A web based viewer allows all eLMS information to be viewed and staff can print out the information for patients.

Patients have a Medication Action Plan developed by their medical officer and these are reviewed prior to discharge from the organisation. There is an Antimicrobial Stewardship Program in place and this is currently being revised to ensure it meets all the requirements of the new National Safety and Quality Health Service Standards. The health service has a limited list of antibiotics which can be prescribed and two Infectious Diseases (ID) Physicians who have the final authorisation to continue use of certain restricted antimicrobials after 72 hours of use. There is also one drug, Moxifloxacin, which cannot be prescribed without prior approval from one of the ID physicians. At least one of the two ID Physicians also participates in daily ICU rounds, and the HIV and TB outpatient clinics (Refer 5.1.2).

There are two pharmacy related risks which have been rated as “very high” on the organisation’s risk register. They are:

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- Risk of medication errors due to look alike medications; and
- Medication administration errors.

Ipswich Hospital is fortunate to have a good number of pharmacists on staff which enables a clinical pharmacy role to be provided. The Pharmacy Department works to the Queensland Health (QH) Pharmacy Procedure which covers preparation of a discharge medication record (DMR), medication history and reconciliation on admission and provision of consumer medication information (CMI). Disposal and wastage of medications are closely monitored and many strategies have been implemented to improve wastage of medications within the Health Service.

High risk medications are regularly reviewed with a particular focus on INR values for patients receiving warfarin.

In summary, there appear to be appropriate systems in place to oversee and maintain medication safety at Ipswich Hospital but this service should be extended to the smaller outlying hospitals within the region.

Mental Health
Policy with regard to medication prescribing, dispensing, administration, storage and other factors is appropriate and clear. There are Drug and Therapeutic Committees that review medication-related policies, errors and results of medication audits. Medication chart audits are conducted and results made available to the services through the Team Leader.

Safety notices are issued, however there is need for a system for dissemination of safety notices to ensure that these always reach target audience.

Medication-related incidents are reviewed regularly. Overall there appear to be appropriate systems in place to oversee medication safety.

There is minimal pharmacy input into care and treatment of the patient. There are no mental health pharmacists and pharmacists are not involved in medication reconciliation, multidisciplinary meetings or admission/discharge processes. Medication is appropriately checked by nursing staff to ensure it is given as prescribed and in a safe manner. At all sites, a Hospital Medication Chart is used to chart prescribed medication.

Capacity of Pharmacy staff to provide medication-related education to staff and consumers is limited due to lack of pharmacy input into mental health services.

Recommendations

Criterion 1.5.1 #1

Surveyor's Comments:

Whilst Ipswich Hospital is fortunate to have a good number of pharmacists on staff which enables a clinical pharmacy role to be provided, some of the rural hospitals have very little pharmacy support.

The teleconferencing facilities between the smaller facilities and Ipswich Hospital are less than optimal and could use significant improvement. As outlined in the APACs Guiding Principles to achieve Continuity in Medication Management and the Clinical Services Capability Framework Level 2 (Ref 2), medication service requires there be access to regular pharmacist medication review, in order to minimise patient risk.

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Mental Health
There is minimal pharmacy input into care and treatment of the patient. There are no mental health pharmacists and pharmacists are not involved in medication reconciliation, multidisciplinary meetings or admission/discharge processes.

Capacity of Pharmacy staff to provide medication-related education to staff and consumers is limited because of lack of pharmacy input into mental health services.

Surveyor's Recommendation: **HPR:No**

Review the provision of pharmacy support:

- at the rural hospitals and provide a physical presence pharmacy support at a level of at least one day per week to assist medication safety programs at these facilities in order to minimise patient risk related to medications;
- within mental health and provide pharmacy input into admission and discharge planning, multidisciplinary team meetings and staff and consumer education and training.

Criterion 1.5.1 #2

Surveyor's Comments:

The survey team visited all areas within the West Moreton Hospital and Health Service. In each site, the management of refrigerators used to store drugs varied from excellent to poor.

Surveyor's Recommendation: **HPR:No**

Implement a process for the regular monitoring and auditing of refrigerators used to store drugs which is consistent across the Service and ensures appropriate storage of temperature-sensitive medications.

Criterion 1.5.1 #3

Surveyor's Comments:

A set process for reporting adverse drug reactions that occur within the patient stay episode to the TGA should be available. WMHHS does not have a set process for this to occur.

Surveyor's Recommendation: **HPR:No**

Establish a process for the reporting of all known adverse drug reactions that occur within the patient stay episode to the Therapeutic Goods Administration (TGA).

Criterion 1.5.1 #4

Surveyor's Comments:

Some of the rural hospitals rely on telephone orders for medications and this is a reasonable practice given the particular context and circumstances of each individual health service. However, all telephone medication orders must be written up by the doctor who gave the telephone order within 24 hours.

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Surveyor's Recommendation: **HPR:No**

Ensure that any telephone orders within WMHHS be written up within 24 hours by the doctor who gave the order and establish a process to monitor compliance with this policy.

Function: Clinical **Standard: 1.5**

Criterion: 1.5.2

The infection control system supports safe practice and ensures a safe environment for consumers / patients and healthcare workers.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.5.2

A risk management approach is taken to infection prevention and control within the WMHHS. This includes a suite of infection control policies and procedures.

WMHHS Infection Prevention and Control (IP&C) staff collect a large amount of clinical surveillance data as part of the program of the Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP) and this is uploaded to the CHRISP system. The infection prevention approach has resulted in a very low rate of hospital acquired infections, especially when compared to the State average, and a staff immunisation program with a “take up rate” of almost 80%.

WMHHS complies with the QH standards for cleaning with clear environmental cleaning guidelines available for both clinical and non-clinical staff and audit results which are very favourable. WMHHS also complies with the AS/NZS for disinfection and reprocessing of reusable medical instruments. There are clearly defined processes within the Central Sterilising Departments (CSD) which are regularly monitored and audited and compliance is high.

Staff receive education, particularly at orientation/induction, on the use of PPE as well as standard and transmission based precautions and occupational exposures and their management. Medical and nursing staff are educated in aseptic non-touch technique (ANTT) during their training and are re-assessed during their employment – specific action is taken to address poor compliance with ANTT.

There is a policy for the management of outbreaks which is currently in use due to a recent (April 2012) outbreak of a Multi-Resistant Organism (MRO) in the region. WMHHS has two Infectious Disease physicians who provide advice and who are utilised daily for ward rounds and management of patients with HIV and TB in the outpatient clinics. These physicians also contribute to the new Antimicrobial Stewardship Program with the Pharmacy Department which, although still new, is strictly monitoring and restricting access to antimicrobial utilisation and prescribing, ensuring clinicians follow evidence based best practice antimicrobial prescribing TGA guidelines.

IP&C staff attend daily ward rounds where they are informed of any infections - this forms the basis of their surveillance audits as well as requested advice and consultation.

The IP&C staff conduct monthly observational studies related to Hand Hygiene (HH) and appropriateness of isolation standards and signage during the ward rounds. Results of audits and surveillance data as well as Infection Prevention Clinical Indicators are reported up to the West Moreton Executive Patient Safety and Quality Committee via the Infection Control Committee. Results are also sent to the ward to enable

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staff to take ownership of them. In addition, this data is reported at the WMHHS 90 day forums where progress is monitored against the annual business plan.

A surveillance database has been in place since 2002 and there is also the eICAT resource provided by QH. All the information from these sources is published on the MyHospitals website and the results are very good.

A weekly IP&C team meeting is held to review clinical indicator data. A process to monitor antibiotic prophylaxis was established in 1998 and the data outcomes has been fed back to the surgical staff since. In addition, the IP&C staff have set up a surgical wound surveillance system with all results reported back to individual surgeons as well as to the IC Committee. A problem with the "documentation" of the administration of prophylactic antibiotics was noted within one unit and action is taking place to address this identified gap.

A VRE Outbreak in Queensland hospitals has been the most challenging activity for WMHHS along with other Multi-Resistant Organisms (MROs). During the floods in 2011, two patients were not screened and were therefore "missed" in the initial phase of admission. This led to a spread of the infection which was eventually brought under control by the limitation of bed movement (identified as a contributing factor) and increased cleaning of shared toilet facilities in particular (which had been identified as a source through the utilisation of a fluorescent pen). The teamwork approach to the problem solving of this situation was very responsive and collaborative and brought the situation under control within a very short period of time. The new patient "MRO screening process" has been revised so that results are obtained more quickly to enable "clearing" of isolation beds and greater availability of general beds in the hospitals.

WMHHS offers staff influenza, pertussis, tetanus/diphtheria, measles/mumps/rubella, Varicella and Hepatitis B vaccinations in line with the current national guidelines for workforce immunisation and the take up rate is very high - around 80%, which is commendable. This is achieved through staff immunisation clinics being open 1-2 days per week and mandatory Hepatitis B immunisation being provided, where necessary, as part of the recruitment process.

Reporting of occupational exposures occurs via the PRIME system for incident reporting.

Development of general public exposure kits for staff in the Emergency Department occurred to assist staff to cope with the influx of consumers exposed to needle stick injuries in the community.

A sharps audit is conducted annually. IP&C staff are represented on the Product Advisory Committee as well as the Medical Advisory Committee, to ensure Infection Prevention and Control input for both invasive devices purchase and use and the new procedure approval process. Blood stream infection rates are closely monitored and infection rates are very low.

All MRO data is reviewed on Friday mornings to prevent "bed movement" over the weekend. Results of audits are provided to staff via the Nurse Unit Manager. The IP&C team work with the ID Physicians to provide:

- written procedures;
- ID consultation; and
- alert stickers.

In addition, a list of patients with transmission based diseases is supplied to the Admitting Officer in the Emergency Department which is then used to update the Emergency Department Information System (EDIS).

There are antimicrobial stewardship processes in place at WMHHS but these systems need greater formalisation to ensure they meet all the requirements of the new National Antimicrobial Stewardship Program guidelines. The WMHHS clinical workforce does have access to therapeutic guidelines for

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antimicrobial prescribing. WMHHS does have a system for monitoring antimicrobial usage and this is developing into a quite robust system through the support of the Pharmacy and IP&C staff.

There are certain protocols for the prescribing of certain antimicrobials which requires the authorisation at either the Registrar or Consultant level, and continuation past 72 hours requires authorisation from the ID Physicians. In addition, access to restricted antimicrobials is very limited and requires access at the highest level of antimicrobial governance in the organisation at the time of request.

There are CSDs at Ipswich Hospital and the Ipswich Dental Clinic and both have extremely high levels of appropriate work and safe sterilisation practices. Compliance with AS/NZS 4187 was clearly evident in the CSD at Ipswich Hospital and compliance with AS/NZS 4815 was clearly evident in the CSD at the Ipswich Community Dental Clinic.

There is a full traceability system in place at Ipswich Hospital where all high risk procedures are conducted and there is a tracking system that can be used to track back to any critical instruments used for dental practices in the Oral Health division.

The Charge Nurse in the CSD at Ipswich Hospital has ensured that an appropriately qualified staff member is in charge and supervises all staff on each shift - there are some Assistant in Nursing (AIN) staff that are currently not specifically trained in this area but a business case has been put forward to address this issue (Refer 2.2.4).

All staff in the Oral Health Division have received appropriate training to run the CSD and all vans have a dental assistant with appropriate sterilisation experience. Overall, infection prevention is well coordinated and conducted within WMHHS.

Mental Health
There is an in-house Laundry at The Park. It was noted, however, that clothes, linen and floor mops are washed in the same washing machines and dryers.

It was also observed at The Park that food and floor mops are transported on the same push trolley.

Recommendations

Criterion 1.5.2 #1

Surveyor's Comments:

Mental Health
It was noted that clothes, linen and floor mops are washed in the same washing machines and dryers at The Park and that food and floor mops are transported on the same push trolley at this facility.

Surveyor's Recommendation: **HPR:No**

Mental Health
Review infection control procedures at The Park and:

- cease the practice of washing and drying linen, clothes and floor mops in the same washing machine and dryer; and
- cease the practice of transporting floor mops and food on the same trolley.

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Criterion 1.5.2 #2

Surveyor's Comments:

Sterile stock in the store room between theatres 5 and 6 is located very close to the Steris Machine and the clean-up area. Sterile items may easily be contaminated by splashed fluids.

Surveyor's Recommendation: **HPR:No**

Relocate the sterile stock in the store room between theatres 5 and 6 to ensure that it is not in close proximity to the Steris Machine and clean up area.

Criterion 1.5.2 #3

Surveyor's Comments:

Many elective surgical patients require prophylactic antibiotics at the time of “knife to skin”. This is generally very well documented throughout the WMHHS, however, at times the documentation may be “patchy” with emergency caesarean sections due to the emergency nature of the procedure. It is known by all staff that this is a requirement to be implemented on each occasion, but documentation in the medical record does not always confirm the practice.

Surveyor's Recommendation: **HPR:No**

Improve the documentation of the administration of prophylactic antibiotics for emergency caesarean sections in the operating theatre.

Criterion 1.5.2 #4

Surveyor's Comments:

Despite generally high rates for Hand Hygiene compliance within Ipswich Hospital, two groups have been identified where "less than optimal compliance" has been demonstrated. They are the Medical Officers and the Emergency Department staff.

Surveyor's Recommendation: **HPR:No**

Work with the staff in the Emergency Department and with Medical Staff in general to improve Hand Hygiene compliance rates.

Criterion 1.5.2 #5

Surveyor's Comments:

There are some Assistant in Nursing (AIN) staff in the CSD at Ipswich Hospital that are currently not specifically trained in this area however a business case has been put forward to address this issue. Whilst this report was provided to the survey team, it was felt that this business case should be expedited to ensure all staff working in the CSD are appropriately trained.

Surveyor's Recommendation: **HPR:No**

Ensure that all AINs working in the CSD of Ipswich Hospital receive appropriate formal education in instrument sterilisation.

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Function: Clinical **Standard: 1.5**

Criterion: 1.5.3

The incidence and impact of breaks in skin integrity, pressure ulcers and other non-surgical wounds are minimised through wound prevention and management programs.

Organisation's self-rating: MA **Surveyor rating:EA**

Overall Comment

Overall Comment 1.5.3

WMHHS has a formal Pressure Injury Prevention and Management Procedure and risk assessment tool which is based on the Waterlow, Statewide and Pan Pacific protocols. There is a Pressure Injury Working Party, which reports up to the Health Service Falls, Tissue Viability and Nutrition Committee. This committee then reports up to the Executive Patient Safety and Quality Committee.

A flow chart has been developed based on the Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury (2011). This requires that all patients have a skin integrity risk assessment conducted within eight hours of admission to the service using a validated risk assessment tool. The last audit of compliance with this procedure demonstrated a result of 64% compared with a Statewide rate of 76%, indicating that continued effort is needed to improve this result. However, benchmarking of this rate over time has also demonstrated a marked reduction in the development of pressure injuries within the region over the past three years.

WMHHS has recently revised the Pressure Injury and Wound Management Plan to include an area in which to document the location (visually) of the wound on the chart.

In addition, the Wound Consultants take digital photographs of serious wounds which are correctly labelled with the patient's unique identification and the date and time the photograph was taken. This enables the wounds to be dressed for the appropriate amount of time (sometimes for up to or more than 2-3 days) but also allows the medical staff and consultants to view the condition of the wound.

The Wound Consultants also assist the staff in the Aged Care Facilities, people in the community and the "Hand 2 Home" staff to manage wounds in the community, preventing many admissions or readmissions to hospital (with associated savings in cost and bed days). Communication with these external clients is often by email but often involves a staff member travelling to a location to provide assistance and advice. The survey team supports the internal process of succession planning to allow for the continuation of this service in the future.

Planned future activities include:

- regular follow up audits of risk assessment compliance using retrospective record audits;
- a satisfaction survey of patients with pressure injuries;
- a review of the patient information brochures related to pressure injuries; and
- an inventory of all the pressure relieving devices available throughout the service and their location.

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The survey team strongly supports and encourages these future activities.

The benchmarking activities, improved results and innovation demonstrated by the service to reduce the number of admissions with a resultant reduction in associated bed days, and cost implications for the organisation were sufficient evidence for the survey team to upgrade the organisation's self-rating of MA to EA.

Recommendations

No Recommendation

Function: Clinical **Standard: 1.5**

Criterion: 1.5.4

The incidence of falls and fall injuries, is minimised through a falls management program.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.5.4

Health Service Policy is in place to inform the process for falls prevention and to minimise harm from falls. A number of risk assessment tools were observed to be in use and one rural site was participating in a trial of a State-wide risk assessment tool. There is a plan in place to implement the State-wide Falls Risk Assessment Tool and post fall management pathway.

Clinical governance for falls prevention is managed through a Falls Prevention Working Party which reports to the Patient Safety and Quality Committee with regular monitoring and evaluation of falls incidents data.

A State-wide bedside audit (2011) has enabled the organisation to compare performance in the management and prevention of falls with other Health Services and between facilities within the WMHHS. Areas for improvement have been identified and an action plan with specific targets developed.

Systems support the ongoing referral of patients at risk of falls to services in the community at discharge. Community Health Services offer group or individual intervention aimed at reducing the risk and minimising harm from falls occurring in the community.

Staff education on the procedure for falls risk screening and management is limited to the orientation program, while some staff may access other general education on falls prevention and management through courses external to the organisation.

It would assist the organisation to have a planned approach to providing education on falls risk screening and assessment, to ensure all relevant staff are aware of their roles and responsibilities. There is information available for staff on evidence based practice for management and prevention of falls through the QH website.

Information for patients and carers on the prevention of falls in hospital has been recently released by QH and other resources such as the Queensland Government's Stay on Your Feet program are provided by the Community Health Services.

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With update of Policy under the new Hospital and Health Service entity there is an opportunity to standardise the processes for falls risk screening and falls risk assessment across the organisation.

Recommendations

No Recommendation

Function: Clinical **Standard: 1.5**

Criterion: 1.5.5

The system to manage sample collection, blood, blood components / blood products and patient blood management ensures safe and appropriate practice.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.5.5

WMHHS has policies and procedures for transfusion of blood and blood products which are based on evidence from the NH&MRC. These policies include the “Massive Blood Transfusion” policy which has been used twice since its introduction two years ago. Blood transfusion risks are well known and have been addressed across the Health Service. The main quality improvement activity in this area has been the introduction by the pathology service of a ‘zero tolerance’ policy for incorrectly labelled blood specimen tubes or incomplete cross match forms. Should such specimens or forms be received, recollection is then required. This policy has seen a resultant significant drop in the number of incorrectly labelled blood tubes or incomplete/incorrect pathology forms.

The blood bank closely monitors the utilisation of blood and blood products which are a scarce resource. This also includes the wastage of blood products and, as a result of wastage audits, fresh frozen plasma (FFP) and platelets need either a Registrar or Consultant to approve the request before these products are thawed for use. This strategy has reduced both the unnecessary utilisation and wastage of these products.

Transfusion-related adverse incidents such as non-haemolytic febrile reactions are benchmarked across the State and this HHS has a much lower rate than its peers. This is thought to be due to under reporting of patients where a febrile episode during, or immediately post, transfusion is often considered to be part of the existing illness, rather than a separate, transfusion-related event. The blood bank plans to conduct a retrospective audit of patients who received blood or blood products to see if any adverse reactions have occurred that were not reported. This is strongly supported by the survey team.

Regular auditing of the medical record has identified good documentation of blood and blood product transfusion in the record overall. Documentation of informed consent for transfusion is considered to be included for surgical patients as part of the overall consent process, but is considered as a separate consent process for medical and other patients. The consent process for blood transfusions and blood products needs to be a separate consent form.

Best practice methodology is utilised for the receipt, collection, transportation and storage of blood and blood products in line with the Australian Red Cross Blood Service and Pathology Queensland. Venepuncture staff are educated and assessed for competency on a regular and ongoing basis. Blood is

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transported to and from the hospital using “Safety View” to ensure all temperature parameters have been met during transport.

Blood is stored in temperature monitored and alarmed refrigerators. There is a separate refrigerator for uncrossmatched blood at Ipswich Hospital to ensure that cross matched and uncrossmatched blood are not mixed up.

All blood and blood product transfusion related incidents and KPIs are reported to the health services’ Executive Patient Safety and Quality Committee (EPS&QC) via the Medicines Management Committee (MMC). These committees receive details of KPIs related to blood and blood product usage, wastage and outliers (those cases that do not fit the normal parameters for blood or blood product transfusion). The majority of blood products are transfused during normal working hours but there are occasions when blood is transfused out of hours.

The Executive Director of Medical Services (EDMS) sits on the MMC and reports any issues arising from this committee directly to the Medical Advisory Committee, as well as any discipline specific committees, to be addressed.

Although there is a good governance structures for the management of blood and blood products within WMHHS, education of both medical and nursing staff should be made a priority. E-learning packages are freely available and WMHHS is encouraged to promote education in this area.

Recommendations

Criterion 1.5.5 #1

Surveyor's Comments:

Documentation of informed consent for transfusions is considered to be included in the overall consent process for surgical patients, but is considered to be a separate consent process for medical and other patients.

Surveyor's Recommendation: **HPR:No**

Develop the consent process for blood transfusions as a separate consent, using the separate QH blood transfusion consent form, for surgical patients.

Criterion 1.5.5 #2

Surveyor's Comments:

Although WMHHS has good governance structures for the management of blood and blood products, education of both medical and nursing staff should be made a priority.

Surveyor's Recommendation: **HPR:No**

Use the established e-learning packages such as the BloodSafe Australia packages which are freely available to train clinical staff in best practice management of blood and blood products.

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Function: Clinical **Standard: 1.5**

Criterion: 1.5.6

The organisation ensures that the correct consumer / patient receives the correct procedure on the correct site.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.5.6

WMHHS has an organisation-wide patient identification and procedure matching system. However, implementation of this system is patchy and sustainability needs to be built into the system to ensure patient safety.

The World Health Organisation's (WHO) Checklist, which is now considered best practice, forms part of this identification and procedure matching system.

The WHO checklist is to be used in any area where a procedure is to take place, particularly operating theatres. The associated "time out" procedure requires the entire team to stop and collectively check that they have the "Correct Patient, Correct Site and Correct Procedure" on all the associated documentation and other necessary items such as x-rays and prostheses.

During the survey, it was observed that the process did not involve all members in the team and there was no dedicated "tools down" time allocated to collectively ensure that all the items on the checklist had been checked. A recommendation has been raised to address this issue.

WMHHS uses a white patient ID wrist band for patient identification which contains the unique UR number, the patient's full name, date of birth (DOB) and sex. This is changed to a red ID wristband if the patient has an allergy and staff know to have only one or the other wristband in place.

During the survey, the situation was noted in the paediatric unit where neonates that had been admitted via the emergency department were wearing either pale blue (for boys) or pale pink (for girls) ID wristbands. When made aware of this issue, all the pale blue and pink ID bands were removed from the Emergency Department and staff will now only use the white or red wristbands.

The survey team was pleased to learn that the Oral Health staff follow the "CCC" procedure – a timeout procedure (using the WHO checklist) – in all areas prior to conducting invasive procedures related to dentistry. Correct patient identification documentation is mandatory for the receipt of specimens in the Pathology Department. Patient identification and use of procedure matching checklists are also well performed in the Radiology Department.

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Recommendations

Criterion 1.5.6 #1

Surveyor's Comments:

A survey team member was present in the operating theatre to witness a “time out” event and only found out it had occurred when they asked when it would occur. The surveyor did not witness a total stop and collective check of the World Health Organisation (WHO) checklist.

Surveyor's Recommendation: **HPR:No**

Prior to the commencement of any procedure in the operating or day procedure theatre, staff are to stop all activity and collectively and simultaneously complete the WHO Checklist.

Function: Clinical **Standard: 1.5**

Criterion: 1.5.7

The organisation ensures that the nutritional needs of consumers / patients are met.

Organisation's self-rating: MA **Surveyor rating:SA**

Overall Comment

Overall Comment 1.5.7

WMHHS currently uses the QH Policy for Nutrition and Food Services, which provides broad overarching principles for nutrition management. A Nutrition Working Party has been established recently with multidisciplinary participation including involvement of food services staff. The Working Party reports through to the Patient Safety and Quality Committee.

The committee has commenced with an evaluation of the current situation in relation to nutrition screening and along with data from a State-wide audit conducted in 2011 has identified that the HHS is well below the State average for nutrition risk screening and other related strategies such as recording of weight at admission and one week following admission. A detailed action plan has been developed to address the areas for improvement.

Education on prevention and management of malnutrition is provided to staff on an ad hoc basis, by the Dietetic staff, but capacity is limited by staff resources. Nutrition screening and management is not included in the staff orientation program.

The nutrition risk screen is currently included within the pressure ulcer risk screen tool; however there is no process to prompt referral for Dietetics review and assessment for patients identified as having malnutrition. The nutrition assessment tool is also currently under review as part of the development of a new admission risk assessment form.

It was noted that strategies have been implemented at some of the smaller rural facilities aimed at improving nutrition for patients. A menu and meal review has been carried out at Boonah Hospital by a Dietitian to evaluate the menu against the nutrition standards. This has led to amendments to portion control, changes to patient meal times to meet patient needs, new menus, the introduction of a supper service and improved patient satisfaction. Results of the reviews have been shared with the other rural hospitals within WMHHS, most of whom have made similar changes.

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Another initiative has been the Red Tray Nutritional Alert and assistance system introduced at Gatton Hospital which aims to alert staff when patients require assistance with access to all or part of their meal.

Outcomes have been demonstrated by increased food consumption and increased weight gain for those patients participating in the project.

Recommendations

Criterion 1.5.7 #1

Surveyor's Comments:

Organisations have a responsibility to optimise the nutrition of their patients, so as to support well being and recovery, and to prevent malnutrition. Providing high quality nutrition care to patients is a complex task which requires a multidisciplinary approach with roles and responsibilities of staff clearly defined and agreed and regularly reviewed.

Surveyor's Recommendation: **HPR:No**

Complete the local Policy for Nutrition Care, which is multidisciplinary in scope, based on National and State guidelines and clearly identifies the roles and responsibilities of staff.

Risk Rating: **Moderate**

Risk Comments:

There is a moderate level of risk to the organisation through the inability to identify and manage patients who are malnourished or at risk of malnutrition, with the consequence of increased potential for other related risks such as pressure ulcers, increased requirement for clinical care, and increased length of stay.

Criterion 1.5.7 #2

Surveyor's Comments:

Strong clinical governance with executive sponsorship will facilitate the implementation of the Nutrition Management Strategy currently being implemented by the Nutrition Working Party.

Surveyor's Recommendation: **HPR:No**

The Hospital and Health Service demonstrates a strategic and coordinated approach in the provision of nutrition risk screening and care for those with malnutrition.

Risk Rating: **Moderate**

Risk Comments:

There is a moderate level of risk to the organisation through inability to identify and manage patients who are malnourished or at risk of malnutrition, with the consequence of increased potential for other related risks such as pressure ulcers, increased requirement for clinical care, and increased length of stay.

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Function: Clinical **Standard: 1.6**

Criterion: 1.6.1

Consumers / patients, carers and the community participate in the planning, delivery and evaluation of the health service.

Organisation's self-rating: MA **Surveyor rating:EA**

Overall Comment

Overall Comment 1.6.1

WMHHS has very active consumer group/s in most of the health services. A consumer also sits on the Board's Quality and Safety Committee and the Board links with other consumers. The consumer on the Board Quality and Safety Committee brings both a consumer perspective and community knowledge.

Consumers are engaged in the community, mental health, Ipswich Hospital and the smaller rural communities. There activities are wide and varied and the contribution they make to the Health Service is greatly valued. The insights and ideas they generate from the community at large give valuable information and assist the Health Service in the way forward. They are commended.

The consumer groups are engaged in many activities including the production of a sexual assault kit, a disaster management brochure for renal clients undergoing haemodialysis, engagement with the community on topics such as the expansion of Ipswich Hospital, Open Days, the new car park and the bus that transports staff from the temporary car park and engagement with neighbours. Complaints to the media have decreased. The consumer feedback form "Tell us what you think" has helped with the complaint process and patient information pamphlets on pressure sores and falls have been produced with consumer help.

The Ipswich Foundation is a Statutory Body under the Hospitals Foundation Act. The Foundation raises funds as one of its goals and allocates money to research and social science, supports a grant program for staff and gives donations. The car park is managed through the Foundation.

Health promotion is encouraged by the Foundation in conjunction with the Council and a wide variety of fitness activities are offered. The Ipswich Foundation is commended on the range of healthy lifestyle activities it brings to the community and the support it gives WMHHS. Given the high level of consumer involvement in the HHS in so many ways, the support and involvement of the Ipswich Foundation and the outcomes achieved the criterion has been re-rated to EA.

Mental Health

Consumers/patients, carers and the community participate in the planning, delivery and evaluation of the health service:

- Consumer workers involved in the MHS Safety and Quality Committee; and
- Consumer workers at The Park have developed a feedback collection system which is subsequently summarised and forwarded to the Quality Co-Ordinator.

The survey team noted that the IMHS Consumer Consultant was a member of the previous MH Executive however no longer sits on the current MHS executive. This is a missed opportunity for the MHS to incorporate the consumer voice and perspective into the strategic planning and delivery of the MHS.

Whilst it was noted that carers who reside within Queensland and interstate have access to teleconferencing and video conferencing facilities (upon request), via The Park Carers' Information

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Handbook, there was little evidence that carers and consumers have information that video conferencing can be utilised to connect with each other. For example, carers suggested to the survey team that Skype facilities could be made available in order for carers to connect with their family member.

A highlight of the survey was to hear from the IMHS Consumer Companions that they are now able to work weekends in order to provide support and activities to consumers who access the IMHS Inpatient Unit. The survey team noted this was not replicated at The Park.

Whilst it is understood that a training calendar for consumer workers has been developed at The Park, a training calendar was not evident for consumer workers within the IMHS.

NGO Sector:
The survey team noted the strong participation of the mental health NGO sector in the MHS and the establishment of a Service Integration Co-Ordinator position directly linking and liaising with clinical MHS. A highlight is the monthly BBQ organised by the NGOs within the area to encourage and enable a broad range of consumers and service providers to socially meet and connect with each other.

The IMHS Inpatient Unit hosts a monthly NGO meeting to enable various NGOs in the area to promote their services to the consumers accessing the Unit. It was noted, however, that a range of mental health NGOs are not included in the discharge planning process for consumers being discharged from the IMHS.

The team also noted that whilst there are some linkages with relevant NGOs at The Park these linkages need to be strengthened for the sustainable future, to ensure consumers being discharged from The Park are connected with relevant NGO services that continue to meet their ongoing needs of living in the general community.

Recommendations

Criterion 1.6.1 #1

Surveyor's Comments:

Feedback is required from the MHS to the consumers.

Surveyor's Recommendation: **HPR:No**

A system to close the quality loop to ensure the MHS provide feedback on how issues put forward by consumers and consumer workers are addressed is implemented and reviewed for its effectiveness.

Criterion 1.6.1 #2

Surveyor's Comments:

Access to videoconferencing facilities at The Park be made available.

Surveyor's Recommendation: **HPR:No**

Information to be proactively made available by the MHS that carers who reside intra or interstate are able to access video conferencing facilities to be able to regularly connect with their family member.

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Criterion 1.6.1 #3

Surveyor's Comments:

Consumer Companions should be sought to support and provide activities across the Units at The Park on weekends.

Surveyor's Recommendation: **HPR:No**

The Park further investigates creative and innovative solutions which decrease the barriers and issues, to enable consumer companions to work weekends to support and provide activities to consumers who access the various units.

Criterion 1.6.1 #4

Surveyor's Comments:

Development of consumer training should occur.

Surveyor's Recommendation: **HPR:No**

The Consumer Workers across the MHS develop ongoing ‘consumer’ training which is non-clinical, recovery focused rather than illness focused and is such that enhances the consumer workers capabilities to effectively undertake their consumer roles within the MHS. That experienced consumers are contracted to deliver such training.

Criterion 1.6.1 #5

Surveyor's Comments:

Involvement of NGOs should be progressed in discharge planning.

Surveyor's Recommendation: **HPR:No**

NGOs within the MHS are incorporated within the discharge planning process of consumers from both the IMHS unit and The Park.

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Function: Clinical **Standard: 1.6**

Criterion: 1.6.2

Consumers / patients are informed of their rights and responsibilities.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 1.6.2

Consumers, patients and carers/families are provided with information on rights and responsibilities when they use the WMHHS.

Patient satisfaction surveys occur irregularly in some services and need to become a regular process with analysis of the feedback and reporting to the Quality and Safety committee occurring.

Mental Health

There are many initiatives being undertaken by the MHS to inform consumers of their rights and responsibilities. This includes provision of rights information posters to consumer workers informing consumers of their rights and responsibilities. The fundamentals are in place and the survey team encourages the MHS to build upon these fundamentals to ensure that all consumers are not only informed of their rights and responsibilities, but that consumers' full rights and responsibilities are upheld.

A challenge for consumers and health services, each from their own perspective, is how consumer participation, input and feedback are genuinely heard and strategies developed and implemented for the enhanced delivery of care the consumer receives. Other challenges include the various tensions that exist between consumer, carer and provider perspectives, actions and reactions; treatment and care versus consumer choice and freedom to receive services and access activities in the least restrictive environment possible. Consumer and carer satisfaction surveys need to be implemented more frequently, at least annually.

Across the Health Service there is the poster "We Care". This is a good incentive for patients, staff and carers.

Recommendations

Criterion 1.6.2 #1

Surveyor's Comments:

Rights and responsibilities posters and pamphlets need to be displayed at the Goodna MHS.

Surveyor's Recommendation: **HPR:No**

Provide a rights and responsibilities poster, rights information pamphlets and a compliments and complaints form at Goodna MHS.

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Criterion 1.6.2 #2

Surveyor's Comments:

Chaplain feedback summary to be included in the Quality framework.

Surveyor's Recommendation: **HPR:No**

The MHS develop a user friendly system for the Chaplaincy service to collate and summarise the feedback being provided to Chaplains to be incorporated into the feedback and quality improvement processes of the MHS to further enhance the delivery of care.

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Function: Clinical **Standard: 1.6**

Criterion: 1.6.3

The organisation meets the needs of consumers / patients and carers with diverse needs and from diverse backgrounds.

Organisation's self-rating: MA **Surveyor rating:EA**

Overall Comment

Overall Comment 1.6.3

WMHHS is a health service that is part of the larger community and this is reflected in various ways and includes the diverse needs of people.

The volunteer service was only developed in the last two years and already has a large number of participants who eagerly take part in many activities like the volunteers who man the inquiry desk inside the front entrance and meet and greet patients and visitors alike. Other volunteer activities include helping the diversional therapist in the rehabilitation ward, playing games e.g. chess, cards and lawn bowls. One volunteer fits wigs and lends wigs for chemotherapy patients and others look after the Museum and work in the Community Plaza to name a few things they do.

The volunteers are given orientation and a handbook. They are trained in fire and safety and given a code of conduct. They are commended for what they do and what they did in the floods.

Interpreter services are easily accessed for the different cultural groups that have English as a second language. There has also been a large increase in the use of Auslan interpreters for the hearing impaired.

The Interpreter Service Information System (ISIS) allows requests to be made online. Whilst a telephone interpreter can be reached quickly, the preference is to use on site interpreters which are usually booked in advance. The Orientation Program for staff includes the use of interpreters and posters are used to advertise the service. A language identification card is used when required.

The Chaplaincy Service plays an important part within Ipswich hospital and other parts of WMHHS e.g. Mental Health. It provides an after-hours service as well as a routine service during each day. Chaplains have a roster and as well as visiting wards and units respond to urgent calls from doctors, nurses, social workers, patients and families. This is a valuable service and is commended.

Mental Health

A range of activities is undertaken by the MHS to support the diverse needs of consumers and carers from diverse backgrounds. A highlight was the interpreter service which provides a broad range of translation services including to consumers accessing the MHS.

Recommendations

No Recommendation

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FUNCTION SUMMARY: SUPPORT

Quality and Risk Management
The governance framework which supports quality and safety across WMHHS is currently under review, with the updated Clinical Governance Framework and Toolkit yet to be endorsed by the newly established Board. These should form the foundation to provide the necessary governance for safety and quality for WMHHS together with guidance for the newly established Board on establishing systems, processes and behaviours necessary to maintain high standards of care, and for continually striving for excellence through continuous improvement.

There are recommendations in this report around the need for integration of the Clinical Governance Framework and Toolkit and the new Strategic Plan and the identification of key priority areas for quality and safety based on the National, State and local agenda for inclusion in the Strategic Plan. Other recommendations relate to standardised reporting of organisational performance against strategies within the Strategic Plan, and the need for the development of an integrated Health Service Quality and Safety Plan (this may form part of the Annual Operational Plan) that articulates the Strategic Plan with WMMHS Clinical Governance Framework and Toolkit.

Staff are enthusiastic and demonstrate a commitment to continuous quality improvement. It was evident to the survey team that there is a quality culture developing across the HHS with good examples of improved service and health outcomes provided, notably the partnerships with the local hospitals and community services.

There are recommendations around reviewing the current committee structure that supports the safety and quality agenda and either establishing or extending the membership of the Patient Safety and Quality Committee to have additional clinician representation. Other recommendations relate to inclusion of standardised reporting of organisational performance against strategies within the Strategic Plan, having a strategic and coordinated approach for implementing and supporting the various quality improvement methodologies across WMHHS and include these in the Clinical Governance Framework and Toolkit, implementing a networked quality register that enables the prioritisation of high risk and low volume activities and reviewing the current education and learning strategies to support quality and safety both at the time of orientation and ongoing.

Generally, risks in the organisation are well understood and managed. However, there remains a great deal of variance in regard to the use and application of local risk registrar at site, facility and business unit level and the demonstrated use of the risk management principles and their processes.

Recommendations are made for an external review (audit) of the risk management framework and supporting system supported by full risk profiling, followed by a review of the education and training program to support the Risk Management Framework. Care needs to be taken, given the different committees that have been allocated roles in monitoring quality and risk management, that the two remain integrated and clinical and non-clinical risks are not viewed in separate streams. The HHS is encouraged to foster the use of the risk register and risk plans as a management tool that can be used across all services.

There are robust processes in place to record and manage adverse patient incidents. Patient Centred Care Committees in all services review these for their areas at their regular meetings and KPIs are included on the Executive Patient Safety and Quality Committee agenda. The organisation is commended on the excellent processes around ensuring that recommendations from root cause analysis processes have been implemented thereby reducing the risk of reoccurrence. Coronial investigations are monitored and updated on the PRIME database.

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There was evidence of links between the quality improvement program and the incidents and complaints management system with evidence that the incident register and complaints register are used to achieve quality improvement and to manage a range of incidents.

The People and Culture division has been proactive in planning and preparing for future workforce needs. They have been addressing significant negative morale issues including outstanding payroll problems and the significant effects of the flood disaster of 2011, as well as external structure changes.

Across the HHS, some cultural change programs have been successfully introduced e.g. "productive ward". WMHHS has invested heavily in the training and preparation of managers to lead their teams through the challenging times ahead.

Performance management education has also received focus but there remains a less than satisfactory completion of performance appraisals which needs to be addressed, particularly amongst senior doctors.

Despite some managers in rural areas being "temporary" for significant periods of time they appear to be enthusiastically leading their teams. However, the role of medical superintendent in rural areas requires clarification. It was felt that medical governance in these areas also needs strengthening and this is the subject of a recommendation.

Whilst there are many education/training opportunities provided by WMHHS, there is an absence of education about safety and quality. This is subject of a recommendation as is ensuring all staff in CSD meet the education requirement of ASNZ 4187.

The development of a computerised Resource Management System by this HHS appears to have been a great success and will assist in collecting important personnel information. The system is being taken up by many other Hospital and Health Services across the State.

The introduction of activity based funding appears to have stimulated activity to improve the availability of accurate and timely information across the HHS both with analogue paper records and developing digital e-records. The drive for change and improvement is clearly seen in the information management criteria and all staff in these areas are congratulated on their effort to support the organisation and continue to make improvements that assist and promote the delivery of high quality clinical services.

There is evidence of successful audit processes and improvement projects across the criteria that have resulted in service improvements e.g. the VLAD reports on coding data quality, audits of paper records to check compliance with Standards and policy, a review by coding staff r of the record during the coding process that introduces a second monitor of quality and compliance with the policy of the record and also the detection of clinical incidents and mishaps. The incidents and mishaps are reported to the clinical head of the department and the Patient Safety and Quality Unit for review.

Health promotion, health protection and surveillance are done particularly well across the WMHHS. Opportunistic engagement and consultation occurs across the various sites and is adapted to local needs to improve the health status of consumers and employees. Data is collected and used to inform targeted activities to increase the uptake of health surveillance.

There are several research projects in progress and the University of Queensland and Ipswich Hospital host a Research Day each year.

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Function: Support **Standard: 2.1**

Criterion: 2.1.1

The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.1.1

A culture of continuous quality improvement exists across the WMHHS with many quality improvement initiatives evidenced in various stages of implementation and maturity, but still providing excellent examples of improved service and patient outcomes (some of which are provided as evidence under the various criteria within the report). There is evidence of a team working together as a Hospital and Health Service.

The establishment of The Head and Neck Clinic which has improved coordination of care and resulted in improved patient clinical outcomes and levels of patient experience and the 'Releasing Time to Care' - Productive Ward Series implemented within the Orthopaedic and Surgical wards at Ipswich Hospital has resulted in increased patient direct care time. Reduction in interruptions and improved patient and staff levels of satisfaction are both excellent examples of strategies resulting in improved clinical and service outcomes.

Ipswich Hospital is considered to be a lead site for the Productive Ward Series. As such, staff from several large leading Hospitals and Health Services have visited to share ideas and learnings regarding the Productive Ward Series, with the benefits of the strategies within the program having been realised and currently being rolled out across the remaining clinical areas at Ipswich and the rural facilities. As such it is recommended that this program and an associated performance indicator to monitor and evaluate the impact of the program be included in the Organisation's Annual Operational Plan.

Through the Clinical Redesign Program and the Patient Flow and Access Strategy initiatives, improvements towards meeting the outcomes of strategic performance indicators have been demonstrated for ED, Outpatient Department and elective surgery waiting times.

Evidence of key foundation policy documents, frameworks and procedures from QH that provide the direction for WMHHS and a local WMHHS Quality Improvement Framework document was available.

The Queensland Health Patient Safety and Quality Plan 2008 – 2012 outlines the expectations for staff and priority areas for quality and safety. The survey team is aware that the governance structure to support quality and safety was under review at the time of survey.

These structures require strengthening with recommendations made regarding the need for integration of the Clinical Governance Framework and Toolkit and the newly developed Strategic Plan, with the Strategic Plan then required to articulate with the Annual Operational Plan and 90 Day Action Plans. The use of the 90 Day Action Plans when the structure and priorities have been identified will prove valuable in monitoring the facilities' progress.

There is an Annual Operational Plan; however there was little evidence of priority areas around quality and safety systems with only three objectives currently contained under Safety. The newly developed Strategic Plan will need to articulate clearly what the key priorities for quality and safety are, based on the National, State and local agenda in order that strategies and actions to meet these can be realised at all

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levels across the Health Service along with specific and measurable performance targets. A recommendation regarding the alignment of key quality and safety priorities in the development of the Strategic Plan to support the organisation in establishing its systems for quality is made.

The survey team saw how quality issues and service improvement are fed back and addressed across the HHS through the current Committee structure, with this structure currently under review as part of the governance framework for quality and safety. The current structure is designed to meet the auditing, reporting and business needs; whilst ensuring connectivity to the Clinical and Corporate Divisions of the wider organisation. There is an Executive Patient Safety and Quality Committee in place with endorsed TOR and meeting agenda chaired by the Executive Officer. Reporting lines have been established between the Divisional Patient Safety and Quality Committees.

All committees have TOR, membership and procedures in place. Agendas and minutes for the Executive Patient Safety and Quality Committee and some Divisional Patient Safety and Quality were reviewed and the survey team was thus able to get some sense of reporting through the to the Executive Patient Safety and Quality Committee on a range of matters requiring discussion.

The links between Divisional Patient Safety and Quality and the wider hospital although in place, still require further strengthening. Currently the structure lacks an Operational Committee to drive the Quality and Safety agenda, with the Executive Patient Safety and Quality Committee and various working groups i.e. Infection Prevention but no Clinician engaged Operational membership Group that are empowered to implement and effect the change.

It is suggested that such a group be considered as part the review of the Committee structure.

As part of the review of the governance structure it is recommended that the structure and process for reporting the outcomes of performance indicators as per the measures in the Strategic Plan be reviewed. It is suggested that a Balanced Score Card approach would be useful, with the built in capacity for clinician narration to address areas of variation.

Currently there is no WMHHS Quality register for the logging and monitoring of all quality improvement activities and initiatives that are being rolled out, audits and compliance activities. There is a recommendation for a networked quality register to be developed, implemented and rolled out across WMHHS.

There is a small quality team which provides support and direction to managers and staff within the various facilities and units across WMHHS. The team members have varying levels of skill mix having undertaken basic training in various accreditation models and their associated principles, whilst some staff have undertaken training in CQI methodology.

In discussion with staff from the various facilities and programmes there is no clear quality improvement language used or strategic and central coordination of the various quality improvement methodologies being rolled out across the various facilities and sites. A recommendation has been raised in regard to this.

Currently there is ad hoc training provided regarding quality improvement and quality systems with no standardised WMHHS Orientation program in place or ongoing education and training regarding quality and safety. A recommendation has been raised in regard to this.

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Recommendations

Criterion 2.1.1 #1

Surveyor's Comments:

At the time of survey the governance structure to support quality and safety was under review with a recently reviewed Clinical Governance Framework and Toolkit in place setting out the fundamentals of a Framework to provide Governance for Safety and Quality across WMHHS. A Strategic Plan to reflect the business of the new organisation was work in progress. There is a current Annual Operational Plan with little evidence of priority areas around quality and safety systems within the Plan.

As part of the review of the governance structure the structure and process for reporting the outcomes of performance indicators as per the measures identified within the Strategic Plan requires review, with currently an ad hoc approach to the various performance indicators and some limited narration evidenced at the time of survey to address areas of variation.

Surveyor's Recommendation: **HPR:No**

Implement the new governance structures to support quality and safety following the current review and its integration with the recently reviewed Clinical Governance Framework and Toolkit including the following:

- Identify the key priority areas for quality and safety based on the National, State and local agenda for inclusion in the Strategic Plan, and their appropriate performance indicators for monitoring by Executive and the Board;
- Develop and implement an integrated District Quality and Safety Plan (this may form part of the Annual Operational Plan) that articulates the Strategic Plan with WMHHS Clinical Governance Framework and Toolkit;
- Review the various systems and process used across in other like services for the reporting of performance indicator data that has the ability to reflect variation and can be rolled out efficiently and effectively across WMHHS. It is suggested that a Balanced Score Card approach would be useful, with the built in capacity for clinician narration to address areas of variation; and
- Implement an identified system for reporting of performance indicators.

Criterion 2.1.1 #2

Surveyor's Comments:

The 'Releasing Time to Care' - Productive Ward Series is a significant quality improvement strategy that is currently being rolled out across the remaining clinical areas at Ipswich and the rural facilities across WMHHS and as such has a great deal of resources and organisational commitment aligned to it.

Currently there is no integration or alignment of this strategy within the organisation's Strategic Plan, and therefore the Annual Operational Plan, and hence no high level performance indicator to monitor and evaluate the overall impact of the programs impact on the service outcomes across the organisation.

Surveyor's Recommendation: **HPR:No**

Include the 'Releasing Time to Care' - Productive Ward Series quality improvement strategy and an associated high level performance indicator to monitor and evaluate the impact of the program in the organisation's Strategic Plan and subsequent Annual Operational Plan.

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Criterion 2.1.1 #3

Surveyor's Comments:

Currently there is no clear quality improvement language used or strategic and central coordination of the various quality improvement methodologies being rolled out across the various facilities and sites, with quality improvement being spoken using various names and acronyms including PDSA, QI, Clinical Redesign – Ripple Effect, Releasing Time to Care' - Productive Ward Series, Clinical Audit.

Surveyor's Recommendation: **HPR:No**

Develop a strategic and centrally coordinated approach for implementing and supporting the various quality improvement methodologies across WMHHS.

Criterion 2.1.1 #4

Surveyor's Comments:

Currently there is no WMHHS wide quality register for the logging and monitoring of all quality improvement activities and initiatives, audits and compliance activities and that links these activities to the Strategic Plan (no plan in place), nor is there a system in place for prioritising improvements to address high risk, low volume issues.

Surveyor's Recommendation: **HPR:No**

A networked quality register be developed, implemented and rolled out across WMHHS and include the following:

- parameters that are measurable and outcome focused i.e. 'SMART' (Specific, Measurable, Appropriate, Realistic and Timely) together with project outcomes;
- corporate and non-clinical activities; and
- a means to enable the prioritisation of high risk and low volume activities and link these to the activities to the Annual Operational Plan.

Criterion 2.1.1 #5

Surveyor's Comments:

Currently there is only ad hoc training provided regarding quality improvement and quality systems with no standardised WMHHS Orientation program in place or ongoing education and training regarding quality and safety.

Surveyor's Recommendation: **HPR:No**

Review the current education and training program for quality and quality systems noting the following:

- develop and implement a standardised orientation program for quality and safety systems, including risk (clinical and workplace) and incident management; and
- develop education strategies to address the ongoing learning and development needs of the organisation. It suggested that consideration be given to developing these to on-line training modules.

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Function: Support **Standard: 2.1**

Criterion: 2.1.2

The integrated organisation-wide risk management framework ensures that corporate and clinical risks are identified, minimised and managed.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.1.2

WMHHS operates within the QH Integrated Risk Management Policy and framework to ensure that both clinical and corporate risks are managed.

The key risks associated with funding and recruitment of qualified, experienced staff to minimise the risks associated with the use of locums and agency are well documented with mitigation strategies implemented and actioned.

There has been a significant increase in the number of medical staff employed and the use of locums is decreasing.

At Boonah and Esk, ambiguity was identified around the medical superintendents' positions in terms of role, responsibility and authority and a need for more formal medical governance at each facility. Some clinical risks at these sites were identified by the survey team regarding the need for improved timeliness of endorsement of medications ordered by phone, review of pathology results and medical assessment prior to transfer, with these risks not identified in the local risk registers (Refer 2.2.3).

The new structures, including governance arrangements, for both risk management and quality improvement are in the process of review and implementation. Clinical risks and non-clinical risks have different pathways and monitoring committees. This is potentially confusing and could result in gaps in monitoring occurring and possible communication difficulties. Risk management may be too strongly aligned to Health and Safety structures in the new model which could result in a limited view about enterprise risk management.

As per 2.1.1, there was no evidence of a WMHHS Risk Management Plan that articulates with the overarching Strategic Plan. There is a recommendation therefore to incorporate a Framework for Quality, Safety and Risk that articulates both the risk management and quality improvement priorities with the HHS's strategic intent as part of the Strategic planning process.

As part of the new Governance Committee structure a review of local committees and their membership is currently underway. Risk is a standing agenda item for all team meetings and clinical services meetings.

Evidence was provided to demonstrate the application of the integration of the risk management and quality improvement principles, e.g. the reduced extravasation risk to paediatric patients through the implementation of new infusion pumps and syringe drivers with guardrail technology.

There are effective policy documents in place along with an electronic data base and a risk register for the Health Service. QH have introduced the Integrated Risk Management Information System (QHRisk) electronic register to record all risks. The risk recording system has been mandated for use across QH and is aligned with the QH Risk Management Policy and Framework. There are limited software licences allocated - the Director, Quality and Safety is responsible for entering all HHS risks into the register whilst

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the Quality Safety Officers are responsible for entering local risks following receipt of a Risk Notification Form.

There is a requirement that all significant risks must be reported to the Executive and to the Patient Safety and Quality Committee in order that they be analysed, evaluated and controlled or treated from a HHS perspective. E-mail prompts are used to ensure that managers are treating risks according to the agreed program. The risk framework is controlled at the HHS level.

Risk Registers are in place at District, hospital and local facility level and across all rural sites. Reports can be drawn from the system by these representatives and members of the Executive Team.

The HHS register is monitored regularly with follow up of an identified risk made by a dedicated member of the Patient Safety and Quality Unit. It was noted during survey that the feedback loop of recommendations and outcomes following the risk management process was not well adhered to. It is therefore recommended that this part of the process be reviewed and strengthened.

There remains a great deal of variance in regard to the use and application of local risk registers at site, facility and business unit level and the demonstrated use of the risk management principles and their processes. This was evidenced at time of survey by members of the survey team through review of the local risk registers and following discussions with local facility and hospital staff. A recommendation is made for the HHS to invest in an external review / audit of the risk management framework and supporting system. This should include risk profiling. Those risks that were identified on the local risk registers were being well assessed and mitigation strategies were generally appropriate.

Staff are advised of the risk management system and their responsibilities in relation to risk management in an ad hoc way, as per 2.1.1, with no standardised WMHHS Orientation program in place or ongoing education and training. This was verified to members of the survey team through review of the registers that showed a proliferation of relatively minor operational risks that appeared capable of resolution by a line manager or OH&S Committee level.

Discussion with staff confirmed that issues do arise about whether events are of an OH&S nature or a matter for recording on the incident register rather than the risk register. A need for further staff education has been recognised and this is supported by the survey team with recommendations listed under 2.1.1 and 2.2.4

Recommendations

Criterion 2.1.2 #1

Surveyor's Comments:

As per 2.1.1 there was no evidence of a HHS Risk Management Plan that articulates with the overarching Strategic Plan.

Surveyor's Recommendation: **HPR:No**

Incorporate as part of the strategic planning process a framework for Quality, Safety and Risk Management that articulates both the risk management and quality improvement priorities with the HHS strategic intent.

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Criterion 2.1.2 #2

Surveyor's Comments:

The HHS register is monitored regularly with follow up of an identified risk made by a dedicated member of the Patient Safety and Quality Unit. It was noted during survey that the feedback loop of recommendations and outcomes following the risk management process was not well adhered to.

Surveyor's Recommendation: **HPR:No**

Develop and implement a process for the feedback of recommendations and outcomes from the risk management process to ensure closure of the risk management loop.

Criterion 2.1.2 #3

Surveyor's Comments:

There remains a great deal of variance in regard to the use and application of local risk registers at site, facility and business unit level and use of the risk management principles and their processes. The local registers show a proliferation of relatively minor operational risks that appeared capable of resolution by a line manager or OH&S Committee whilst existing extreme risks had not been included in the local risk registers and therefore had not been escalated through the risk management process through to the District e.g. building fire risks at Laidley and Esk.

Surveyor's Recommendation: **HPR:No**

Undertake an external review (audit) of the risk management framework and supporting system including risk profiling.

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Function: Support **Standard: 2.1**

Criterion: 2.1.3

Health care incidents are managed to ensure improvements to the systems of care.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.1.3

There was evidence of links between the quality improvement program and the incidents and complaints management system with evidence that the incident register and complaints register is used to achieve quality improvement and to manage a range of incidents.

Complaints and Incident Management Policy Directives from QH along with Incident Management Guidelines are in place. Relevant Clinical Incident Management Procedures and work practices have been developed to guide practice at the local level.

The principles of Open Disclosure are included in the Clinical Incident Implementation Standard, local clinical incident management procedures as well as within the PRIME – CI.

It was evident that the principles and philosophies of Open Disclosure are being adhered to by staff when managing incidents and complaints with all of these processes working effectively to prompt the Patient Safety Officers (PSOs) to ensure open disclosure principles are part of the incident management process. Key staff have undertaken training in Open Disclosure. Key senior clinical staff and Executive staff have completed the QH Clinical Disclosure Program while clinical staff undertake a modified training program.

Evidence was provided of the reporting process being used for the management of incidents across WMHHS which demonstrated that incident management is done well.

There are three processes currently in place for the management of incidents: clinical incidents are logged into PRIME - CI which enables tracking and risk rating according to a set matrix, complaints and compliments of a clinical nature are logged into PRIME – CF and occupational, health, safety and risk incidents into another system. Staff have access to the PRIME – CI reporting system, with a good culture of reporting evident across all disciplines.

Regular reports from these systems are reported to, and monitored by, the hierarchy of Patient Safety and Quality Committees and Management Committees and the Clinical Review Committee along with ad hoc reports, with various sub committees responding to aggregated data e.g. Medicine Management Committee.

A review of the governance structure to support quality and safety was currently underway at the time of survey. A recommendation is made around this relating to committee structures.

As part of this review consideration should be given to a more integrated and coordinated approach for the management of all risks and incidents. From a governance perspective and from an integrated risk management perspective there is a recommendation made regarding the management of sentinel events and SAC1s through the Root Cause Analysis (RCA) and Human Error and Patient System (HEAPS) methodologies to achieve a strengthening of the process of feedback of recommendations in order that lessons can be learnt and actions implemented in order to complete the quality cycle.

A Clinical Incident Triage Procedure has recently been developed and is to be introduced as part of the

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new QH Clinical Incident Management Information Systems Policy. The intent of the procedure is to provide rigor ensure the appropriate investigation is being undertaken on an adverse event or incident. It will assist the organisation in meeting timelines for the management of RCAs as prior to this all sentinel events were managed through the RCA process. At the time of last survey, there were 96 outstanding corrective actions. These have been significantly reduced to 50 outstanding as at June 2012.

Performance measures are in place for handling incidents according to the SAC scoring. Challenge remains meeting the benchmark of 45 working days for completion of an RCA. It is hoped that the recently developed Clinical Incident Triage Procedure will assist the organisation in moving towards meeting its performance targets.

SAC 1 incidents are reported to Executive Patient Safety and Quality Committee. It is their brief to review these incidents and endorse recommendations for implementation. Implementation of a Quality Check of Clinical Incident Analysis Recommendations Work Instruction has improved the strength of recommendations made. SAC 2 and 3 incidents are trended and reviewed by the Executive Patient Safety and Quality Committee with evidence of action to address findings from the data in the form of HHS working groups.

A review of incidents reported and the risk rating of these identified that most incidents were appropriately risk rated, with approximately 10% of incidents requiring re – rating.

Currently, ad hoc training is provided to some staff (medical/nursing) at orientation on their responsibilities in regard to incident and risk management and their responsibilities in relation to the reporting of incidents. With no current standardised WMHHS Orientation program in place or ongoing education and training, recommendations are therefore listed under 2.1.1.to address this. Training should include Risk Management and Incident Management. The education and training program also needs to include medical coders across WMHHS, as it was identified at survey that coders were unsure what to do if they identified a clinical incident at the time of coding a patient file (Refer 2.3.1).

Recommendations

Criterion 2.1.3 #1

Surveyor's Comments:

At the time of survey it was noted that the management of sentinel events and SAC1s through the RCA and HEAPS methodology and the feedback of recommendations in order that lessons can be learnt and actions implemented in order to complete the quality cycle could be improved, with often times either no feedback received of the changes to be made or a lag in the process. Many of the recommendations from the RCA process have application across the greater WMHHS.

Surveyor's Recommendation: **HPR:No**

It is recommended that as part of the governance review and the review of committee structure that the reporting and feedback of performance against the organisation's performance targets and the lessons learnt and recommendations from incident investigations be included as part of this process.

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Criterion 2.1.3 #2

Surveyor's Comments:

It was identified at the time of survey that the medical coders were unsure of what to do with a clinical incident if it was identified during the course of their coding. There is currently no work flow process in place for these incidents to be logged into PRIME - CI nor have staff had education and training in the area of clinical incidents and the PRIME - CI system.

Surveyor's Recommendation: **HPR:No**

Develop and implement a work flow process for medical coders to enable them to record relevant incidents and provide training for this process.

Function: Support **Standard: 2.1**

Criterion: 2.1.4

Health care complaints and feedback are managed to ensure improvements to the systems of care.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.1.4

Consumer feedback and the complaints management process is managed exceptionally well across WMHHS in line with relevant policies and frameworks as determined by QH.

It was evident that the principles and philosophies of Open Disclosure are being adhered to by staff when managing complaints, with the QH Complaints Policy incorporating the principles of Open Disclosure, and the program implemented across WMHHS through structured training. Key senior clinical staff and Executive staff including the Director, Integrated Mental Health Services and Clinical Director have undertaken the QH Clinical Disclosure Program while clinical staff undertake a modified training program.

There was evidence of a robust complaints management framework in place with all complaints entered into the electronic PRIME - CF Incident Management System and risk rated according to a set matrix.

A Consumer Liaison Officer manages the Consumer Feedback and Complaints Management System and Ministerials regarding patient care, patient experience and quality of care.

A new initiative to support and strengthen consumer feedback - the “Tell us What You Think” form – was recently introduced at Ipswich Hospital. This has already proved valuable in capturing minor, low level feedback that would normally have been missed. The strategy is to be implemented across the HHS as part of the consumer feedback process.

It was not clear to the survey team what information is included in the admission and referral packs provided to patients and the information provided to them upon entry to the organisation regarding the complaints process. It is suggested that the information provided to patients and the process of distribution and placement be reviewed. To strengthen this, a recommendation has been made regarding

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the acknowledgement and understanding of the complaints handling process by the patient. It is suggested that this may be incorporated with management of the patients' rights and responsibilities.

Currently there is ad hoc training provided on Consumer Feedback Management, as per the QH Health Policy Statements with no standardised WMHHS Orientation program in place or ongoing education and training.

Performance around complaints management and consumer feedback is a KPI reported to the WMHHS Executive on a monthly basis. Data for the reporting period 1 January 2011 – 31 December 2011 showed that a total of 364 complaints had been received (average of 30 per month), 98% of these were acknowledged within 5 days (benchmark 100%), with 77% of these closed within 35 days (benchmark 80%). The majority of complaints are around communication, treatment issues and access e.g. Emergency Department waiting times and elective surgery waiting times. The Patient Flow and Access Strategy that has recently been introduced demonstrates improvement around benchmarks for Emergency Department waiting times and elective surgery waiting times.

Consumer compliments are also monitored within the PRIME – CF system and the total compliments collected and reported back to staff. For the above reporting period 424 compliments were received.

Evidence of reporting both outcomes of the complaints handling process and WMHHS's performance in meeting their KPIs was provided. Regular reports are presented to the Executive Quality Patient Safety Committee. Successful resolutions within the complaints handling process were evidenced at the time of survey with several examples provided.

Recommendations

Criterion 2.1.4 #1

Surveyor's Comments:

It is unclear as to what information is given about how to make a complaint. The complaints handling process is included in the admission and referral packs provided to patients and the information provided to them upon entry to the organisation.

Surveyor's Recommendation: **HPR:No**

Review and standardise the information regarding the complaints management process and how this information is provided to the patient upon entry to the various facilities across WMHHS.

Criterion 2.1.4 #2

Surveyor's Comments:

Currently there is no process in place to evaluate whether patients have acknowledged and understood the information provided regarding the complaints handling process and the process for making a complaint.

Surveyor's Recommendation: **HPR:No**

Develop a process to evaluate the acknowledgement and understanding of the complaints management system and information provided. It is suggested this may be incorporated with the patients' rights and responsibilities process.

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function: Support **Standard: 2.2**

Criterion: 2.2.1

Workforce planning supports the organisation's current and future ability to address needs.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.2.1

The survey team viewed the strategic Workforce Plan for the Health Service for the next five years. This includes consideration of the redevelopment and service changes anticipated. The impact of output based funding and new models of care are matters which will influence the organisation's capacity to deliver the Plan as well as the impact of the many strategies being implemented (including joint community development projects with the City Council and tertiary institutions) to increase the available workforce in the area.

The People and Culture Department is responsible for Human Resources (HR) policies, managing industrial issues, resolving payroll discrepancies and a significant amount of staff training, workforce planning and OH&S. The Department is driving an innovative approach to recruit staff to health professions - the "Ipswich Moreton Health Alliance" in conjunction with local government, local secondary college, TAFE, private hospital provider, Springfield developer, aged care facility and indigenous groups. A workforce planning committee meets regularly.

The Department has been addressing the major salary difficulties caused by ongoing issues within the State-wide payroll system. This has created tensions over many months between employees and employers but appears to be working towards reaching satisfactory solutions.

Efforts to address the low level of uptake by university students from the Ipswich area into health related careers are commendable. This includes career days and work experience opportunities for secondary school children, as well as school based traineeships for students in Years 10 and 11.

Whilst budget control rests with the various cost centre managers, an instrument of delegation provides guidance regarding responsibilities for HR management. Various reviews and assessments are undertaken to ensure that the organisation has the correct skill mix to meet organisational requirements. A nursing dependency system (TrendCare) is used to determine nursing hours per patient days and a proactive Nursing Support Department manages the shift by shift response to resource requirements as well as patient location and patient transfer/transport.

There are a range of workplace policies, primarily provided by QH which are accessible via the staff intranet.

Orientation, supervision on initial employment days, and mandatory training (including medication administration) assist to minimise errors and accidents. The Nurses' award minimises fatigue and there is a strong fatigue management system in place for medical staff. Doctors are required to complete the fatigue management education package on commencement and the Director of Medical Services monitors its implementation. The survey team viewed minutes of meetings relating to workforce planning, skills shortages and fatigue management.

WMHHS has been funded for a 1.6FTE Palliative Care Physician but for eighteen months 0.6FTE has been vacant. The organisation advised that a potential overseas recruit was rejected because Ipswich is not considered an area of need and therefore Australian registration was rejected by the Australian Medical Council.

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Like many other rural areas in Australia, WMHHS has experienced a chronic shortage of dentists. There are significant waiting periods for oral health services. This is despite the provision of new facilities including new mobile vans and services.

Recommendations

Criterion 2.2.1 #1

Surveyor's Comments:

WMHHS has been funded for 1.6FTE Palliative Care Physician but for eighteen months 0.6FTE has been vacant.

Surveyor's Recommendation: **HPR:No**

WMHHS pursues recruitment to the vacant funded Palliative Care position so as to meet the specialist service demand in the area and ensure continuing employment of the existing appointees.

Criterion 2.2.1 #2

Surveyor's Comments:

Similar to many other rural areas in Australia, WMHHS has experienced a chronic shortage of dentists. There is significant waiting periods for oral health service. This is despite the provision of new facilities including new mobile vans and services.

Surveyor's Recommendation: **HPR:No**

WMHHS develop a plan of recruitment to overcome the chronic shortage of dentists, promoting the excellent new oral health facilities now available within the new HHS.

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function: Support **Standard: 2.2**

Criterion: 2.2.2

The recruitment, selection and appointment system ensure that the skill mix and competence of staff, and mix of volunteers, meets the needs of the organisation.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.2.2

All recruitment for WMHHS, except junior medical officers, is channelled through QH located at Mt Gravatt, though it is unknown if this will continue with the establishment of the new Hospital and Health Service boundaries.

Locally, the recruitment and appointment process for nursing is managed through the nursing recruitment department for nursing /midwifery (this has been evaluated and improvements made) and the medical department for medical recruitment. The People and Culture Department manages all other appointments, which are not managed by health support/QH.

A designated employee manages the group volunteers, informally monitoring volunteer satisfaction. The volunteers advised the survey team of their orientation and mentoring processes. Currently their key role is greeting visitors at the main entrance and directing people to various locations throughout the health service. It is suggested that some be dedicated to accompanying patients to the Day Procedure Unit as there are currently delays in patient arrival which can lead to disruptions for the service (Refer Recommendation under 3.2.2).

The “Rostering Rules” booklet was noted to be used by nursing staff to ensure skill mix in wards and departments.

Recommendations

No Recommendation

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function: Support **Standard: 2.2**

Criterion: 2.2.3

The continuing employment and performance development system ensures the competence of staff and volunteers.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.2.3

The survey team was impressed by the Resource Management System (RMS) which has been developed at Ipswich and is being adopted by many other Health Services throughout QH. The RMS not only captures attendance at in-service activities, appraisal and qualification but also tracks facility and teaching equipment bookings. TrendCare captures appraisals completed by nursing staff.

There is a range of storage systems to ensure personnel documents associated with the performance development system are secure. The main file is stored with QH at Mt Gravatt. Where files are stored locally, they are held by the cost centre manager and kept in secure storage.

A system is in place to ensure all clinicians maintain their registration with managers checking AHPRA annually. There are codes of conduct for the various craft groups and the use of “above” and ‘below” the line of acceptable behaviour was noted, being used with good effect in rural health services.

There is a system in place should there be complaints about staff. Due to failure of the State-wide payroll system the survey team was advised that there had been errors of payment affecting approximately 75% of staff. This had caused inordinate disquiet but the People and Culture Department are to be congratulated on their determination to work with staff to address both over and underpayment situations. Similarly they are commended on the efforts made to address staff personal needs during the external disaster of 2011. Many examples were provided by staff of distressing situations which had impacted on their work capacity. This experience is subject of a review and will provide valuable “lessons learnt” to deal with any future disasters.

Ipswich has been the lead agent introducing “the Productive Series” into all medical wards. The results have been impressive in terms of staff morale and increasing direct care time. The model is being rolled out into other wards and to the rural health services who are introducing the “Productive Community hospital.”

The People and Culture Department sends reminders to managers to address outstanding performance appraisals. Many staff advised that they had undertaken an annual performance management appraisal. Some areas e.g. rural health services, have a higher completion rate than others but most are capturing the majority of their workforce for regular formal feedback with senior doctors being the exception. The survey team noted that approximately 35% had undertaken performance appraisal although there is a plan in place to improve this compliance. Medical Administration needs to persist with their plan until 100% are completed annually or in accordance with HHS expectation.

The nursing recruitment department routinely reviews position descriptions prior to advertising any position above the base line employees. There is a transition to nursing program managed via the Nursing Education department and an award provision which is available to all nurses for their ongoing education (excluding casuals and temporarily employed staff).

An annual needs analysis is undertaken by Nursing Education and a calendar of education activities developed for each six months.

Organisation: West Moreton Hospital and Health Service
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In the rural health services (Boonah and Esk), there is ambiguity around the medical superintendent's positions in terms of role, responsibility and authority of medical superintendent. This causes some communication difficulties and there was concern about the medical governance of these services as well as stewardship and propriety (Refer 2.1.2).

The survey team was concerned that at both Boonah and Esk there is ambiguity around the medical superintendent's positions in terms of role, responsibility and authority of medical superintendent. There needs to be more formal medical governance at each facility as well as improved timeliness of endorsement of medications ordered by phone, review of pathology results and medical assessment prior to transfer. There was also an absence of performance appraisal.

Recommendations

Criterion 2.2.3 #1

Surveyor's Comments:

It was noted that approximately 35% of senior doctors had undertaken performance appraisal. A plan needs to be in place to improve this compliance.

Surveyor's Recommendation: **HPR:No**

Ensure that all senior doctors and medical superintendents undertake performance appraisal annually.

Criterion 2.2.3 #2

Surveyor's Comments:

At Boonah and Esk there is ambiguity around the medical superintendent's positions in terms of role, responsibility and authority. There is a lack of formal medical governance at each facility and an absence of performance appraisals of the incumbents.

Surveyor's Recommendation: **HPR:No**

The PD for Medical Superintendents at rural health services should include clear information regarding the position's responsibility for safety and quality of the service, lines of communication as well accountability and delegated responsibility.

Criterion 2.2.3 #3

Surveyor's Comments:

All position descriptions need to be regularly reviewed and updated.

Surveyor's Recommendation: **HPR:No**

WMHHS ensure all position descriptions are regularly reviewed/updated.

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function: Support **Standard: 2.2**

Criterion: 2.2.4

The learning and development system ensures the skill and competence of staff and volunteers.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.2.4

There have been some excellent leadership programs provided to WMHHS, particularly education and support to performance manage staff and have the “difficult conversations”. These programs include ‘leading the way into the future” for nurse managers with titles such as “putting rubber to the road”, Setting the Scene, and Sailing into Supervision. A Survey Monkey tool was used to evaluate the latter.

Effective Aggressive Behaviour Management training has been undertaken resulting in a commendable reduction of lost days and work cover costs.

The OH&S Unit have been involved in plans for the redevelopment ensuring there is improved provision for managing the bariatric patient. They have also rolled out a Participative Ergonomics in Food Service programme, aggression management, manual handling and fire training across the HHS.

Funding is being sort for the proposed program for beginning practitioners in midwifery- this will be a necessary education/support program for first year graduates from the dual degree or bachelor midwifery degree. It was noted that WMHHS provides clinical placement for RAAF employees.

The survey team noted that although incident reporting is included in the orientation for some clinical staff there are no information sessions about safety, risk and quality. This should be provided for every staff member, both clinical and non-clinical as well as volunteers. A recommendation has been raised under Criterion 2.1.1 regarding this issue.

The provision of clinical educators attached to various wards who ensure clinical competence in the various specialties was also noted.

Not all staff working in the CSD area of decontamination and sterilisation are suitably qualified. A recommendation has been raised under Criterion 1.5.2 regarding this issue.

Recommendations

No Recommendation

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function: Support **Standard: 2.2**

Criterion: 2.2.5

Employee support systems and workplace relations assist the organisation to achieve its goals.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.2.5

Employees at WMHHS have access to an Employee Assistance Program via a State wide telephone number. This service is free and confidential. It is suggested that WMHHS consider educating suitable staff to provide peer support when groups are faced with traumatic situations.

Staff are provided with information about rights and responsibilities at the time of orientation. WMHHS has invested heavily in training managers to develop leadership skills.

Flexible work arrangements are in place including for lactating mothers and transition to retirement for a senior nursing staff member.

A staff satisfaction survey is undertaken every two years.

The HHS provides a parking system for those staff working on late/night shifts to ensure their safety, with time off and bus transport to collect their car and bring it to the car park as well as being provided with free parking for the remainder of their shift.

A social club at Ipswich provides various support activities and a range of scholarship/bursary funding is made available by the auxiliary.

Examples were provided where practical assistance was given to individuals adversely impacted by the State wide payroll difficulties as well as support provided by the organisation to individuals affected by the floods.

Recommendations

No Recommendation

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function: Support **Standard: 2.3**

Criterion: 2.3.1

Health records management systems support the collection of information and meet the consumer / patient's and organisation's needs.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.3.1

There has been significant effort made to improve the storage of medical records including a complete review of Ipswich Hospital record storage areas.

All files are now stored on shelves and a program of archiving and culling has been completed.

A Master Patient Number has been introduced at State level which has increased the rigour around use of the local unique patient identifier. Documentation is subject to regular audit of content for compliance with standards and policy and the system manager runs audit processes to confirm data accuracy e.g. monthly VLAD reports from PSQ.

In addition to these routine reports, adverse events/clinical incidents have been detected by coding staff at Ipswich Hospital during routine file reviews. These complications are reported to appropriate staff within the organisation who can review and investigate the instances and, when necessary, progress corrective action to minimise risk to patients or recurrence of the adverse event. There is, however, no formal mechanism for feedback to these staff at the conclusion of investigations (Refer 2.1.3).

It is suggested that a formal process for providing feedback to notifiers of incidents be developed. This process will maintain an open and transparent line of communication and promote safety within the organisation.

Recommendations

No Recommendation

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function: Support **Standard: 2.3**

Criterion: 2.3.2

Corporate records management systems support the collection of information and meet the organisation's needs.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.3.2
Corporate records have been moved into a purpose build storage area on the Ipswich Hospital campus. This has provided the opportunity to reorganise the records with improved safety and access to these records.

Recommendations

Criterion 2.3.2 #1

Surveyor's Comments:

There appears to be no staff member responsible for the management of the archiving and culling processes for corporate records.

Surveyor's Recommendation: **HPR:No**

It is recommended that responsibility for the maintenance of corporate records be delegated to a specific position that is familiar with the regulations for record storage, archiving, culling and destruction of corporate records to ensure that standards are met.

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function: Support **Standard: 2.3**

Criterion: 2.3.3

Data and information are collected, stored and used for strategic, operational and service improvement purposes.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.3.3

New information management technology has been introduced across the WMHHS which has provided substantial improvement in timely access to a patient's electronic records in the Ipswich Hospital. Examples of such technology include HBCIS, the Emergency Department Information System (EDIS) Viewer (which makes patient information available across the Queensland Health system) PractiX online Medicare claiming which has improved the management of Medicare billing and reduced delays in billing and the Resource Management System, an in-house system that that has developed from an inventory system to now record mandatory training, motor vehicle management and other functions.

Recommendations

Criterion 2.3.3 #1

Surveyor's Comments:

The introduction of Viewer and EDIS in the Ipswich Hospital has demonstrated significant improvement in functionality over the HBCIS, particularly in relation to patient identification at the first presentation to hospital or emergency. Currently, the Viewer and EDIS are not available to the rural hospitals and do not appear to be in scope for HSIA however there is a meeting with HSIA in late August to discuss planning for WMHHS.

Surveyor's Recommendation: **HPR:No**

It is recommended that the WMHHS negotiate with HSIA to accelerate the roll out of Viewer software to the rural hospitals to facilitate patient identification at presentation to the hospital and in doing so reduce the risk associated with incorrect patient identification.

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function: Support **Standard: 2.3**

Criterion: 2.3.4

The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.3.4

Much of the I&CT innovation is coordinated centrally and managed through the local WMHHS IC&T Committee. There has been significant change across the HHS that appears to have been well planned and coordinated.

Of particular note is the introduction of voice recognition systems for radiologists. This has enabled timely radiology reporting within Ipswich Hospital and across the rural hospitals of WMHHS and in doing so has closed a recommendation from the previous OWS in Criterion 1.1.2 (OWS0808).

Recommendations

No Recommendation

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function: Support **Standard: 2.4**

Criterion: 2.4.1

Better health and wellbeing is promoted by the organisation for consumers / patients, staff, carers and the wider community.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.4.1

Health promotion, health protection and surveillance are done particularly well across the WMHHS. Data are collected and used to inform targeted activities to increase the uptake of health promotion and surveillance.

Opportunistic and innovative engagement and consultation occurs across the various sites, being adapted to meet local needs to improve health status of consumers and employees. Services have been reconfigured and made available outside business hours to increase consumer participation in these important initiatives.

WMHHS staff have worked hard to engage with the community and collaborative service providers to maximise exposure to health promotion, protection and surveillance activities. This was of particular note in cohorts of the population who are traditionally under-represented in these activities.

WMHHS is commended on the high rates of employee immunisation.

Recommendations

No Recommendation

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function: Support **Standard: 2.5**

Criterion: 2.5.1

The organisation's research program develops the body of knowledge, protects staff and consumers / patients and has processes to appropriately manage the organisational risk associated with research.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 2.5.1

Policies, guidelines and processes support research. The organisation is actively encouraging research. Ipswich Hospital, in collaboration with the University of Queensland, hosts an annual Research Day where current research is presented by way of oral or poster presentations. Research policies and guidelines are consistent with the requirements specified in the Health Research Management Policy.

There is a HHS Health Research and Ethics Committee (HREC), which has consumer representation. Terms of reference are reviewed annually. The HHS HREC submits an annual report of research activity to the NH&MRC in accordance with guidelines. For the 2011 calendar year there were a total of 41 research protocols approved (15 from within WMHSD and 26 external to WMHSD).

Clinical audits are approved prospectively by the DMS. Subsequent governance is overseen by the Director, Quality and Safety.

There is scope to review the current clinical audit tool in line with the NH&MRC checklist with the aim of identifying potential research projects that may result from undertaking the clinical audit prospectively and forwarding them to the HREC Committee for approval at this time, thus preventing avoidable approval delays.

The organisation is encouraged to progress the proposal of joint appointments and/or funding opportunities for WMHHS and the University of Queensland for research positions.

Recommendations

No Recommendation

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

FUNCTION SUMMARY: CORPORATE

WMHHS is in the midst of a great amount of change. A new Board and Chairperson were appointed from 1 July 2012. A new Chief Executive (CE) commenced recently and legislated Board committees are in place. A new interim Executive is to commence shortly. It is intended to create a Health Service that will put in systems that will sustain the whole of WMHHS and re-establish the right health service for this time.

Apart from the Board Committees there is a Committee Structure that will need to be reviewed. Delegations are in place and a risk action plan has been developed.

Credentialing and scope of practice are well organised throughout WMHHS and most faculties are represented on the credentialing Committee which also has a nursing representative. The CE signs off on medical staff appointments.

WMHHS manages its external service providers effectively and meets all the requirements to achieve MA rating.

WMHHS is in transition following organisational restructure within QH. It currently uses the QH policy framework and policies, which was in place prior to 1 July 2012 and therefore meets the requirements to achieve an MA rating. The WMHHS will be developing its own policy framework, system and policies within the next year.

Occupational Health and Safety (OH&S) is managed well across the Health Service by an OH&S team. Policies, guidelines and protocols are easily accessed and support the OH&S Plan. OH&S is integrated into management meetings and reports to an OH&S committee. OH&S is taken seriously across the Health Service with emphasis on radiation safety, manual handling, use of appropriate equipment, e.g. for bariatric patients, and staff take responsibility for notifying and recording incidents.

A major building extension to provide a new clinical block at Ipswich Hospital is underway and will be completed in 2014. This has caused disruption for staff who are nevertheless managing the circumstances very well. Temporary signage is in place however, it is difficult to find some departments e.g. day surgery. It is suggested that a volunteer could be available to assists day patients to find the unit.

BEMS and Biomedical Technical Support (BTS) are well managed data bases that add value to maintenance areas of the Health Service. However, some of the rural hospital buildings have risks associated with them that need attention. These risks have been placed in the risk register.

Waste is managed well and appropriately. There is a waste management committee and a waste management plan. Waste is regularly monitored and results are fed back to the relevant managers and staff. Many initiatives are in place to conserve resources including saving rain water for gardens and laundering and the use of solar panels on the car park roof which means less electricity is consumed by coal fired burners.

The extreme weather event of 2011 has led to excellent disaster planning and multiagency testing is ongoing. Fire reports have been acted upon and recommendations implemented in a planned manner.

Security has seen many improvements in recent years and there is a security policy and security plan in place. Duress alarms are available and staff are actively encouraged to wear them.

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function: Corporate **Standard: 3.1**

Criterion: 3.1.1

The organisation provides quality, safe health care and services through strategic and operational planning and development.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 3.1.1

There has been a great deal of change within QH over the last few years culminating in the latest change from 1 July this year when a new Board and Chairperson were appointed. The Board has undergone formal induction. A new CE, appointed by the Board, commenced three weeks prior to the survey and the majority of the Executive have been in acting positions for some time.

A new interim Executive is to be appointed from late August, of which the current Acting Executive is aware. It is intended that this will be the leadership group that will train other leaders.

Considerable change is still to occur within the WMHHS as systems are put in place to sustain the health system, and re-establish the most appropriate health service.

The committees overseen by the Board (Board Committees) are the Executive Committee, Quality and Safety Committee and the Finance Committee and are required by legislation. A consumer sits on the Quality and Safety Committee and the Patient Safety Committee. The CE is to review the Committee Structure with the Executive in the near future and in line with the new Governance Structure. The interim Executive/Structure will consider performance, finance and clinical operations in the first instance. The Executive Director of Finance position is still to be filled, however current finance managers are ably taking responsibility for finances in the interim.

QH has developed and implemented the Strategic Plan and a twelve month Operational Plan from 1 July 2012. A Health Services Plan cascades to the Operational Plan. A Planning Day was held before the Board was appointed and a Planning Day with the Board has occurred since.

It will be of use to monitor, analyse and evaluate the new governance and committee structure within the WMHHS and review the outcomes by the next accreditation survey.

Recommendations

No Recommendation

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function: Corporate **Standard: 3.1**

Criterion: 3.1.2

Governance is assisted by formal structures and delegation practices within the organisation.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 3.1.2

WMHHS has a committee structure in place that will be reviewed under the new Governance Structure that was implemented by the Queensland Government on 1 July 2012. With appointment of the Board on this date, three Board Committees were instituted (Refer 3.1.1). The Board's Quality and Safety Committee includes a consumer which is commended.

Delegations are in place from the Board to the CE and from the CE to other Executive members and formally to other persons e.g. HR. A risk action plan has been developed.

External auditing is in place with results reported to the Board. An internal auditing process is being investigated. Cost centres are part of departments, wards and units and are attached to KPIs A crime and misconduct commission is in place and locally there is an assessment committee which looks at public interest disclosure handled by the Health Service. This should allow for ethical decision making.

Recommendations

No Recommendation

Function: Corporate **Standard: 3.1**

Criterion: 3.1.3

Processes for credentialling and defining the scope of clinical practice support quality, safe health care.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 3.1.3

There have been a number of changes to credentialing in Queensland in the last year based on a 2008 State wide policy and the introduction of APHRA. Mutual recognition for medical staff, nursing staff and allied health staff has occurred and State wide credentialing does occur where a medical practitioner is credentialed at another hospital e.g. Royal Brisbane and Women's Hospital. Scope of Practice is not included in this as all hospitals must do their own scope of practice review. This occurs at WMHHS.

The Credentialing and Scope of Practice Committee (with terms of reference) has membership from most medical faculties and a nursing representative.

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All new medical applicants require referee reports, registration with APHRA, indemnity, up-to-date continuing medical education (CME). The CE signs off on all appointments of medical staff, whilst an interim credentialing process of three months is available while waiting for interim checks.

CME must be kept up to date by all medical staff and a review is implemented if this does not occur. Non employment is considered if this does not happen after a twelve month period. Dentists are covered in the same way. Junior doctors who go to small hospitals are credentialed.

Peer review and Morbidity and Mortality (M&M) meetings and reviews are in place for medical staff.

Not all Allied Health staff are required to register e.g. Dieticians, Social Workers and Exercise Physiologists. Occupational Therapists, Physiotherapists, Podiatrists and Psychologists all register with APHRA and this is in place.

Nurse Practitioners undergo a credentialing process and scope of practice review to which they work. Credentialing documents go to the credentialing committee.

Private Practice Midwives have a referral pathway and can claim Medicare. Credentialing processes are in place as well as scope of practice.

Overall, the credentialing process appears to be well managed.

Recommendations

No Recommendation

Function: Corporate **Standard: 3.1**

Criterion: 3.1.4

External service providers are managed to maximise quality, safe health care and service delivery.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 3.1.4

WMHHS manages its external service providers in several ways. The Health Services Support Agency undertakes the tendering process for Service wide contracts, purchasing and service agreements. WMHHS is responsible for memoranda of understanding (MOU) and partnerships of low value, relationships with universities, grants, licenses, leases and non-government organisations (NGOs). Services are obtained for building maintenance, waste management, pest control and some cleaning services.

All agreements, MOUs and tenders are risk assessed. Tenders undergo a formal evaluation process and equipment or supplies are purchased according to standing offer arrangements. When tenders are awarded, there is debriefing with the unsuccessful tenderers. Successful tenderers are given a kit, which includes an offer document, letter of acceptance, details about non-conformance and KPIs.

Prior to starting at the Health Service contractors are given a handbook, which outlines occupational health and safety requirements and provides essential information related to key risk issues including

Organisation: West Moreton Hospital and Health Service
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asbestos, working at heights and in confined spaces. They also undertake site visits and if they are undertaking work in clinical areas are given relevant infection control information.

Staff within the HHS manage the contracts and ensure that performance targets are met. Non-compliance with occupational health and safety obligations has resulted in cancellation of contracts.

There is a well established central contracts register, which has had some recent key improvements made to ensure that it includes all required information, including details of government land records for leases and dates for the disposal of contractual records against specific disposal schedules. Records of all previous contracts are archived.

Recommendations

No Recommendation

Function: Corporate **Standard: 3.1**

Criterion: 3.1.5

Documented corporate and clinical policies and procedures assist the organisation to provide quality, safe health care.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 3.1.5

Currently WMHHS uses the QH policy framework and most of its policies, including health directives, but from 1 July 2012 WMHHS has become a statutory body and is now required to implement its own policy system. The QH policies may still be used until WMHHS has developed replacement policies.

Policies are mainly accessed electronically via the QH and WMHHS intranets. The WMHHS policies are mainly procedures or work instructions, which guide staff activity. There is evidence that these policies are developed by staff, with stakeholder consultation regarding content. The policies are implemented following endorsement. Policies are based on evidence - based practice using various sources. Staff are informed about the new policies via alerts on the intranet and education is provided when required. Policies are reviewed biennially unless more frequent revision is required for a specific policy.

It is recognised that WMHHS is in a state of transition due to restructuring changes and there is a lot of work to be undertaken to develop and implement a new policy system. There is no evidence of ongoing evaluation of individual policies apart from a general evaluation of the existing policy system, which has resulted in recognition that it requires improvement.

Some benchmarking was undertaken to identify best practice systems and processes. An action plan has been devised, which will help guide the activities required to develop the policy system. Strategies are in place to undertake this work under the direction of the WMHHS Board.

Feedback from many staff suggests that the current WMHHS intranet is not user-friendly and it is difficult to access site-specific policies. Staff are able to easily find those QH policies, which are relevant to this health service.

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Recommendations

Criterion 3.1.5 #1

Surveyor's Comments:

It is difficult to find policies on the WMHHS intranet. Comment from staff who were asked to find policies was that they found it very hard to locate specific policies on the WMHHS intranet but could find them on the QH website. Access to policies was via the procedures tab.

Surveyor's Recommendation: **HPR:No**

Upgrade the policy site on the West Moreton Hospital and Health Service intranet to make it more user-friendly and allow staff to easily access current endorsed policies.

Function: Corporate **Standard: 3.2**

Criterion: 3.2.1

Safety management systems ensure the safety and wellbeing of consumers / patients, staff, visitors and contractors.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 3.2.1

A culture of safety is evident within the WMHHS and is multidisciplinary in nature. Governance is sound, being overseen by a Health Service-wide OH&S Committee (reporting to the Chief Executive Officer), and to which local level committees at Ipswich Hospital, the Park and Community Health services report. OH&S is integrated into management meetings at the rural sites and OH&S representatives are in evidence across all areas in the organisation. OH&S activities are managed by a service-wide Occupational Health and Safety Team.

Policies, guidelines and protocols are comprehensive, easily accessed and compliance-monitored, with a documented evaluation program built into the organisation's OH&S plan. For the most part, compliance with policy is high, although there are small pockets where adherence to specific elements is less than optimal, including ad hoc monitoring of lead aprons for damage which may result in accidental radiation exposure to staff and maintenance of the organisation's bed stock, which places both staff and patients at manual handling risk.

Despite these issues, OH&S risks are routinely identified from a variety of sources and are assessed, treated and placed on the Risk Register as required. Reporting of OH&S risks via the incident reporting system is strongly encouraged and staff are well aware of their responsibilities in this regard.

Ergonomic issues and occupational violence have been identified as key risks. Both have comprehensive management plans in place to mitigate the risks and an excellent Aggressive Behaviour Management program is in place.

A significant manual handling risk remains in the handling of deceased bariatric patients and the current nature of training of the security team to deal with aggressive patients and visitors exposes clinical staff to potential harm.

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A comprehensive education program is in place and includes both on-line elements and face to face sessions. The rural sites are well serviced in all OH&S aspects and can access 24 hour assistance if required.

Non-employees, including contractors, are comprehensively oriented to site and their compliance with OH&S requirements rigorously monitored. This was abundantly evident in regards to construction of the new clinical block. The OH&S team is well represented at a range of meetings about progress of the construction in order to ensure that the completed building meets OH&S obligations. Cooperation between contractors and OH&S staff is strong.

Radiation safety, including personal monitoring, is well managed and under the direction of the Radiation Safety Officer, although testing and tagging of lead aprons in Radiology could be more systematic and thorough. A Laser Safety Program is in place in the Operating Theatre.

A comprehensive, well-controlled system for the management of dangerous goods and hazardous substances is in place. A regular six monthly audit program has been introduced to detect and remove unauthorised chemicals and hazardous substances. This intervention, which does take extra time, could be facilitated by the introduction of a proactive system to prevent such material entering the organisation in the first instance.

The organisation is well-resourced with manual handling aids and new equipment following a recent audit. Capacity will be further enhanced with the opening of the new building, which will incorporate many additional features. Education in regard to manual handling is thorough, targeted and comprehensive with dedicated physiotherapy support. The manual handling program, which includes manual handling training as part of employee return to work following workplace injury, has produced positive results as evidenced by reduced WorkCover claims and reduced injury levels.

The organisation keeps the use of latex to a minimum and has a Latex Policy in place to reduce the risks of exposure to staff and patients who may have allergies to this product. A contact dermatitis register is in place to monitor staff.

Recommendations

Criterion 3.2.1 #1

Surveyor's Comments:

Lead aprons in the operating theatres at Ipswich Hospital have not been routinely checked for cracks or damage. Some aprons which have been tested and tagged have dates recorded which are indecipherable. Tags are missing from some aprons at the rural sites although assurance was given that they are regularly tested.

Surveyor's Recommendation: **HPR:No**

Introduce a system which ensures that all lead aprons throughout WMHHS are checked and legibly tagged at least annually in accordance with radiation standards.

Criterion 3.2.1 #2

Surveyor's Comments:

Staff in the CSD Unit are faced with many potential and real OH&S risks which have been formally assessed, evaluated and documented in a formal report back in February 2012. One of these risks involved staff having to remove heavy orthopaedic instruments from the ultrasonic machine. The lower

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level control was to reduce the height of the unit by adjusting the bench height of the unit and also to reduce the number of instruments placed in the ultrasonic unit. The higher level control was to purchase a new self loading ultrasonic machine at a significant cost.

The survey team was presented with the formal CSD risk assessment document and noted the actions that have been taken so far.

Surveyor's Recommendation: **HPR:No**

The replacement of the current ultrasound machine in the CSD unit with a self-loading unit that will be able to process large numbers of orthopaedic instruments with no manual handling risks for staff is required.

Criterion 3.2.1 #3

Surveyor's Comments:

Although a bed maintenance program is in place across the organisation, outcomes are sub-optimal with only approximately 70% beds maintained annually. Similarly, mattress replacement is ad hoc. The risks to patients and staff of poorly maintained beds are significant and a more robust system to accurately record, maintain and/or replace damaged stock is required.

Surveyor's Recommendation: **HPR:No**

Introduce a bed maintenance and mattress replacement program including performance measures to monitor compliance.

Criterion 3.2.1 #4

Surveyor's Comments:

With the increasing numbers of bariatric patients requiring health care, there is a need to ensure that equipment is in place to manage the associated occupational health and safety risks to staff across the care spectrum. Whilst WMHHS has a Bariatric Working Party which oversees requirements in this regard, the transfer of deceased bariatric patients from morgue trolleys into bariatric coffins poses a risk to staff and loss of dignity to the deceased person.

Surveyor's Recommendation: **HPR:No**

Improve the current manual handling equipment and practices in the morgue associated with the care of bariatric patients.

Criterion 3.2.1 #5

Surveyor's Comments:

Unauthorised chemicals and medical equipment may come into the organisation, often via sales representatives accessing individual staff. This circumvents appropriate evaluation; asset registry and adequate trialing pre-purchase.

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Surveyor's Recommendation: **HPR:No**

Implement a system to meet medical representatives to avoid unauthorised chemicals and medical equipment being utilised within the organisation without appropriate evaluation.

Function: Corporate **Standard: 3.2**

Criterion: 3.2.2

Buildings, signage, plant, medical devices, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 3.2.2

The Ipswich Hospital campus of WMHHS has undergone significant redevelopment in recent years which will continue until 2014 when construction of the new Clinical Block is completed. This has necessitated multiple route changes; the introduction of numerous 'work arounds' to accommodate temporary relocations and decanting of wards to facilitate extensive building and rebuilding. This obviously places strain on the organisation's staff, patients and visitors in regard to way finding, building maintenance, and back of house services.

Despite the large number of temporary signs and way finding mechanisms throughout the hospital during construction, and a recent informal signage audit, it is still difficult to find some departments, e.g. the Day Procedure Unit. This results in unnecessary anxiety for patients and visitors, and may delay procedures in the DPU due to patients arriving late because they have had difficulty in locating the unit.

Oral Health Services in Ipswich are located close to the hospital and are in attractive new premises. Signage indicating the location of the service, which is in a suburban street, is very poor and the premises cannot be identified until one is almost directly in front.

Less than optimal signage was also noted in regard to toilet facilities at the mental health service and at Laidley, where emergency signage associated with the location of evacuation sheets and instructions for break glass alarms are absent.

Signage to rural sites has been improved and the location of health services is now clear and unambiguous.

Recent extreme weather events in the area, including floods and most recently bush fires, have heightened awareness of the need to keep buildings well maintained and in a good state of repair.

Buildings at all sites are very well maintained and compliant with the necessary laws, standards and guidelines. Cleanliness was much in evidence and clinical areas are mostly free from disorder. Many areas are introducing productive ward strategies which assist in stock control and clutter reduction.

BEMS and BTS maintain extensive databases which incorporate a wide range of logs and audit schedules and which are, in the main, up to date and accurate. Logging, tracking and turn-around times associated with defective equipment requiring repair meet user needs and both services are well regarded by all health facilities in the service. Bed stock maintenance /mattress replacement is an

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exception to the otherwise exemplary maintenance program, although the difficulties of tracking beds in a busy clinical environment are acknowledged. Beds are numbered but only 70% per year are reliably maintained (Refer 3.2.1).

The Health Technology Equipment Replacement Program (HTER) is in place to assist in keeping equipment up to date.

Whilst the rural sites have arrangements with local contractors for repairs and maintenance, particularly those of an urgent nature, oversight of repair and maintenance services remains the responsibility of BEMS.

Fleet management is comprehensive and well documented.

A Clinical Products Committee oversees the introduction of medical devices to ensure appropriate evaluation prior to purchase and provision of adequate training (usually incorporated within agreements with suppliers/manufacturers). The Committee includes biomedical engineers, OH&S team representatives and infection control personnel.

A range of mechanisms is in place to evaluate the effectiveness of current systems in regard to buildings, signage, plant and related services. These include incident and hazard reporting, audits and quality improvement activities. The outcomes of such mechanisms include the purchase of a significant amount of new and improved equipment across most services and amendments to work practices to improve effectiveness.

Recommendations

Criterion 3.2.2 #1

Surveyor's Comments:

Despite the large number of temporary signs and way finding mechanisms throughout Ipswich Hospital during construction of the new building, it is still difficult to find some departments, e.g. the Day Procedure Unit. This results in unnecessary anxiety for patients and visitors and may delay procedures in the DPU due to patients arriving late because they have had difficulty in locating the unit.

Surveyor's Recommendation: **HPR:No**

Conduct a further review of signage throughout the Ipswich Hospital campus with consideration given to signage of a more permanent nature than sheets of paper temporarily adhered to walls. Volunteers could be considered to escort patients to the Day Procedure Unit.

Criterion 3.2.2 #2

Surveyor's Comments:

There is no signage indicating the location of toilets in the mental health facility.

Surveyor's Recommendation: **HPR:No**

The location of all toilet facilities in mental health common areas should be identified by clear signage.

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Criterion 3.2.2 #3

Surveyor's Comments:

Signs identifying the location of Albac evacuation sheets were absent at Laidley and where there were glass panels protecting emergency alarms there was no instructions in relation to breaking the glass.

Surveyor's Recommendation: **HPR:No**

Display signs which advise staff of the location of evacuation sheets and give instructions to break the glass in an emergency.

Criterion 3.2.2 #4

Surveyor's Comments:

Signage indicating the location of Oral Health Services, which is an off-site service in a nearby suburban street, is very poor.

Surveyor's Recommendation: **HPR:No**

Review and improve the signposting to the off-site Oral Health Service to assist the public in locating the service.

Function: Corporate **Standard: 3.2**

Criterion: 3.2.3

Waste and environmental management supports safe practice and a safe and sustainable environment.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 3.2.3

The organisation manages its waste appropriately and there is growing awareness of the importance of 'green' initiatives to reduce waste and better manage utilities such as electricity and water. WMHHS has a well-developed waste management plan and a waste management committee to oversee its implementation. An audit and evaluation program is in place and waste is regularly monitored, with results fed back to relevant managers and staff.

Environmental services staff undergo training in waste management, particularly in regard to waste categories and colour coding for various types of hazards. Throughout the clinical areas waste bins are easily accessed, recognisable by type and clearly signed. Improvements have been made to reduce wrong types of waste being placed in the various bins.

In caring for the environment, solar panels are in place over the car park at Ipswich Hospital to reduce reliance on coal fired electricity production for hot water and rain water collection is present at many sites. Various uses for rain water including garden watering and laundering of linens, in accordance with relevant standards, were noted.

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Numerous design elements which will facilitate waste management and reduce the organisation's carbon emissions have been incorporated into the new clinical block at Ipswich Hospital.

Recommendations

No Recommendation

Function: Corporate **Standard: 3.2**

Criterion: 3.2.4

Emergency and disaster management supports safe practice and a safe environment.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 3.2.4

The region serviced by WMHHS was severely affected by an extreme weather event, with significant loss of life, in 2011. The massive floods have had a profound effect on the State, and the local area in particular, which has led to a renewed appreciation of the importance of comprehensive, coordinated disaster planning.

WMHHS has taken its responsibilities in this area with great seriousness and as a result, its disaster planning is now thorough and collaborative with State and local governments. An Incident Management Team (IMT) led by Executive management is in place and formal processes using standard operating procedures have been developed. Training to IMT members has occurred.

A disaster plan is in place and multiagency testing of the plan is ongoing in order to embed preparedness. Regular evaluation has led to continuing amendment and improvement. All areas of the Health Service now have business continuity plans in place. These are very well accepted by local managers who appreciate the specific guidance provided should a situation arise.

The Fire Safety Officer is a valued resource which has seen multidisciplinary compliance with fire training increase dramatically and fire preparedness reach a high standard. Similarly, contractors to the organisation are well prepared.

Fire Reports are up to date, comprehensive and recommendations arising are acted upon in a planned manner. Fire Wardens are appropriately identified, trained, and systems are regularly tested.

It is noted that the rear corridor in the busy Operating Theatre at Ipswich Hospital is a designated evacuation route yet is routinely impeded by a large amount of equipment.

Given the hospital's increasing busyness and complexity it was further noted with concern that there was no formal Medical Emergency Team (MET) to respond to the deteriorating patient at Ipswich hospital (Refer Recommendation 1.1.1).

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Recommendations

Criterion 3.2.4 #1

Surveyor's Comments:

The rear corridor in the Operating Theatre at Ipswich Hospital is a designated evacuation route yet is routinely impeded by a large amount of equipment.

Surveyor's Recommendation: **HPR:No**

All equipment should be permanently cleared from the rear corridor in Operating Theatre and compliance with any directive to this effect be regularly audited.

Function: Corporate **Standard: 3.2**

Criterion: 3.2.5

Security management supports safe practice and a safe environment.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment 3.2.5

Many improvements have been made to security management in recent years. A Security Policy and a Security Plan are in place; the latter includes the identification and control of emerging security risks. In particular, incidents of aggression and violence have increased in recent years and have been identified as a major risk to the organisation.

Personal alarms and duress alarms are widely available and staff are actively encouraged to wear and use such devices for their own safety. False alarms have been reduced to minimal levels due to the addition of a two part mechanism to instigate a call for assistance. This increases the effectiveness of security staff response who now know that the activation of an alarm is no longer most likely to be accidental.

Aggressive behaviour management training has enthusiastic dedicated resources and excellent training facilities. A plan to roll out the ABM to all areas of risk is in place and wards and departments at greatest risk are highly compliant in completing the training.

However, security personnel undertake aggression and violence management training on an ad hoc basis only and not all staff are appropriately trained. This lack of consistent training leads to unwarranted escalation of violence on occasion, or even failure to render physical assistance to clinical staff when required.

A review of the security environment across all facilities within WMHHS has led to numerous physical improvements including amended lock down procedures, secure lock installations and swipe cards/ PIN code access to high risk areas.

A recent Code Purple at Ipswich gave the organisation the opportunity to test systems in this regard.

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Recommendations

Criterion 3.2.5 #1

Surveyor's Comments:

Security staff undertake aggression and violence management training on an ad hoc basis only. This lack of consistent training leads to unwarranted escalation of violence on occasion, or even failure to render physical assistance to clinical staff when required.

Surveyor's Recommendation: **HPR:No**

Introduce Aggressive Behaviour Management training as a mandatory competency for all security staff.

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Rating Summary

Clinical

Criterion	Organisation's self-rating	Surveyor Rating	HPR
Crit. 1.1.1	MA	MA	
Crit. 1.1.2	MA	MA	
Crit. 1.1.3	MA	MA	
Crit. 1.1.4	MA	MA	
Crit. 1.1.5	MA	MA	
Crit. 1.1.6	MA	MA	
Crit. 1.1.7	MA	EA	
Crit. 1.1.8	MA	MA	
Crit. 1.2.1	MA	MA	
Crit. 1.2.2	MA	MA	
Crit. 1.3.1	MA	MA	
Crit. 1.4.1	MA	MA	
Crit. 1.5.1	MA	MA	
Crit. 1.5.2	MA	MA	
Crit. 1.5.3	MA	EA	
Crit. 1.5.4	MA	MA	
Crit. 1.5.5	MA	MA	
Crit. 1.5.6	MA	MA	
Crit. 1.5.7	MA	SA	
Crit. 1.6.1	MA	EA	
Crit. 1.6.2	MA	MA	
Crit. 1.6.3	MA	EA	

Support

Criterion	Organisation's self-rating	Surveyor Rating	HPR
Crit. 2.1.1	MA	MA	
Crit. 2.1.2	MA	MA	
Crit. 2.1.3	MA	MA	
Crit. 2.1.4	MA	MA	
Crit. 2.2.1	MA	MA	
Crit. 2.2.2	MA	MA	
Crit. 2.2.3	MA	MA	
Crit. 2.2.4	MA	MA	
Crit. 2.2.5	MA	MA	
Crit. 2.3.1	MA	MA	
Crit. 2.3.2	MA	MA	
Crit. 2.3.3	MA	MA	
Crit. 2.3.4	MA	MA	
Crit. 2.4.1	MA	MA	
Crit. 2.5.1	MA	MA	

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Corporate

Criterion	Organisation's self-rating	Surveyor Rating	HPR
Crit. 3.1.1	MA	MA	
Crit. 3.1.2	MA	MA	
Crit. 3.1.3	MA	MA	
Crit. 3.1.4	MA	MA	
Crit. 3.1.5	MA	MA	
Crit. 3.2.1	MA	MA	
Crit. 3.2.2	MA	MA	
Crit. 3.2.3	MA	MA	
Crit. 3.2.4	MA	MA	
Crit. 3.2.5	MA	MA	

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Recommendations from Current Survey

Function: Clinical **Standard:1.1**

Criterion: 1.1.1

Assessment ensures current and ongoing needs of the consumer / patient are identified.

Criterion 1.1.1 #1

Surveyor's Recommendation: **HPR:No**

The Ipswich Hospital introduce a formal MET System or similar process to respond to the deteriorating patient.

Criterion 1.1.1 #2

Surveyor's Recommendation: **HPR:No**

The Pre Admission clinic be reviewed so that the resources can be used more effectively allowing for more patients to be seen through this clinic.

Function: Clinical **Standard:1.1**

Criterion: 1.1.2

Care is planned and delivered in collaboration with the consumer / patient, and when relevant the carer, to achieve the best possible outcomes.

Criterion 1.1.2 #1

Surveyor's Recommendation: **HPR:No**

Develop a system to monitor compliance with care planning, and document consumer involvement in the process.

Function: Clinical **Standard:1.1**

Criterion: 1.1.3

Consumers / patients are informed of the consent process, and they understand and provide consent for their health care.

Criterion 1.1.3 #1

Surveyor's Recommendation: **HPR:No**

Review the consent process for photographing and digital recording to ensure staff understand how and when photographs and digital images may be obtained and stored and how to gain adequate patient consent for this.

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Criterion 1.1.3 #2

Surveyor's Recommendation: **HPR:No**

Review all consent forms and develop a single consent form for all invasive procedures except blood. Monitor the use of the new consent form for compliance and evaluate the outcome.

Function: Clinical **Standard:1.1**

Criterion: 1.1.4

Outcomes of clinical care are evaluated by healthcare providers and where appropriate are communicated to the consumer / patient and carer.

Criterion 1.1.4 #1

Surveyor's Recommendation: **HPR:No**

Introduce Mortality and Morbidity meetings for all medical disciplines covering all departments within Ipswich Hospital and the West Moreton HHS.

Function: Clinical **Standard:1.1**

Criterion: 1.1.5

Processes for clinical handover, transfer of care and discharge address the needs of the consumer / patient for ongoing care.

Criterion 1.1.5 #1

Surveyor's Recommendation: **HPR:No**

Cease the use of taped recorded handover and introduce clinical handover at the bedside throughout the Ipswich Hospital and West Moreton HHS.

Criterion 1.1.5 #2

Surveyor's Recommendation: **HPR:No**

Review and progress medical handover, across the Ipswich Hospital and Health Service so that all medical areas are involved.

Criterion 1.1.5 #3

Surveyor's Recommendation: **HPR:No**

WMHHS develop a handover template (example ISBAR) that will capture all aspects of the patient's care at point of discharge.

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Function: Clinical **Standard:1.2**

Criterion: 1.2.2

Access and admission / entry to the system of care is prioritised according to health care needs.

Criterion 1.2.2 #1

Surveyor's Recommendation: **HPR:No**

WMHHS explore opportunities to establish a call centre to assist the Oral Health Service to improve access to the service by using the full functionality of the Information System for Oral Health (ISOH) program including the telephone questionnaire triage system.

Function: Clinical **Standard:1.3**

Criterion: 1.3.1

Health care and services are appropriate and delivered in the most appropriate setting.

Criterion 1.3.1 #1

Surveyor's Recommendation: **HPR:No**

Mental Health
Develop methods to obtain feedback from referrers and the wider community about appropriateness of mental health services delivered generally and to specific populations.

Criterion 1.3.1 #2

Surveyor's Recommendation: **HPR:No**

Review the material used to make Seclusion Room walls in the High Dependency Unit at Ipswich Hospital and ensure a more durable material is used to reduce the likelihood of damage.

Criterion 1.3.1 #3

Surveyor's Recommendation: **HPR:No**

Explore alternate options to ensure the external environment is more appropriate to meet needs of the consumers in the Mental Health High Dependency Unit at Ipswich Hospital.

Criterion 1.3.1 #4

Surveyor's Recommendation: **HPR:No**

Progress the Business Case regarding increased computer facilities across the mental health service to ensure that there are sufficient computers available to staff to enable full utilisation of CIMHA and other data systems.

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Criterion 1.3.1 #5

Surveyor's Recommendation: **HPR:No**

Develop processes across the HHS to ensure paediatric inpatient services are provided in a physical setting appropriate to the needs of children, and that care is provided by clinical staff with minimum core competencies in paediatric care.

Function: Clinical **Standard:1.5**

Criterion: 1.5.1

Medications are managed to ensure safe and effective consumer / patient outcomes.

Criterion 1.5.1 #1

Surveyor's Recommendation: **HPR:No**

Review the provision of pharmacy support:

- at the rural hospitals and provide a physical presence pharmacy support at a level of at least one day per week to assist medication safety programs at these facilities in order to minimise patient risk related to medications;
- within mental health and provide pharmacy input into admission and discharge planning, multidisciplinary team meetings and staff and consumer education and training.

Criterion 1.5.1 #2

Surveyor's Recommendation: **HPR:No**

Implement a process for the regular monitoring and auditing of refrigerators used to store drugs which is consistent across the Service and ensures appropriate storage of temperature-sensitive medications.

Criterion 1.5.1 #3

Surveyor's Recommendation: **HPR:No**

Establish a process for the reporting of all known adverse drug reactions that occur within the patient stay episode to the Therapeutic Goods Administration (TGA).

Criterion 1.5.1 #4

Surveyor's Recommendation: **HPR:No**

Ensure that any telephone orders within WMHHS be written up within 24 hours by the doctor who gave the order and establish a process to monitor compliance with this policy.

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Function: Clinical **Standard:1.5**

Criterion: 1.5.2

The infection control system supports safe practice and ensures a safe environment for consumers / patients and healthcare workers.

Criterion 1.5.2 #1

Surveyor's Recommendation: **HPR:No**

Mental Health
Review infection control procedures at The Park and:

- cease the practice of washing and drying linen, clothes and floor mops in the same washing machine and dryer; and
- cease the practice of transporting floor mops and food on the same trolley.

Criterion 1.5.2 #2

Surveyor's Recommendation: **HPR:No**

Relocate the sterile stock in the store room between theatres 5 and 6 to ensure that it is not in close proximity to the Steris Machine and clean up area.

Criterion 1.5.2 #3

Surveyor's Recommendation: **HPR:No**

Improve the documentation of the administration of prophylactic antibiotics for emergency caesarean sections in the operating theatre.

Criterion 1.5.2 #4

Surveyor's Recommendation: **HPR:No**

Work with the staff in the Emergency Department and with Medical Staff in general to improve Hand Hygiene compliance rates.

Criterion 1.5.2 #5

Surveyor's Recommendation: **HPR:No**

Ensure that all AINs working in the CSD of Ipswich Hospital receive appropriate formal education in instrument sterilisation.

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Function: Clinical **Standard:1.5**

Criterion: 1.5.5

The system to manage sample collection, blood, blood components / blood products and patient blood management ensures safe and appropriate practice.

Criterion 1.5.5 #1

Surveyor's Recommendation: **HPR:No**

Develop the consent process for blood transfusions as a separate consent, using the separate QH blood transfusion consent form, for surgical patients.

Criterion 1.5.5 #2

Surveyor's Recommendation: **HPR:No**

Use the established e-learning packages such as the BloodSafe Australia packages which are freely available to train clinical staff in best practice management of blood and blood products.

Function: Clinical **Standard:1.5**

Criterion: 1.5.6

The organisation ensures that the correct consumer / patient receives the correct procedure on the correct site.

Criterion 1.5.6 #1

Surveyor's Recommendation: **HPR:No**

Prior to the commencement of any procedure in the operating or day procedure theatre, staff are to stop all activity and collectively and simultaneously complete the WHO Checklist.

Function: Clinical **Standard:1.5**

Criterion: 1.5.7

The organisation ensures that the nutritional needs of consumers / patients are met.

Criterion 1.5.7 #1

Surveyor's Recommendation: **HPR:No**

Complete the local Policy for Nutrition Care, which is multidisciplinary in scope, based on National and State guidelines and clearly identifies the roles and responsibilities of staff.

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Criterion 1.5.7 #2

Surveyor's Recommendation: **HPR:No**

The Hospital and Health Service demonstrates a strategic and coordinated approach in the provision of nutrition risk screening and care for those with malnutrition.

Function: Clinical **Standard:1.6**

Criterion: 1.6.1

Consumers / patients, carers and the community participate in the planning, delivery and evaluation of the health service.

Criterion 1.6.1 #1

Surveyor's Recommendation: **HPR:No**

A system to close the quality loop to ensure the MHS provide feedback on how issues put forward by consumers and consumer workers are addressed is implemented and reviewed for its effectiveness.

Criterion 1.6.1 #2

Surveyor's Recommendation: **HPR:No**

Information to be proactively made available by the MHS that carers who reside intra or interstate are able to access video conferencing facilities to be able to regularly connect with their family member.

Criterion 1.6.1 #3

Surveyor's Recommendation: **HPR:No**

The Park further investigates creative and innovative solutions which decrease the barriers and issues, to enable consumer companions to work weekends to support and provide activities to consumers who access the various units.

Criterion 1.6.1 #4

Surveyor's Recommendation: **HPR:No**

The Consumer Workers across the MHS develop ongoing ‘consumer’ training which is non-clinical, recovery focused rather than illness focused and is such that enhances the consumer workers capabilities to effectively undertake their consumer roles within the MHS. That experienced consumers are contracted to deliver such training.

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Criterion 1.6.1 #5

Surveyor's Recommendation: **HPR:No**

NGOs within the MHS are incorporated within the discharge planning process of consumers from both the IMHS unit and The Park.

Function: Clinical **Standard:1.6**

Criterion: 1.6.2

Consumers / patients are informed of their rights and responsibilities.

Criterion 1.6.2 #1

Surveyor's Recommendation: **HPR:No**

Provide a rights and responsibilities poster, rights information pamphlets and a compliments and complaints form at Goodna MHS.

Criterion 1.6.2 #2

Surveyor's Recommendation: **HPR:No**

The MHS develop a user friendly system for the Chaplaincy service to collate and summarise the feedback being provided to Chaplains to be incorporated into the feedback and quality improvement processes of the MHS to further enhance the delivery of care.

Function: Support **Standard:2.1**

Criterion: 2.1.1

The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.

Criterion 2.1.1 #1

Surveyor's Recommendation: **HPR:No**

Implement the new governance structures to support quality and safety following the current review and its integration with the recently reviewed Clinical Governance Framework and Toolkit including the following:

- Identify the key priority areas for quality and safety based on the National, State and local agenda for inclusion in the Strategic Plan, and their appropriate performance indicators for monitoring by Executive and the Board;
- Develop and implement an integrated District Quality and Safety Plan (this may form part of the Annual Operational Plan) that articulates the Strategic Plan with WMHHS Clinical Governance Framework and Toolkit;

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- Review the various systems and process used across in other like services for the reporting of performance indicator data that has the ability to reflect variation and can be rolled out efficiently and effectively across WMHHS. It is suggested that a Balanced Score Card approach would be useful, with the built in capacity for clinician narration to address areas of variation; and
- Implement an identified system for reporting of performance indicators.

Criterion 2.1.1 #2

Surveyor's Recommendation: **HPR:No**

Include the 'Releasing Time to Care' - Productive Ward Series quality improvement strategy and an associated high level performance indicator to monitor and evaluate the impact of the program in the organisation's Strategic Plan and subsequent Annual Operational Plan.

Criterion 2.1.1 #3

Surveyor's Recommendation: **HPR:No**

Develop a strategic and centrally coordinated approach for implementing and supporting the various quality improvement methodologies across WMHHS.

Criterion 2.1.1 #4

Surveyor's Recommendation: **HPR:No**

A networked quality register be developed, implemented and rolled out across WMHHS and include the following:

- parameters that are measurable and outcome focused i.e. 'SMART' (Specific, Measurable, Appropriate, Realistic and Timely) together with project outcomes;
- corporate and non-clinical activities; and
- a means to enable the prioritisation of high risk and low volume activities and link these to the activities to the Annual Operational Plan.

Criterion 2.1.1 #5

Surveyor's Recommendation: **HPR:No**

Review the current education and training program for quality and quality systems noting the following:

- develop and implement a standardised orientation program for quality and safety systems, including risk (clinical and workplace) and incident management; and
- develop education strategies to address the ongoing learning and development needs of the organisation. It suggested that consideration be given to developing these to on-line training modules.

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Function: Support **Standard:2.1**

Criterion: 2.1.2

The integrated organisation-wide risk management framework ensures that corporate and clinical risks are identified, minimised and managed.

Criterion 2.1.2 #1

Surveyor's Recommendation: **HPR:No**

Incorporate as part of the strategic planning process a framework for Quality, Safety and Risk Management that articulates both the risk management and quality improvement priorities with the HHS strategic intent.

Criterion 2.1.2 #2

Surveyor's Recommendation: **HPR:No**

Develop and implement a process for the feedback of recommendations and outcomes from the risk management process to ensure closure of the risk management loop.

Criterion 2.1.2 #3

Surveyor's Recommendation: **HPR:No**

Undertake an external review (audit) of the risk management framework and supporting system including risk profiling.

Function: Support **Standard:2.1**

Criterion: 2.1.3

Health care incidents are managed to ensure improvements to the systems of care.

Criterion 2.1.3 #1

Surveyor's Recommendation: **HPR:No**

It is recommended that as part of the governance review and the review of committee structure that the reporting and feedback of performance against the organisation’s performance targets and the lessons learnt and recommendations from incident investigations be included as part of this process.

Criterion 2.1.3 #2

Surveyor's Recommendation: **HPR:No**

Develop and implement a work flow process for medical coders to enable them to record relevant incidents and provide training for this process.

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Function: Support **Standard:2.1**

Criterion: 2.1.4

Health care complaints and feedback are managed to ensure improvements to the systems of care.

Criterion 2.1.4 #1

Surveyor's Recommendation: **HPR:No**

Review and standardise the information regarding the complaints management process and how this information is provided to the patient upon entry to the various facilities across WMHHS.

Criterion 2.1.4 #2

Surveyor's Recommendation: **HPR:No**

Develop a process to evaluate the acknowledgement and understanding of the complaints management system and information provided. It is suggested this may be incorporated with the patients' rights and responsibilities process.

Function: Support **Standard:2.2**

Criterion: 2.2.1

Workforce planning supports the organisation's current and future ability to address needs.

Criterion 2.2.1 #1

Surveyor's Recommendation: **HPR:No**

WMHHS pursues recruitment to the vacant funded Palliative Care position so as to meet the specialist service demand in the area and ensure continuing employment of the existing appointees.

Criterion 2.2.1 #2

Surveyor's Recommendation: **HPR:No**

WMHHS develop a plan of recruitment to overcome the chronic shortage of dentists, promoting the excellent new oral health facilities now available within the new HHS.

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Function: Support **Standard:2.2**

Criterion: 2.2.3

The continuing employment and performance development system ensures the competence of staff and volunteers.

Criterion 2.2.3 #1

Surveyor's Recommendation: **HPR:No**

Ensure that all senior doctors and medical superintendents undertake performance appraisal annually.

Criterion 2.2.3 #2

Surveyor's Recommendation: **HPR:No**

The PD for Medical Superintendents at rural health services should include clear information regarding the position's responsibility for safety and quality of the service, lines of communication as well accountability and delegated responsibility.

Criterion 2.2.3 #3

Surveyor's Recommendation: **HPR:No**

WMHHS ensure all position descriptions are regularly reviewed/updated.

Function: Support **Standard:2.3**

Criterion: 2.3.2

Corporate records management systems support the collection of information and meet the organisation's needs.

Criterion 2.3.2 #1

Surveyor's Recommendation: **HPR:No**

It is recommended that responsibility for the maintenance of corporate records be delegated to a specific position that is familiar with the regulations for record storage, archiving, culling and destruction of corporate records to ensure that standards are met.

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Function: Support **Standard:2.3**

Criterion: 2.3.3

Data and information are collected, stored and used for strategic, operational and service improvement purposes.

Criterion 2.3.3 #1

Surveyor's Recommendation: **HPR:No**

It is recommended that the WMHHS negotiate with HSIA to accelerate the roll out of Viewer software to the rural hospitals to facilitate patient identification at presentation to the hospital and in doing so reduce the risk associated with incorrect patient identification.

Function: Corporate **Standard:3.1**

Criterion: 3.1.5

Documented corporate and clinical policies and procedures assist the organisation to provide quality, safe health care.

Criterion 3.1.5 #1

Surveyor's Recommendation: **HPR:No**

Upgrade the policy site on the West Moreton Hospital and Health Service intranet to make it more user-friendly and allow staff to easily access current endorsed policies.

Function: Corporate **Standard:3.2**

Criterion: 3.2.1

Safety management systems ensure the safety and wellbeing of consumers / patients, staff, visitors and contractors.

Criterion 3.2.1 #1

Surveyor's Recommendation: **HPR:No**

Introduce a system which ensures that all lead aprons throughout WMHHS are checked and legibly tagged at least annually in accordance with radiation standards.

Criterion 3.2.1 #2

Surveyor's Recommendation: **HPR:No**

The replacement of the current ultrasound machine in the CSD unit with a self-loading unit that will be able to process large numbers of orthopaedic instruments with no manual handling risks for staff is required.

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Criterion 3.2.1 #3

Surveyor's Recommendation: **HPR:No**

Introduce a bed maintenance and mattress replacement program including performance measures to monitor compliance.

Criterion 3.2.1 #4

Surveyor's Recommendation: **HPR:No**

Improve the current manual handling equipment and practices in the morgue associated with the care of bariatric patients.

Criterion 3.2.1 #5

Surveyor's Recommendation: **HPR:No**

Implement a system to meet medical representatives to avoid unauthorised chemicals and medical equipment being utilised within the organisation without appropriate evaluation.

Function: Corporate **Standard:3.2**

Criterion: 3.2.2

Buildings, signage, plant, medical devices, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

Criterion 3.2.2 #1

Surveyor's Recommendation: **HPR:No**

Conduct a further review of signage throughout the Ipswich Hospital campus with consideration given to signage of a more permanent nature than sheets of paper temporarily adhered to walls. Volunteers could be considered to escort patients to the Day Procedure Unit.

Criterion 3.2.2 #2

Surveyor's Recommendation: **HPR:No**

The location of all toilet facilities in mental health common areas should be identified by clear signage.

Criterion 3.2.2 #3

Surveyor's Recommendation: **HPR:No**

Display signs which advise staff of the location of evacuation sheets and give instructions to break the glass in an emergency.

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Criterion 3.2.2 #4

Surveyor's Recommendation: **HPR:No**

Review and improve the signposting to the off-site Oral Health Service to assist the public in locating the service.

Function: Corporate **Standard:3.2**

Criterion: 3.2.4

Emergency and disaster management supports safe practice and a safe environment.

Criterion 3.2.4 #1

Surveyor's Recommendation: **HPR:No**

All equipment should be permanently cleared from the rear corridor in Operating Theatre and compliance with any directive to this effect be regularly audited.

Function: Corporate **Standard:3.2**

Criterion: 3.2.5

Security management supports safe practice and a safe environment.

Criterion 3.2.5 #1

Surveyor's Recommendation: **HPR:No**

Introduce Aggressive Behaviour Management training as a mandatory competency for all security staff.

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Recommendations from Previous Survey

Function:Clinical **Standard:1.1**
Criterion: 1.1.1 Assessment ensures current and ongoing needs of the consumer / patient are identified.

Recommendation: E5 OWS 0911.1.1.1#1 **High Priority:** No

Recommendation:

Review all options for the provision of vehicles for the Ipswich Rural Community Mental Health Team to ensure that a more effective and efficient system of vehicle allocation can be provided.

Action:

Community Health Service is undertaking a review of fleet management. A business case was completed and an action plan and timeline have been developed. More cars provided. Now developing a system for the use of cars by clinicians.

Completion Due By: October 2014

Responsibility: ED Community Health

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

A review of fleet management has been undertaken and has led to more cars being provided.

Recommendation: PR1010.1.1.1 **High Priority:** No

Recommendation:

Gatton Hospital to develpp an admission policy/procedure which includes exclusion criteria.

Action:

This recommendation was transferred from Toowoomba Hospital membership – 715134 after Darling Downs West Moreton districts separated effective from 1 July 2011.

In 2011 Health Service facilities were assessed against the Clinical Services Capability Framework (CSCF).

Although the recommendation specifically relates to Gatton Hospital, it has been applied to all the rural facilities in the Health Service. The rural facilities are developing a combined document specifying admission and exclusion criteria profiling equipment and staff skills available, clinical staffing requirements, and exclusion limits.

The Rural Back Transfer working group has developed a service profile summary for each facility to allow easier identification of patients who can be ‘stepped down’ to a rural facility. This has clarified the

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equipment and allied health services available at the facility. The process will be documented in an inter-facility bed management procedure.

Completion Due By: August 2012

Responsibility: ED NM&RHS

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

Action required to address this recommendation has occurred.

Recommendation: PR0810.1.1.1 **High Priority:** No

Recommendation:

Implement a system to monitor compliance with risk assessments, and usefulness of tools.

Action:

A project is underway to develop a Patient Risk Assessment and Management tool which is effective and useful for clinicians while increasing the knowledge base and skills of health care workers around clinical risk assessment. The overarching goal of the project is to assist in preventing adverse events, through improvement of existing tools, systems and staff awareness.

A staged trial of the tool will commence in July 2012 for three (3) months. An audit tool has been developed as part of the project, and monthly audits and consumer feedback will be done during the trial period. A risk assessment tool reference group was established to review audit outcomes or suggestions to improve the effectiveness of the tool.

The team is also developing a daily care plan that links in with the new risk assessment document. A gap analysis is being undertaken to ensure these two documents meet the National Standards.

A new suite of State-wide paediatric forms has been implemented in the Children's Sunshine Ward to better match the assessment needs of the patients and staff. The forms include Initial Clinical Assessment Risk Screening Tool and Daily Patient Care Record & Risk Assessment for infants and children.

The Clinical Documentation Review Committee is reviewing the content of existing documentation to ensure interface with the other documentation and relevance to positive patient outcomes. The Committee is currently developing a project plan for a Medical Records Forms and Content Project.

Completion Due By: August 2012

Responsibility: ED NM&RHS

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

This is in the process of being implemented and a plan is in place to complete this process.

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Function:Clinical **Standard:1.1**
Criterion: 1.1.2 Care is planned and delivered in collaboration with the consumer / patient, and when relevant the carer, to achieve the best possible outcomes.

Recommendation: E5 OWS 0911.1.1.2#1 **High Priority:** No

Recommendation:

Make progress with a recovery-based model of care with consumer/carer participation and review the documentation to ensure it demonstrates how this has been achieved.

Action:

IMHS - Managed via the IMHS strategic Plan and strategic planning processes, including operational and 90 day planning, inclusive of the implementation of the endorsed statewide models of service. The IMHS Consumer Consultant and Consumer Liaison officer attended the inaugural National Mental Health Recovery Forum in June 2012, and are now developing information packages to be delivered to staff forums and examining consumer support activities to identify areas for change and improvement.

The Models of Care in High Security including Extended Treatment Rehabilitation and Forensic Unit has been developed with extensive consultation with all staff groups and consumers. The High Security Operational plan is in draft stages, undergoing consultation processes with staff and consumers. The draft plan will includes strategies to address, Recovery and Individualised Care; Continuity of Care/Linkages; Consumer, Carer and Family Participation; Service Quality and Effectiveness – Workforce Development; Service Quality and Effectiveness – Environment Safety and Security; Service Quality and Effectiveness – Research and Development; Dual Diagnosis. The next phase of this will be to evaluate the effectiveness of the planning framework and the model of care. Nursing plan is being constructed for across the facility. This plan is being developed in consultation with the Care Planning and Consumer Participation Workgroups. The Facility Operational Plan is in the development phase. Business Unit 1 will develop their Operational Plan once this work is completed. Extended treatment and Rehab and Dual Diagnosis has undergone significant change including reviewing its model of care in light of the redevelopment. Medium Security are in the process of initiating a structured day program across all wards.

Completion Due By: October 2014

Responsibility: ED MHS

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

The IMHS Consumer Liaison Officer and Consumer Consultant investigated this issue and packages are being developed that will support staff and consumer groups.

Recommendation: OWS08081.1.2 **High Priority:** No

Recommendation:

(i) All x-rays be reported for safe patient care and quality assurance.
(ii) Routine feedback be provided to rural hospitals regarding outcomes of care when patients are referred to Ipswich.

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Action:

(i) As well as VMO radiologists reporting on-site, Medical Imaging have established off-site reporting workstations for the VMO radiologists for billable patients.

Approval was received in April 2012 for funding to put in a small site solution to address technology issues with the off-site reporting workstations. The Information Division currently working on solution to improve off-site processing speed.

A business case was approved to recruit and train three (3) additional administration staff at Ipswich Hospital Medical Imaging for patient report processing.

Voice recognition technology was installed in Ipswich Hospital Medical Imaging in December 2011. This has improved the workflow for image reporting. Under the previous process, the report was dictated, the typists would listen and type the report, the radiologist would need to check the report details, and often have to recheck images. Under the new process using the voice recognition technology, as the radiologist dictates the report it appears on the screen, the radiologist reviews the details immediately, updates the changes, and electronically verifies the report when they are finished dictating. Workflow has improved from days to minutes for a verified report. The typists are now doing quality control steps, checking patient details are correct, and reporting for off-site reports digital dictation, until the technological solution is resolved.

Through the combination of all these improvements, the outstanding sound files have reduced from approximately 4000 outstanding sound files to none in May 2012. The administration staff are getting through each day's work daily so there is no longer any backlog.

Images reported for year to date to March 2012 within 72 hrs is 84.3 % reported. For the same timeframe to March 2011 within 72 hrs 68.1% reported. This is an improvement of 16.2% of images reported within 72hrs.

(ii) The eMR Viewer program was implemented across the District. This program is a read-only web-based system that consolidates key patient information from various QH enterprise systems and facilities allowing it to be viewed in one place and designed to improve access to information for clinicians and staff. This, along with the information in the Electronic Discharge Summary program, allows staff from other facilities to access information about patients transferred.

A Rural Back Transfer working group has been established with representation from the rural facilities and Ipswich Hospital. A transfer envelope has also been developed to determine documentation and communication requirements for transfers between facilities. The Rural Back Transfer process has been evaluated in February 2012. 13 people responded to the survey, with 80% of staff surveyed indicating the patient flow process is better now than 12 months ago, and 90% confirming back transfers are better coordinated than in the past.

In June 2012 the group was resurveyed. 22 people responded to the survey, with almost 40% of respondent ants indicating the patient flow process is better now than 12 months ago, and 50% confirming the flow process is better now than in the past. Staff were also asked if they use the Viewer and EDS to find information about transferred patients with and 58% agreeing they did. Only 25% of staff indicated they were satisfied with the transfer feedback received.

Improving the communication back to the rural hospitals regarding outcomes of care when patients are referred to Ipswich will be an ongoing issue.

Completion Due By: August 2012

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Responsibility: EDMHS

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

Radiologists are now working off site for billable radiology patients. The provision of patient information back to the rural hospitals has improved as evidenced by the survey team.

Function:Clinical **Standard:1.1**
Criterion: 1.1.3 Consumers / patients are informed of the consent process, and they understand and provide consent for their health care.

Recommendation: E5 OWS 0911.1.1.3#1 **High Priority:** No

Recommendation:

Develop protocols to ensure that voluntary patients have understood their rights and that this can be audited.

Action:

IMHS - Rights information is provided on admission and receipt confirmed via the admission checklist. Consumer information group sessions are provided on the ward to consolidate understanding. Check questions have been included in the All of ward meeting agenda to identify consumer concerns and issues, Plan to review the process and data in August 2012.

The Park - The Statement of rights form is used on admission by the Consumer Advocate to ensure Consumers are given information about their rights including relevant brochures on the Statement of Rights. The form includes a section to record if the Consumer understood their rights. If they didn't this is recorded in the Consumers notes and discussed with staff. The Consumer Advocate records this discussion in a note book. The form is sent to Medical Services for record keeping. The forms became part of the Mental Health Act Audit 2011 run by the Mental Health Alcohol and Other Drugs Directorate Queensland Health; the Mental Health Act and Compliance team.

Whilst there is a Consumer Advocate on Staff Consumers are encouraged to approach any staff with issues or concerns.

Regarding ECT: The Consumers are given the information by the

Unit Staff and are shown a DVD of the procedure. The CNC in charge of ECT, then visits the individual Consumers to consolidate understanding. Only then is the consent for treatment form offered to the Consumer. NO ECT or other such procedures are conducted with Voluntary Consumers without their signed consent.

Completion Due By: December 2012

Responsibility: IMHS Nursing Director

Organisation Completed: No

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Surveyor's Comments: **Recomm. Closed:** Yes

Information on Rights and Responsibilities is given to all patients at pre-admission or admission. This process is to be audited in the near future.

Recommendation: E5 OWS 0911.1.1.3#2 **High Priority:** No

Recommendation:

Develop a means of signifying the consumer's role in the development of and consent to care plans, perhaps by an entry in the electronic or paper record.

Action:

IMHS - A new Recovery and Treatment plan has been developed and released as part of the state wide standard suite of forms.

The Park -The Care Planning Workgroup has initiated a programme whereby Consumers take part in the development, planning and implementing of their own care plans is currently in place at The Park. Within this structure, Consumers who consent will sign off on their care plans to show that they have been involved and approve of the current plan in place. Currently, a paper record is kept of this and filed in the Consumers Clinical File. Clinicians record in notes if a Consumer refuses to sign off on their care planning.

Completion Due By: August 2012

Responsibility: ED MHS

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

Consumers are now being involved in their care plans and sign off to show their involvement.

Recommendation: PR0810.1.1.3 **High Priority:** No

Recommendation:

1. Complete the booking process review and implement the “no consent, no booking” protocol for all public and private patients requiring elective surgery.

2. Implement the Queensland Health Audit Tool relating to consent for invasive procedures for each surgical speciality.

3. Implement a process to ensure that the consumer feedback consent form is completed in accordance with Queensland Health requirements.

Action:

1 & 2
Audits have been undertaken in 2011 and 2012 around the three recommendations on consent. The audit showed improved result for consent for the no consent no booking process.

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Overall, the Informed Decision Making policy audit were positive, with 100% of consent forms present, signed by the patient/ substituted decision maker, and signed and dated by the medical officer. However, there are several opportunities for continued improvement, particularly in Dental, and around the patient/ substitute decision maker name and date being recorded on the consent form. The audit showed improved results for the issues highlighted in the 2011 audit.

Four (4) recommendations have been made from the results of the audit around dental consents, consents from private rooms, documentation, and policy and procedure awareness. The audit report and results have been tabled at the Surgical Business Unit Governance meeting, and the Patient Safety and Quality Meeting.

A formal procedure has been developed to reinforce the memo sent to surgeons by the Deputy Director Medical Services regarding the No Consent No Booking Process.

Operating Theatre has implemented a folder which is put on the end of the patients' bed if there is no consent on the chart. The bed does not leave theatre reception until the consent is completed.

3. Additional training has been provided to administration staff at the training day in March 2012 regarding administration staff requesting patients complete the feedback consent form.

The consumer feedback consent documentation was re-audited in June. In 2011 22% of charts audited contained a valid feedback consent form. This has increased to 53% in 2012. In 2011 66% of charts that contained valid feedback consent were correctly reflected in HBCIS. In 2012 this figure has risen to 87.24%. Overall there has been a 31% increase in compliance with the completion of the feedback consent audit.

In-service and/or education programs will continue and be rolled out to the rural facilities.

Completion Due By: August 2012

Responsibility: ED MS

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

1. A No Consent, No Booking policy has been implemented.

2. Audits have been completed in 2011 and 2012 on the No Consent, No Booking policy.

3. A decision making audit has shown very good results.

Recommendation: OWS08081.1.3 **High Priority:** No

Recommendation:

Consistent with Queensland Health policy and based on best practice, the timeliness of provision of documented informed consent be improved for all elective invasive procedures so that it is available for further discussion and confirmation, either at the pre-admission clinic or on admission (as appropriate to the particular patient journey).

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Action:

Audits have been undertaken in 2011 and 2012 around the three recommendations on consent. The audit showed improved result for consent for the no consent no booking process.

Overall, the Informed Decision Making policy audit were positive, with 100% of consent forms present, signed by the patient/ substituted decision maker, and signed and dated by the medical officer. However, there are several opportunities for continued improvement, particularly in Dental, and around the patient/ substitute decision maker name and date being recorded on the consent form. The audit showed improved results for the issues highlighted in the 2011 audit. Four (4) recommendations have been made from the results of the audit around dental consents, consents from private rooms, documentation, and policy and procedure awareness. The audit report and results have been tabled at the Surgical Business Unit Governance meeting, and the Patient Safety and Quality Meeting.

A formal procedure was developed and implemented regarding the No Consent No Booking Process. Routine audits from part of current audit schedule for Operating Theatre.

Operating Theatre has implemented a folder which is put on the end of the patients' bed if there is no consent on the chart. The bed does not leave theatre reception until the consent is completed.

Completion Due By: August 2012

Responsibility: ED MS

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

This is the same as the previous recommendation.

Function:Clinical **Standard:1.1**
Criterion: 1.1.5 Processes for clinical handover, transfer of care and discharge address the needs of the consumer / patient for ongoing care.

Recommendation: PR0810.1.1.5 **High Priority:** No

Recommendation:

Provide simple and clear criteria for admission and transfer at each site to assist in the timely transfer of patients to the most appropriate level of care.

Action:

The Clinical Services Capability Framework provides a detailed list of each facilities capabilities.

An annual assessment against the criteria is undertaken. The 2011 assessment of the rural facilities against the Clinical Services Capability Framework (CSCF) determined Gatton and Esk Hospitals are Level 2 facilities with a Level 1 Pharmacy.

The Rural Back Transfer working group has developed a service profile summary for each facility to allow easier identification of patients who can be 'stepped down' to a rural facility. This has clarified the

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equipment and allied health services available at the facility. The process will be documented in an inter-facility bed management procedure, currently under development.

Completion Due By: August 2012

Responsibility: ED NM&RHS

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

Each facility's capabilities are explained in the Clinical Services Capabilities Framework.

Function:Clinical **Standard:1.3**
Criterion: 1.3.1 Health care and services are appropriate and delivered in the most appropriate setting.

Recommendation: E5 OWS 0911.1.3.1#1 **High Priority:** No

Recommendation:

Audit the clinical records across all Services on a regular basis, to ensure that the policy is complied with by all services.

Action:

IMHS - Portfolios have been assigned across all teams and a standard audit tool has been developed and placed on the common drive to capture audit results across IMHS. The audit cycle is six monthly and the first cycle is not yet complete. Audit results are tabled through the IMHS Patient Safety and Quality Committee and at clinical review meetings.

The Park - Info Access Unit at the Park audits the clinical records on a regular basis. The Clinical Initiatives Coordinator with work with the Nurse Unit Managers/Clinical Nurse Consultants to audit the consumer notes for discrepancies in standard entries. A three monthly audit schedule has been developed. Results of these audits are report at the Clinical Record Steering Committee. The discrepancies and their resolution are reported in the minutes. The meeting is attended by all team leaders who are expected to report on progressive changes to current practice.

Completion Due By: October 2012

Responsibility: ED MHS

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

An audit process (six monthly) has been put in place to audit clinical records. The first cycle is not yet complete, however it will be useful to evaluate the process at the end of the first cycle.

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Recommendation: E5 OWS 0911.1.3.1#2 **High Priority:** No

Recommendation:

Develop longitudinal strategies to address staff and consumer issues, incorporating a recovery focused model of care.

Action:

IMHS - Captured by CPOC and staff surveys and included in management planning. Managed via the IMHS strategic Plan and strategic planning processes, including operational and 90 day planning, inclusive of the implementation of the endorsed statewide models of service. Further supported by the planned Team Leader and staff training. Team meeting structures with information flow up through the IMHS committee structure for executive management and action. The IMHS review of the internal committee structures to improve communication and issue capture.

The Park - In 2011, People and Culture conducted a review of culture within High Security Inpatient Service. This review has formed the basis of a working party to roll out the recommendations from that review. This includes strengthening linkages teams. Review of Senior Nursing Structure in High Security Inpatient Service has allowed for the establishment of the Local unit based Work Improvement Group (WIG) that links with the business units Work improvement group. The Clinical Nurse Consultants (CNC) chair the local WIGS. CNCs have assisted in the instillation of move towards unit based teams and provide a linkage across the teams and within the business units management committee. The Unit based teams are led by the psychiatrists. The CNC's have also supported the structured day program which meets the needs of the recommendations that came from the security review. The CNCs provide clinical leadership as well as a method for data collection in relation to activities and the amount of time spent in the activities. The structured day program has started in High Security Inpatient Service and Medium Security.

Completion Due By: October 2012

Responsibility: ED MHS

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

Staff and consumer satisfaction surveys have been implemented, however more frequent surveys would be useful.

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Function:Clinical **Standard:1.5**
Criterion: 1.5.2 The infection control system supports safe practice and ensures a safe environment for consumers / patients and healthcare workers.

Recommendation: PR0810.1.5.2 **High Priority:** No

Recommendation:

Implement strategies to improve hand hygiene compliance by those staff groups and departments/wards with poor compliance.

Action:

The hand hygiene compliance at Ipswich Hospital has improved considerably.

Overall Hand hygiene compliance from Sept – Nov 2011 68% to Dec-Feb 2012 76%. Significant improvements have been made in 6B, RDU, 6A, and with medical officers over the last couple of years.

Ipswich Hospital has reached 82% in May 2012 for hand hygiene compliance. It is the first time in the 80 percentile since the national hand hygiene program was introduced in 2009. The nurses achieved 85% and the doctors are fast catching up and achieving better results than ever at 75%.

Six wards have achieved 90% plus. Our leading champions are SCN, RDU, CSW, 6B, 6A & OPD.

The hand hygiene results are benchmarked on the My Hospitals website against national results and minimum standards.

Hand Hygiene is a KPI in all Executives KPI's.

Individuals have taken the lead in specific units to increase hand hygiene compliance. There is increased reporting and accessibility of information and an increased number of observations of hand hygiene practice. The HHA collection requirements have been met. The number of infection prevention staff has increased from 1.4 to 2.4 Clinical Nurses.

90 day forums and 90 day action plans have been implemented for Infection Prevention, and are linked in with the Patient Safety & Quality Unit. The rural facilities attend the forums to ensure they have the opportunity to have input in actions required.

The portfolio for the rural facilities has been delegated to an Infection Prevention CN. The facilities also continue to have infection prevention champions who provide education to rural staff, with the support of the Infection Prevention team.

Completion Due By: August 2012

Responsibility: ED NM&RHS

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

Compliance by staff with hand hygiene procedures has improved significantly as evidenced across the health service.

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Function:Clinical **Standard:1.6**
Criterion: 1.6.1 Consumers / patients, carers and the community participate in the planning, delivery and evaluation of the health service.

Recommendation: E5 OWS 0911.1.6.1#1 **High Priority:** No

Recommendation:

Investigate the feasibility of providing videoconferencing facilities at The Park (being a State wide facility) to enable carers and family members to have increased contact with the consumer residing at this facility.

Action:

The Park - HSIS provides access to videoconferencing with the Consumers' significant others at the Consumers request, however, there have been very few requests to date. Tele/videoconferencing is also available for court proceedings that occur out of region if required. A record of this information is written in the individual Consumers file, by date and sequence of occurrence.

Completion Due By: August 2012

Responsibility: ED MHS

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

While video conferencing is available, little is done to encourage consumers/families to use it. It could be used as a therapeutic tool or in a recreational way. This should be encouraged by staff.

Recommendation: E5 OWS 0911.1.6.1#2 **High Priority:** No

Recommendation:

Review the details of visiting hours in the Carers' Information booklet at The Park to ensure factual information is provided to carers regarding times and days for visiting.

Action:

The Park - The inconsistencies between the Actual visiting hours and the Advertised visiting times noted in the last ACHS survey in 2011, have been amended.

Completion Due By: August 2012

Responsibility: ED MHS

Organisation Completed: Yes

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Surveyor's Comments: **Recomm. Closed:** Yes

The information available regarding visiting hours has been reviewed and now reflects actual visiting hours.

Recommendation: E5 OWS 0911.1.6.1#3 **High Priority:** No

Recommendation:

Investigate the feasibility of consumer services providing additional weekend social activities in a range of locations to reduce the boredom and social isolation of consumers.

Action:

IMHS - The Consumer Companion Program was expanded in 2011 to provide Consumer Companions in the Acute Mental Health Unit on weekend shifts giving consumers a greater range of engagement while in the Acute Mental Health Unit. Engagement and activity data recorded by the Consumer Companions indicate the weekend activity aligns with the week day data, Staff feedback indicates that the Consumer Companions provide valuable support to consumers on weekends.

The Park - A business case was developed in order to investigate the possibility of expanding the roles of Consumer Companions on weekends. This business case was tabled at the Park Executive Management Committee and the decision was made that the service could not support weekend work due to financial constraints (The Mental Health Alcohol and Other Drugs Division Consumer, Family and Carer Team has not funded or sanctioned the facility for weekend work), there are restrictions regarding the provision of supervision for Consumer Companion team members over weekend incurring a level of risk; and that Consumer Companions do not have access to facilities and resources outside of normal working hours. Rehabilitation services provide some weekend activities. Consumer Services Staff are looking at how best to build the capacity of consumers to find meaningful things to occupy their weekends.

Completion Due By: August 2012

Responsibility: ED MHS

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

While it is noted that Consumer Companions spend time with acute MH patients at weekends, it would be useful to assess the activities in which they are involved and document the benefits. The findings could be presented to the Quality and Safety Committee. A new recommendation is included in the current report.

Recommendation: E5 OWS 0911.1.6.1#4 **High Priority:** No

Recommendation:

Undertake an independent evaluation of all the consumer roles with a view on how these roles can be progressed and developed.

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Action:

The Park - Recent restructure by the department of health has seen the Consumer Companion (CC) program handed over to the Hospital and Health Service for management. This includes supervision of these roles. A plan has been developed for the Park to ensure the best possible outcome from supervision is achieved. An audit, October 2011 of Consumer Companions and Consumer Representative's training was undertaken to ascertain gaps in education needs. A training calendar has been developed utilising the resources of the school of Mental Health. Consumer Services staff will be conducting a review in October 2012.

Completion Due By: October 2014

Responsibility: ED MHS

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

The Consumer Companion role has been reviewed, and consumer companions are available at weekends.

Recommendation: E5 OWS 0911.1.6.1#5 **High Priority:** No

Recommendation:

Develop mechanisms for the documentation of informal feedback given to the consumer workers for potential evaluation in the future.

Action:

IMHS - An implementation strategy and forms have been developed and implemented for the Consumer Worker Feedback process. This enables consumer workers to record informal feedback received from a range of sources including consumers, carers, co-workers, management. Once feedback forms are completed, they will be actioned (if necessary) and recorded by the Consumer Liaison officer. It is currently planned to review and evaluate the captured data and process on a quarterly basis. Issues and trends identified will be tabled at the IMHS Executive Management and also the Patient Safety and Quality Committees.

The Park - Consumer forum minutes with Consumer issues are sent to the ward seniors and also to the Patient Safety Officer for recording on the Patient Safety Round record. Issues remain on the notes from the Patient Safety Round until they are resolved. Feedback is then sent to the Consumer Representatives and Consumer Companions regarding the resolution of Consumer Issues. An audit process has been developed and will be put in place at the end of the twelve month period, October 2012. Consumer Services Staff and Consumer Representatives will conduct the audit.

Completion Due By: October 2014

Responsibility: IMHS ND

Organisation Completed: No

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Surveyor's Comments: **Recomm. Closed:** Yes

A plan is in place for an audit process to commence in October 2012.

Recommendation: OWS08081.6.1 **High Priority:** No

Recommendation:

The current profile of consumer input be mapped to identify any gaps and, if necessary, an action plan be developed to guide further input from the community.

Action:

Targeted Community Engagement Strategies have been developed and implemented for the Ipswich Hospital Expansion / Car Park and Redevelopment project at The Park - Centre for Mental Health.

A Hospital and Health Service Consumer and Community Engagement Strategy is being implemented. Drafting of specific strategies has commenced.

The Community Engagement Procedure will be updated to reflect the endorsed strategy. The self assessment completed on part 2 consumer partnership in service planning National Health Standards will be used to development an action plan to be reported on to the Chief Executive and Board Chair whilst formalise committee structure for the hospital and health service is implemented.

A Divisional Consumer and Community Engagement activity register has been drafted for consultation. This will be an online tool which will capture activities outside the formalised committee or work group structure.

Communications and Engagement have collected Community Engagement Strategies from the local governments to incorporate into the Health Service strategy. The Health Service has consulted with Health Consumers Queensland, has organised consumer representative to attend the training sessions offered by Health Consumers Queensland. This Consumer representative participates in the Executive Patient Safety and Quality Committees.

The District Health Services Plan is due for review and will include a community engagement component, as required by the health service model.

The Partnership Council for the West Moreton Health Service aims to develop and sustain partnerships between service providers involved with primary health care initiatives, education and research to facilitate improved health outcomes for the community. The objectives include: to improve access to health care services and preventative programs; to support and enhance health care planning; to influence primary healthcare resource allocation through consultation and representation; to enhance health consumer and community engagement with health service planning and development; to meet regularly to develop an understanding of each other's service and the opportunities and challenges that we share; to provide information on the strategic direction of each other's organisations and, where possible, provide an opportunity to contribute to local planning; and to provide an opportunity for service difficulties to be raised and discussed. Current membership includes:

- West Moreton Health Service DCEO (WMHSD)
- West Moreton Health Service Mental Health (WMHSD MH)
- West Moreton Health Service Community Health (WMHSD CH)
- St Andrews Ipswich Private Hospital
- Ipswich City Council
- University of Queensland

Organisation: West Moreton Hospital and Health Service
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- Blue Care
- Ozcare
- West Moreton Public Health Unit
- Kambu Medical Centre
- Consumer Representative
- General Practitioner
- Spiritus

The Partnership Council is in the process of developing a networking and information session for local primary health care providers. The Health Forum will be held quarterly with the first session in July 2012.

Completion Due By: August 2012

Responsibility: Chief Executive

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The Consumer and Community Engagement Strategy has been implemented for the WMHHS.

Function:Clinical **Standard:1.6**
Criterion: 1.6.2 Consumers / patients are informed of their rights and responsibilities.

Recommendation: E5 OWS 0911.1.6.2#1 **High Priority:** No

Recommendation:

Survey consumers to ascertain the level of receipt, knowledge and understanding of rights information provided to them.

Action:

IMHS - Covered to some extent via Consumer Perceptions of Care and MHAODD audits. Planning under way to identify appropriate timing during care and mechanism for internal survey.

Investigating ways to promote awareness and understanding of consumer rights & responsibilities. Looking at inclusion of topic on Morning Ward Meeting agenda – discussing and then following up, asking nurses to speak to individual consumers who express interest in discussing further. Also captured via the evaluation of the Consumer information group sessions conducted in the AMHU.

The Park - This is an ongoing process carried out by Consumer Services it involves the Orientation package available to Consumers, Consumer Representatives that report back any issues experienced by consumer, workshops and individual consultation sessions for the Consumer. The Consumer Advocate, Consumer Aboriginal and Torres Strait Islander Liaison Officer, the Consumer Consultant and the Consumer Liaison Officer, the Consumer Representatives and the Consumer Companions have a focus to support Consumers in ascertaining their rights. The Patient Perceptions of Care Survey Results have been delivered to the Park. An action plan will be developed in order to address any concerns from the survey.

Completion Due By: October 2014

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Responsibility: IMHS ND

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** No

This recommendation remains open.

Recommendation: E5 OWS 0911.1.6.2#2 **High Priority:** No

Recommendation:

Work in partnership with the Consumers & Carers Advisory Forum to develop mechanisms for consumers to gain increased access to advocacy support when they attend mental health review tribunal hearings, especially consumers who have little or no carer/family support.

Action:

IMHS - Mechanisms exist via the roles of allied persons (MHA 2000), and documented pathways and requirements exist.

The Consumer Liaison Officer commenced delivery of Allied Person Presentations in the Acute Mental Health Unit in early 2012 to assist consumers in identifying what an Allied Person is, and who may be an appropriate person. This group is offered on a weekly basis. Additional support gained through the "Mental Health Legal Service".

The Park - A review of consumer carer support systems is undertaken on admission and recorded in the Consumer files. This guides the level of support needed. The Consumer Advocate and the Consumer Aboriginal and Torres Strait Islander Liaison Officer attend MHRT hearings in order to provide advocacy support to consumers who need that level of support. This is done in consultation with the Consumers Carer/Family. Court documents and consumer files and Consumer Advocate and Aboriginal and Torres Strait Islander Liaison Officer roles record their attendance.

Completion Due By: October 2014

Responsibility: IMHS Service Manager

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

Increased advocacy is being addressed by the Consumer Liaison Officer.

Recommendation: E5 OWS 0911.1.6.2#3 **High Priority:** No

Recommendation:

Ensure the Rights and Responsibilities posters are clearly displayed throughout the Service's facilities and the information is included in information packages and booklets.

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Action:

IMHS - issue and circulation of new MHA2000 rights posters. The new posters have been placed throughout the service and the information is also provided to consumers with their orientation packs.

The Park - The Consumers Rights and Responsibilities are a large part of the Consumer Orientation Package. The Rights and Responsibilities for Consumers Posters are currently being developed by Consumer Services Staff, utilising the information contained in the Orientation Package. The Consumer Orientation Package has been upgraded for High Security Inpatient Services. Plans are in place to record this and present it to consumers in digital voice recorded format. The Orientation Package identifies Consumer Rights and Responsibilities.

Completion Due By: October 2014

Responsibility: IMHS Service Manager

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

This has occurred.

Function:Support **Standard:2.1**
Criterion: 2.1.2 The integrated organisation-wide risk management framework ensures that corporate and clinical risks are identified, minimised and managed.

Recommendation: PR0810.2.1.2 **High Priority:** No

Recommendation:

Ensure all sites and service/business units have a current local risk register with education and support provided by the Patient Safety and Quality Unit where appropriate.

Action:

The Health Service procedure and risk recording template have been updated in line with the changes to the state-wide policy. Existing risks have been re-rated against the new risk matrix.

All sites and Divisions have a current local risk register, ie:

- District
- Ipswich Hospital
- Medical Business Unit
- Surgical Business Unit
- Children's and Family Health Services
- Boonah Hospital
- Esk Hospital
- Gatton Hospital
- Laidley Hospital
- Community Health
- Oral Health

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- Mental Health
- Corporate Services

Issues continue to be identified through a range of arenas including the Integrated Strategy and Planning Framework, Governance meeting, team meetings and through Patient Safety Rounds. Current controls and additional controls for identified risks are reviewed and updated.

Risks reviewed at Executive Management meetings and if completed satisfactorily are removed byt Patient Safety & Quality Unit responsible officer.
Patient Safety & Quality officer responsible for managing risk registers provides education and assistance to Managers when issues of compliance arise.

Completion Due By: August 2012

Responsibility: ED NM&RHS

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The actions taken support closure of this recommendation, with a District Risk Register now in place along with the establishment of Hospital and local facility based and business units risk registers that report into the District Risk Register.

The District Risk Register is managed by the Director, Patient Safety & Quality Unit with identified Patient Safety Officers from the Patient Safety & Quality Unit responsible for managing risk registers and providing education and assistance to Managers when issues of compliance arise.

Function:Support **Standard:2.1**
Criterion: 2.1.3 Health care incidents are managed to ensure improvements to the systems of care.

Recommendation: PR0810.2.1.3 **High Priority:** No

Recommendation:

Develop a mechanism across the District to ensure timely completion of root cause analyses and other reviews, and implementation of their recommendations.

Action:

The Patient Safety Improvement Centre are considering a change to the recommended timeframe of 45 working days for completion of RCAs to 90 days as they have recognised that across the state the 45 day timeframe is unrealistic given circumstances surrounding Patient Safety Officer (PSO) workload and RCA processes.

Monthly progress updates and annual PADs are being used as a mechanism to ensure timely completion of root cause analysis. Monthly reporting of RCAs in process and State-wide QHERS reports to follow up outstanding corrective actions for clinical incident management is tabled at the Patient Safety and Quality Committee. These reports are also communicated to Directors and Managers monthly.

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Completed a workplace instruction on triage and open disclosure commencement. Completed an RCA management workplace instruction which includes notify the Commissioning Authority if an RCA completion is delayed outside the standard and reasons why.

During development of RCA recommendations, the Quality Officer is involved to ensure achievable and realistic recommendations and outcome measures.

At the time of last survey, there were 96 outstanding corrective actions. These have been significantly reduced to 50 outstanding as at June 2012.

To further improve completion of RCAs, the PSOs workload will be reduced by educating department managers to complete their own HEAPS analysis, so PSOs will be able to complete RCAs more closely to the desired timeframes. Interested staff will be trained in the skills of RCAs to allow them to complete without PSO involvement.

Completion Due By: August 2012

Responsibility: ED NM&RHS

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The actions taken support the closure of this recommendation. It is anticipated that the Clinical Incident Triage Procedure that has recently been developed to provide rigor and ensure the appropriate investigation is being undertaken on an adverse event or incident will assist the organisation in meeting timelines for the management of RCAs. Prior to this all sentinel events were managed through the RCA process.

Function:Support **Standard:2.2**
Criterion: 2.2.1 Workforce planning supports the organisation's current and future ability to address needs.

Recommendation: OWS08082.2.1 **High Priority:** No

Recommendation:

The development of the workforce plan be expedited. (It is acknowledged that the District has made a significant commitment to achieving this objective and it is important that the imminent amalgamation with Toowoomba and Darling Downs Health Service District does not impede the progress of this development).

Action:

A Strategic Workforce Plan has been developed for the West Moreton Health Service, building on the work that had started when Darling Downs and West Moreton were amalgamated districts. The plan considers issues, evidence and strategies required to deliver a sustainable workforce across the Health Service for the next 5 years, including redevelopment and expansion projects. It is recognised additional workforce planning is needed regarding the Ipswich Hospital Expansion, but further service modelling is required before this can be completed.

Organisation: West Moreton Hospital and Health Service
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The ongoing annual review of the Health Service Workforce Plan will be incorporated into the Health Service planning cycle.

Completion Due By: August 2012

Responsibility: ED P&C

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The survey team viewed the strategic workforce plan for the Health Service for the next five years. This includes consideration of the redevelopment and service changes anticipated. The impact of output based funding and new models of care are matters which will influence the organisation's capacity to deliver the plan as well as the impact of the many strategies being implemented (including joint community development projects with the City Council and tertiary institutions) to increase the available workforce in the area.

Function:Support **Standard:2.2**
Criterion: 2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.

Recommendation: OWS08082.2.3 **High Priority:** No

Recommendation:

(i) A strategy be developed to ensure that all employees participate in the new Performance and Development (PAD) system. The strategy could include enhanced promotion and training of PAD across the organisation and regular auditing of this requirement across all departments and facilities.

(ii) The supervision arrangements for junior medical staff undertaking rural relief duties be formalised to ensure that they receive adequate orientation, on-site teaching, supervision and general support.

(iii) The current registration status and scope of practice for all health professionals be readily accessible to rural managers.

(iv) Time be made available to ensure that there is adequate access to education and mandatory training for medical staff.

Action:

(i) The Organisational Development unit communicates regularly through email reminders to managers regarding staff PADs. The regular communication combined with manager/ supervisor training and the iManage network have increased awareness of PAD responsibilities and generated requests for specific training in PAD completion. Organisational Development facilitating this training.

A process to capture PAD compliance is being rolled out and will be used by most disciplines. However nursing details will be recorded in Trendcare.

The Medical Education Unit do mid-term and end term rotation assessments for junior doctors, interns, JHOs and, SHOs using a standardised Ipswich Hospital assessment form. PHOs assessed quarterly. All assessments are maintained in the Medical Education assessment database. Registrars are assessed

according to college requirements and individual divisions are responsible for their registrars. SMOs are reviewed by medical administration.

Current compliance with PADs across the District is at 41%.

(ii-iv) The information provided for this recommendation was sufficient for it to be closed at Periodic Review 2010, but as (1) was unable to be closed, this recommendation was also left open.

(ii) The allocation of junior doctors to rural health facilities is the responsibility of the Rural Coordination Unit (RCU) and therefore junior doctors from Ipswich Hospital can, and will, be allocated to facilities outside our scope of responsibility and Health Service. The RCU has responsibility for all students on rural rotation.

Ipswich Hospital Medical Education Unit continues to provide the rural facilities in our health service with documentation, as well as ensure the RCU requirements of relieving doctors are met. The "Guidelines for Clinical Supervisors of Junior Medical Officers" which outline the requirements for orientation, supervision and education of Ipswich Hospital junior doctors providing relief in these areas are provided to our rural facilities as part of an annual mail out.

Copies of the junior doctors' education session presentations are also forwarded to junior doctors undertaking rural relief terms by the Ipswich Hospital Medical Education Unit.

(iii) The Senior Medical Officer Credentialing Database is the main source for accessing the Scope of Clinical Practice and review dates for Senior Medical Officers in the West Moreton sector. The database is accessible to all staff across the District on the intranet and can be found on the District Resources System.

Nursing registrations are maintained through the Director of Nursing/ Facility Managers at each facility.

Dental Officer registrations are maintained through the ED Oral Health office.

The ED of Allied Health is sent regular HP registration compliance reports from QH HR State-wide reporting team for DD-WM current registrations. The report is forwarded to the Discipline Directors to check if accuracy. If there are any outstanding registrations, the discipline directors follow-up with staff. A spreadsheet is maintained through the ED Allied Health with registration details of allied health professionals. Each discipline maintains a spreadsheet of registration details. Details are checked at the time of employment and annually thereafter.

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(iv) The Medical Education Unit ensures all Interns complete mandatory training requirements as part of the extended Intern Orientation Program. Other junior doctors, including International Medical Graduates, who commence duties throughout the calendar year complete mandatory training requirements as part of compulsory attendance at Health Service Orientation and completion of specified online mandatory training modules.

The Ipswich Hospital Medical Education Unit have accreditation current to mid-2013 from the Post Graduate Medical Education Council of Queensland for Internships assessments. The Medical Education Unit complete rotation assessments for all junior doctors (Interns, JHOs and SHOs) at mid-term and end of term using the Ipswich Hospital standard assessment form. PHOs are assessed quarterly. All assessments are maintained in the assessment database.

Attendance data is monitored regularly. Medical Officers do not receive a statement of service if they do not meet their training requirements and attendance levels.

Completion Due By: August 2012

Responsibility: ED P&C

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

i) The Workforce and Culture department communicates regularly with Managers regarding the completion of annual PADs. Training of managers is included in a number of workshops for various disciplines and levels.

Nursing staff are regularly appraised and the registrars' appraisals are managed by the relevant specialist College. It is suggested that WMHHS, as the employer, retain a copy of these appraisals for future reference. JMOs, Interns and Senior House Officers are appraised by their Director at the end of each placement and an Improving Performance Action Plan is completed if required. However, completion by senior doctors remains at a relatively low level (35%). Medical administration has developed a plan to address this but this is the subject of a further recommendation in the current report as is the appraisal of Medical Superintendents and rural doctors if they are WMHHS employees.

ii) The survey team was advised that support mechanisms provided by the medical superintendent are in place to support rural doctors and that the co-ordination unit ensures appraisal of this staff group. Numerous resources for doctors to use were sighted, including "Guidelines for Clinicians supervising junior medical officers" (2012), Medical Education Orientation (Oct 2011), RMO Clinical training portfolio (Nov 2011) RMO orientation Nov 2011, Australian Junior Doctor Curriculum framework 2011 and Ward Call for JMOs (Oct 2011) and "How to succeed during internship" (2011).

iii) Medical Administration distributes information about medical registration and scope of practice for medical staff to all facilities across the West Morton Hospital and Health Service, including the rural areas, on a monthly basis.

iv) Doctors are provided with many opportunities for education and mandatory training, including on site education. There is a calendar of forthcoming sessions and a generous sabbatical/study leave and education allowance is provided.

Organisation: West Moreton Hospital and Health Service
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Function:Support **Standard:2.2**
Criterion: 2.2.4 The learning and development system ensures the skill and competence of staff and volunteers.

Recommendation: OWS08082.2.4 **High Priority:** No

Recommendation:

(i) A comprehensive all-encompassing staff development plan be developed, based on a formal needs assessment of all departments and disciplines.

(ii) A proactive approach be developed to ensuring that there is optimal participation in mandatory training sessions. (It is suggested that auditing the implementation of the Policy and Procedure "Mandatory Training" across all sites could be a pivotal component of this approach).

Action:

(i) A Training Needs Analysis has been completed through the Organisation Development Unit, People and Culture Division to identify non-clinical training priorities for staff and managers from a District-wide perspective for clinical and non-clinical staff.

Developmental areas identified through the TNA survey include dealing with difficult conversations, change management and dealing with difficult people. Executive will use the information to determine priorities and funding requirements.

The recent TNA survey results confirm the results from the 2011 Better Workplaces staff survey. The Health Service has identified priorities and developed an action plan based on the Better Workplaces Survey result. Corporate funding is being sourced for the following key focus areas: Top 500 course participation for managers/ supervisors, Energising from Conflict sessions, Change Management and Inspiring Leaders Workshops.

(ii) Mandatory Training Guidelines have been endorsed by Executive. Each discipline has an appendix to specify their individual mandatory training sessions as well.

The role and responsibility of educators in the District is being clarified to ensure optimal use of staff resources. Budget implications are also being considered around releasing and backfilling staff to attend training. Additional work around a framework is being developed.

Twice yearly block mandatory training sessions have been implemented for Hotel Services to provide staff adequate opportunities to attend mandatory training.

Mandatory training sessions for nursing staff has improved. Initially mandatory training was ad hoc. In 2011 2 weeks of block training commenced. This was improved to incorporate re-credentialing of trainers. And in 2012, sessions commenced once a month for mandatory credentialing competency assessment. Some allied health staff also participate in this day.

Medical officer and intern training is held annually at the start of the year.

Allied health training is managed through each individual unit.

Completion Due By: August 2012

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Responsibility: ED P&C

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

i) A comprehensive training needs analysis has been conducted and a plan, based on priorities identified, has been developed. PRIME reports as well as performance appraisal also contribute to the plan.

ii) Various craft groups have tailored mandatory training and managers ensure optimal participation in mandatory training. The Executive has endorsed each discipline's list. Using a block approach or whole day approach rather than isolated sessions has resulted in greater attendance. This has also been the experience at the rural health services.

Function:Support **Standard:2.3**
Criterion: 2.3.3 Data and information are collected, stored and used for strategic, operational and service improvement purposes.

Recommendation: E5 OWS 0911.2.3.3#1 **High Priority:** No

Recommendation:

Utilise the Information Management Operational Plan to ensure that there is a timely and progressive strategy for the full implementation of CIMHA across the Service.

Action:

IMHS - CIMHA Only Implementation Business Case developed and endorsed by the IEMRC. The CIMHA Only Implementation working group established to progress actions in line with the business case.

The Park - The role out of CIMHA across the facility is monitored and evaluated by the monthly review of Provision of Service (POS) data. This is tabled at the CIMHA Reference Group which meets bimonthly. This data can be analysed by team, consumer, clinician or intervention type. The Clinical Initiatives Coordinator provides support and training to staff in relation to the role out of CIMHA. The Reference group are currently scoping and consulting to plan the next phase of the CIMHA roll out.

Completion Due By: October 2014

Responsibility: ED MHS

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

The introduction of CIMHA across the service is progressing.to plan.

Recommendation: E5 OWS 0911.2.3.3#2 **High Priority:** No

Recommendation:

Develop an Information Management Operational Plan for Service level initiatives in conjunction with the State-wide plan.

Organisation: West Moreton Hospital and Health Service
Orgcode: 715130

Action:

A strategic and operational Information Management Plan has been has been developed. The Committee structure to oversee implementation has been reviewed and realigned.

IMHS - MHISC sits on the district ICT committee and provides input to district plans, both operational and strategic, and maintains the CIMHA information systems plan.

The Park - Information Management Team has provide input into the District Contingency Plan for Information Systems, Corporate Systems and Desktop Services. An Emergency preparedness plan have been developed for the facility in line with the District plan. The facility plan is in part a response to the flood relief of 2011 and also in part developed as a result of the last onsite survey.

Completion Due By: October 2014

Responsibility: EM MHS/ED Corp services

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

An Information Management Plan has been developed.

Function:Support **Standard:2.3**
Criterion: 2.3.4 The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).

Recommendation: E5 OWS 0911.2.3.4#1 **High Priority:** No

Recommendation:

Review access to computers across the Service to ensure that there are sufficient computers available to staff to enable the full utilisation of CIMHA and other data systems.

Action:

IMHS - A Audit of all computer assets and their allocation has been conducted and this information is now being analysed to support a business case for additional assets as appropriate.

The Park - A review of access across the facility has been undertaken by the Service Manager. A business case has been developed in order for additional resources. This was done in consultation with the Unions. Unions are happy with the progress of this issue as reported at the Local Consultative Committee.

Completion Due By: October 2012

Responsibility: IMHS Service Manager

Organisation Completed: No

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Surveyor's Comments: **Recomm. Closed:** Yes

There would appear to be a lack of computers across the Health Service especially in MH. A Business case is being prepared in this regard. This recommendation is closed and a new recommendation raised under Criterion 1.3.1 in the current report.

Recommendation: OWS08082.3.4 **High Priority:** No

Recommendation:

A District information technology plan (supporting the Queensland Health plan) be developed to address the local issues of information technology provision.

Action:

The West Moreton ICT Strategic Plan 2012 outlines the District's ICT priorities. The District ICT Governance Committee meets monthly to monitor the progress of the plan. Updates and evaluation of the ICT plan are also detailed in the Corporate Services 90 day forum.

A 5yr District ICT plan has also been developed which identifies opportunities for improvement across the district.

The District Information Systems Support Unit and Information Divisions have upgraded the phone system across the District and updated the server capabilities. A software and hardware replacement program is ongoing, and the upgrade of the wireless facilities through Ipswich Hospital in conjunction with the Expansion is underway.

Completion Due By: August 2012

Responsibility: ED Corporate Services

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The West Morton HHS ICT Strategic Plan 2012 has been developed and implemented.

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Function:Corporate **Standard:3.1**
Criterion: 3.1.5 Documented corporate and clinical policies and procedures assist the organisation to provide quality, safe health care.

Recommendation: PR0810.3.1.5 **High Priority:** No

Recommendation:

Develop a method of tailoring policies, guidelines and procedures, and for assigning responsibility for adherence relevant to the role and size of individual sites.

Action:

Procedure Management Procedure, templates and process have been reviewed. The recent legislation chance has seen the Hospital and Health Service need to develop a transition plan for policies and undertake a Health Service Directive gap analysis and implementation process.

Approving authority for clinical and non-clinical procedures will occur through the appropriate Executive Director, with the procedure noted at the appropriate Committee.

Patient Safety & Quality maintains a spreadsheet to manage the review process. Creating new procedures follows the development procedure. The responsibility for custodian ship of procedures and workplace instructions is delegated to the Director, Manager, Team Leader position throughout the Health Service. These staff members are responsible for ensuring there are appropriate procedures and work place instructions for their work areas and audit to assess compliance procedures and work place instructions are being adhered to.

Completion Due By: August 2012

Responsibility: ED NM&RHS

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

All Policies come from Queensland Health at this point in time and local guidelines are being implemented.

Function:Corporate **Standard:3.2**
Criterion: 3.2.1 Safety management systems ensure the safety and wellbeing of consumers / patients, staff, visitors and contractors.

Recommendation: E5 OWS 0911.3.2.1#1 **High Priority:** No

Recommendation:

Rubbish be collected and stored in bags which cannot be used for self-harm.

Action:

IMHS - Direction provided by the IMHS Nursing director to remove all non-perforated plastic bags from

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within the IMHS Mental Health units. Follow up review conducted of all storage areas to confirm the availability of only perforated plastic bags. New linen bags provided as part of a new linen supply contract. A new initiative involving the use of shopping baskets at the entry of the AMHU to prevent the entry of shopping bags into the unit. Ongoing checks occurring to confirm compliance.

Completion Due By: October 2014

Responsibility: IMHS ND

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

Non-perforated rubbish bags have been removed from the IMHS and alternatives have been introduced, thus removing the potential for self-harm from these items.

Recommendation: E5 OWS 0911.3.2.1#3 **High Priority:** No

Recommendation:

Ensure that supplies are not stored on the floor in any part of the Service and that staff are reminded about this important matter.

Action:

IMHS - Inspections conducted and staff reminded of the importance of using appropriate storage.

Completion Due By: October 2014

Responsibility: IMHS ND

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

Appropriate storage is now used.

Recommendation: PR0810.3.2.1 **High Priority:** No

Recommendation:

1. Develop a more robust tracking system for all mandatory training so that staff who have not performed the mandatory training are easily identified.

2. Audit the information in ChemAlert in order to eliminate the inconsistencies in the material safety data sheets in the system and ensure that all the appropriate material safety data sheets are captured in the system.

3. Develop a process to identify and record new chemicals that are dangerous or hazardous substances.

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Action:

1. A learning management program was planned for rollout across the state as the second part of the payroll system implementation. However, due to the large and ongoing nature of the issues with the Queensland Health payroll system, the learning management program has been deferred indefinitely. There are ongoing corporate level strategic discussions regarding a new state-wide learning management system.

As an alternative, the Hospital and Health Services is in the process of implementing the Resource Management System (RMS) to record mandatory training and PAD compliance. The system can produce reports on attendance, and compliance. It also has the capacity to send prompt email when mandatory training is due.

In the interim and as part of the roll out phase, paper based records are being kept at a local division level on attendance at mandatory training and for PAD compliance. Until the RMS system is fully operational, there is no central location of this information. For nursing staff, Trendcare functionality is being utilised, and for medical officers to the PHO level, the Medical Education Unit database records mandatory training requirements and attendance. For other areas, managers/ supervisors keep records.

The RMS system being rolled out across West Moreton is also being adopted by other Districts across Queensland Health. The Manager of DISSU is the trainer for the system, and provides onsite training for other sites in the use of RMS.

Discussions are being held at both the State and local Executive levels to look at further options for a learning management system.

2. The ChemAlert details are reviewed for each site in 6 monthly internal audits. OH&S have developed a spreadsheet to electronically record 6 monthly audits. Where issues are identified, action plans are developed and for hazardous substances inconsistencies followed up. OH&S have reviewed and updated the internal audit tool to meet legislative requirements, and to include a Hazardous Chemical Stock-take form.

Completion Due By: August 2012

Responsibility: ED P&C

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The learning tracking system has been deferred due to problems with the payroll information system and are beyond the HHS control.

Six monthly audits are in place at each site for ChemAlert.

New chemicals are now included in the Stock Take form.

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Function:Corporate **Standard:3.2**
Criterion: 3.2.2 Buildings, signage, plant, medical devices, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

Recommendation: E5 OWS 0911.3.2.2#1 **High Priority:** No

Recommendation:

Improve the environment of the Barrett Unit e.g. dark corridors and furniture requiring repair.

Action:

Funding has been set aside to buy new furniture for the unit with a particular focus on replacing the couch that was torn and worn.

A quote has been sourced to build skylights into the building to alleviate the dark corridors. This strategy will not happen until the new financial year.

Completion Due By: October 2014

Responsibility: ED MHS

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

While this is yet to occur, evidence indicated that money has been set aside for new furniture and quotes for skylights have been sought. A timeframe is in place for the work to be done.

Function:Corporate **Standard:3.2**
Criterion: 3.2.3 Waste and environmental management supports safe practice and a safe and sustainable environment.

Recommendation: E5 OWS 0911.3.2.3#1 **High Priority:** No

Recommendation:

Develop a robust system for monitoring and reducing carbon emissions.

Action:

Low wattage and energy efficient lighting and equipment is used where possible and installed as items are replaced.

Completion Due By: October 2014

Responsibility: ED Corporate Services

Organisation: West Moreton Hospital and Health Service
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Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

Energy saving devices have been put in place.

Function:Corporate **Standard:3.2**
Criterion: 3.2.4 Emergency and disaster management supports safe practice and a safe environment.

Recommendation: E5 OWS 0911.3.2.4#1 **High Priority:** No

Recommendation:

The organisation ensures that all staff have completed mandatory training by the end of the calendar year as planned.

Action:

IMHS staff training management spreadsheet developed. The spreadsheet is stored on the district G drive so that all Team leaders can monitor and update team training. Remedial action has been taken and ongoing monitoring continues. Compliance is monitored and managed via the Team Leader meeting and the PAD process.

Completion Due By: October 2014

Responsibility: IMHS Service Manager

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

Action has been taken to ensure mandatory training is occurring. Team leaders are responsible and records are in place.

Recommendation: E5 OWS 0911.3.2.4#2 **High Priority:** No

Recommendation:

Where mental health services are part of an acute hospital, methods be devised to identify and monitor mental health compliance with mandatory training.

Action:

IMHS staff training management spreadsheet developed for Community teams. The spreadsheet is stored on the district G drive so that all Team leaders can monitor and update team training. Remedial action has been taken and ongoing monitoring continues. Compliance is monitored and managed via the Team Leader meeting and the PAD process.

The mental health units use a staff training database in conjunction with Trendcare.

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Completion Due By: October 2014

Responsibility: IMHS Service Manager

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

Mandatory training for mental health staff is captured on Trendcare wherever they work.

Recommendation: PR0810.3.2.4 **High Priority:** No

Recommendation:

1. Review signposting for access in medical emergencies at all the rural hospitals.

2. Develop and document the management of external emergencies.

Action:

1. The way-finding audits have been actioned by local facilities. Discussions have been held with local councils to facilitate additional directional road signage to the rural facilities.

All facilities have reviewed visibility of internal emergency signage to ensure clear directional signage in hospital grounds.

Rural facilities have held discussions with local councils regarding directional signage to the facilities, but were unable to secure extra signage due to funding issues.

2. An internal chemical audit is completed for each site every six months by the local manager or local Health & Safety representative (HSR). OH&S is advised of new products by the area HSR or the Manager. OH&S risk assesses chemicals in conjunction with the manager and HSR. OHS super users manage ChemAlert to add new chemicals and remove old chemicals from ChemAlert.

If an SDS does not exist for a chemical, corporate process are followed for HAZMAT to create SDS.

Completion Due By: August 2012

Responsibility: ED P&C, ED Corporate Services

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

A review of signposting has taken place at the rural hospitals in conjunction with the local councils and action will be taken to improve signage in the rural areas. External emergencies have been documented.

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Function:Corporate **Standard:3.2**
Criterion: 3.2.5 Security management supports safe practice and a safe environment.

Recommendation: E5 OWS 0911.3.2.5#1 **High Priority:** No

Recommendation:

Carry out a security risk analysis of extended care units with a view to ensuring staff wear duress alarms in accordance with the Services policy.

Action:

The Park - There is a key and duress alarm register in E.T.R. Upon commencement of work, staff obtain a duress alarm and a set of keys and sign the corresponding numbers for both in the register. At the completion of shift, the correlating keys and duress are handed over to the relieving staff members, with any leftover sets being signed back into the register prior to staff leaving the building. This process was improved to further enhance the safety of all staff members, by conjoining the keys and duress alarms. It is now not possible to obtain a key without a duress alarm. Spot checks are still conducted on an ad hoc basis to audit compliance.

Completion Due By: October 2014

Responsibility: ED MHS

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

There is a process in place to ensure that duress alarms are collected at the beginning of a shift and returned at the end.

Recommendation: E5 OWS 0911.3.2.5#2 **High Priority:** No

Recommendation:

Develop a system for backing up security officers in the event of multiple calls for assistance.

Action:

The stated expectation for a Code Black situation where security cannot attend is to call the Queensland Police Service for assistance.

Completion Due By: October 2014

Responsibility: ED MHS/ED Corp Services

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

When security staff cannot attend a Code Black the process is to call the police.

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Recommendation: E5 OWS 0911.3.2.5#3 **High Priority:** No

Recommendation:

Develop a mechanism to ensure that security officers maintain their credentials and licences.

Action:

In-line with the Health Services Act, security officers only need to be appointed by the delegate, ie the Chief Executive, and to have undertaken mandatory ABM training which is the current practice.

Completion Due By: October 2014

Responsibility: ED MHS/ED Corp Services

Organisation Completed: No

Surveyor's Comments: **Recomm. Closed:** Yes

Under the Health Services Act security staff can be employed by the Chief Executive who is responsible for ensuring their licences and credentials are in order.