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

West Moreton South Burnett Health Service District

Ipswich, Qld

Organisation code: 71 51 30

Survey date: 18-22 August 2008

Advanced Completion: 15 December 2008

ACHS Accreditation Status: ACCREDITED

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 by a health care organisation, of requirements of national health care 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
3 - Summary of Recommendations from the Current Survey
4- Recommendations from the Previous Survey

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 (except criterion 1.3.1 which is a developmental criterion)

- 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 need to be implemented but may have only basic systems in place. At this level there will be compliance with legislation and policy that relates to the criterion.

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 very little or no monitoring of outcomes or efforts at continuous improvement.

MA –Moderate Achievement- An MA rating requires that all the elements of LA and SA have been achieved and that efficient systems in collecting relevant outcome data, monitoring, evaluation procedures and methods of improvement are in place.

EA – Extensive Achievement- In the EQuIP 4 program, all the elements in LA, SA and MA must be achieved. Also organisations will be able to demonstrate extensive achievement in a criterion if they satisfy one or more of the following requirements:
• internal or external benchmarking and subsequent system improvement, and / or
• the conduct of research that relates to that particular criterion, and / or
• the implementation of what would be considered to be advanced systems that relate to that criterion, and / or
• proven, excellent outcomes in that particular criterion.
Some organisations may be able to demonstrate achievement in more than one of these elements.

OA- Outstanding Achievement- The 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 that organisation is the best in Australia. It may mean that the organisation can demonstrate that it is one of the best or is outstanding amongst its peers.

Developmental Criterion (1.3.1) -
A developmental criterion is one that the ACHS has introduced to organisations for the purpose of creating awareness and for commencing collaborative national action in a specific area of health care. There is one developmental criterion that has been introduced in EQuIP 4 – criterion 1.3.1 - Health care and services are appropriate and delivered in the most appropriate setting.
When a developmental criterion is introduced:
• organisations will work towards achieving the elements of the criterion
• progress towards achievement of the criterion will be discussed during survey but will not be taken into account when determining the accreditation status of the organisation
• a progressive evaluation of the implementation of the standard / criterion will be undertaken by the ACHS

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)-
These are applied to a particular criterion where
• 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 High Priority Recommendation. A HPR 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 0106.1.1.1 is a recommendation from an OWS conducted in January 2006 with a criterion number of 1.1.1

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.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

FUNCTION SUMMARY: CLINICAL

It was pleasing to note the steady improvement and standardisation of practice developing across the District since the previous EQuIP event. In particular, considerable resources and attention have been provided to the rural facilities, with resultant improvements in care systems and outcomes emerging in data to support anecdotal feedback by patients and staff. Examples include the extensive efforts to improve and standardise practice and equipment in rural emergency departments, improvements in clinical consultation and transfer processes between rural sites and Ipswich Emergency Department, moves to provide digital imaging facilities allowing consultation and reporting, investment in education, commencement of the Rural Rehabilitation Team, allocation of patient safety and quality resource personnel to all sites and clinical units, and the progressive roll out of best practice strategies across all sites.

Patient care is core business, and there is widespread evidence of improvements in patient risk assessment, documentation of care plans and care delivery, and early identification of discharge needs. Improvements are also noted in handover practice and communication strategies using the S (situation) B (background) A (assessment) R (recommendation) model, SBAR, which could be applied in many other settings to good effect. Increasing multidisciplinary case review is enhancing appropriate and timely management, with increasing use of information technology solutions such as "the Hub" at Laidley as a practical approach for rural facilities. Specific comments and recommendations have been made under each criterion.

Referrals are prioritised to ensure that clinical needs are addressed in an appropriate and timely manner. This is most evident by the changes to the processing of referrals to the Outpatient Clinics at Ipswich Hospital with resultant good outcomes. Referral links from the rural hospitals to Ipswich Hospital have consolidated.

Evidence-based pathways, such as the venous thromboembolism prevention program and the ‘Liverpool Care Pathway’ for palliative care, have been implemented. The introduction of the “Transforming Care at the Bedside” model of care has seen benefits for patients and staff at Ipswich Hospital. This model of care has attracted widespread interest throughout Australia.

Systems are in place to ensure that timely and safe discharge/transfer of patients occurs across the organisation. Discharge planning is commenced on admission and strong interdisciplinary teamwork exists to support patients who may be at risk of delayed discharge or unplanned readmission. Ipswich Hospital manages the Hand to Home program, which is active within both inpatient areas and in the community. The smaller sites utilise multidisciplinary staff effectively within resource allocation. Systems are in place to promote effective liaison with external services. A range of evaluative methods is used across the organisation, appropriate to various sites.

Support of patients with chronic illness is provided through a range of programs and services. There are established processes for referrals to and liaison with multiple external service providers. Programs for education and ongoing support for people with chronic illness are well established in each site. It is noted that the incidence of severe chronic disease is significant within some communities and teams, such as the community health team at Cherbourg, are commended for their efforts to increase uptake of programs by enhancing accessibility of services. Active participation from the local communities is encouraged by the hospitals, and the self-management of the consumer group by members of the local community at Laidley Hospital is an example of a sustainable support service for people with chronic disease.

The organisation provides for the needs of dying patients by providing appropriate environments for their care. Ipswich Hospital has an in-patient palliative care unit, and also provides an outreach service for those wishing to remain at home. The service also conducts outpatient clinics and consultancy service for patients in the District and at the local private hospice. Weekly case conferencing occurs, as well as monthly interagency meetings with the local private hospice and non-government agencies such as Blue Care. Rural hospitals have sought to dedicate special rooms for similar care in their centres so as to ensure the privacy and comfort of the patient and family. Cultural needs are also assisted in a supportive manner where possible. Of special note was the assistance to the indigenous community of Cherbourg in performing the ‘smoking ceremony’ for their deceased community members. There is excellent education for staff, and evaluation of client management occurs.

Clinical documentation improvements have resulted from regular auditing of patient record and discharge plan content and ongoing education of clinicians through a range of initiatives, such as coders attending grand rounds and meeting regularly with nurses and allied health staff.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
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Function: Clinical **Standard:** 1.1
Criterion: 1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.

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

Surveyor's Comments:

Improvements have been made based on evaluation of the relevance and compliance with assessment tools in a wide variety of settings. Particular improvements have been made in the assessment of risk, with widespread use of multidisciplinary meetings to discuss clinical and discharge risk issues and new document tools are about to be implemented to consolidate this. At Ipswich the Medical Assessment and Planning Unit (MAPU) is demonstrating dramatic improvements in the quality and timeliness of assessment of medical patients presenting to the Emergency Department. The involvement of pharmacists at Ipswich and via telemedicine discussions at Laidley has improved the range of inputs to needs and risk assessment. Nutrition needs assessment is expanding across the service and access to allied health skills for assessment has improved, with the development of the Rural Rehabilitation Team and some successes with local recruitment, though efforts continue. The Fit for Surgery Program provided by physiotherapy at Ipswich is offering alternative and interim treatment based on best practice assessments, with demonstrated improved outcomes for patients.

Operating theatres review reasons for cancellations, including health condition factors, thus providing solid evaluation and feedback to clinicians of the adequacy of elective surgical patient assessment. Improved handover practices at Ipswich include a requirement to review the adequacy of nurse assessment at appropriate change of shift intervals relevant to the particular ward setting. All rural sites reported the great assistance that is now available for medical officers when they contact the senior medical officer on duty in the Emergency Department at Ipswich to assist with clinical assessment issues. Nevertheless, several doctors were unaware of the on-line evidence-based simple assessment flow charts for common presentations (eg chest pain, common paediatric presentations) except at Boonah where the wider experience of emergency medicine makes this readily known amongst the group. It is suggested that some of these one page guides might be printed and laminated for quick reference. This issue is particularly important for the inexperienced junior medical officers who rotate with minimal direct orientation and supervision of their assessments, except when they initiate support via telephone to Ipswich. This matter is further discussed under criterion 2.2.3 and is the subject of a recommendation.

Despite the availability of adequate current assessment document tools, compliance with completion is patchy, especially at Ipswich, Kingaroy and in mental health services (see separate report).

At the rural hospitals, decisions about admission and transfer are largely based on clinical judgement about the self-assessed capacity of those on duty at the time of presentation. The government's Service Capability Framework is available but unwieldy for quick reference and not specific to individual site resource availability on a day to day basis. This poses some risks for patients and challenges for staff on successive shifts, as well as occasional debate with receiving registrars at Ipswich.

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

(i) Compliance with the use of assessment documentation tools be improved.
(ii) Clearly documented, practical, easy reference admission and exclusion criteria be developed for each rural facility based on the site capability framework, so that front line staff can make consistent timely decisions about transfer out and that tertiary acceptance is more transparent.

Mental Health

(i) An evaluation of the mental health consultation/liaison nurse role and workload in the emergency department of the Ipswich Hospital be undertaken.
(ii) The quantity and quality of office space and computer access available to all community mental health teams be reviewed.
(iii) A review of office security and sound-proofing at South Burnett Community Mental Health be undertaken.

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(iv) The allocation of specific, rather than pool, vehicles to the Ipswich Rural Community Mental Health Team be considered so that assessment tools and other requirements [including those for physical examination, such as sphygmomanometers] can be stored in the vehicles.
(v) Consumer transport needs be reviewed in order to facilitate their access to assessment and other clinical services in South Burnett.
(vi) Access to assessment and other clinical services for South Burnett consumers in the older age group be reviewed.

Function: Clinical **Standard:** 1.1
Criterion: 1.1.2 Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.

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

Surveyor's Comments:

Multidisciplinary meetings are held with varying frequency at most sites and in most departments, with key decisions documented in the patient record as well as some teams documenting group issues for further service development. These activities have increased across the service and represent an important improvement for care planning and delivery that needs to continue to expand. There are still deficiencies in access to on-site pharmacists in rural settings in order to oversee nurse and doctor clinical decision making and practice, and this is further discussed at criterion 1.5.1.

Although the use of evidence-based clinical pathways is still variable and little use is made of variance data, there is increasing implementation, both at Ipswich and at the peripheral sites, or reference to these as a guide for care planning and delivery. In general medicine, staff anticipated that implementation of pathways will improve accountability and evidence-based practice for common conditions, as well as assist legibility and consistency of documentation. Future evaluation will decide this. *Trend-care* is now widespread across the health service and being used to better match appropriate skill mix of nursing resources, with reports of actualisation demonstrating improvement across all shifts. In Oral Health there are regular evaluations of adequacy of content and documentation of care plans, and clinical coders also do this at rural and Ipswich Hospitals.

Tools are expanding for rural emergency departments to access best practice clinical guidelines consistently across the District. Refer to comments under criterion 1.1.1 about the need to make these readily available, especially to junior doctors and locums. Mechanisms for tracking changes in health status include a mapping tool seen at Boonah to track changes between admissions for recurrent patients and the use of the bedside handover model at Ipswich. It is suggested that clinical champions from Boonah and Ipswich, respectively, might assist to implement these widely, especially in the rural facilities. The data from the i-stat machines is being used, for example, at Laidley, where readily available reports track the links between blood results, eg troponin levels, and disposition of the patient which thus monitors implementation of best practice clinical guidelines. Improvements in access to allied health and uptake by some staff of training for flexible roles are improving the diversity of skills available to deliver patient care. The commitment of increased resources for nurse educators at rural sites is also enhancing skills, with a focus on core competency assessment and training. There is evidence of consumer participation and provision of information about care in patient satisfaction data, such as the Queensland patient satisfaction survey of 2005, which provides good performance on benchmarked data with the latest report of 2007 data currently awaited. The telephone follow-up of all surgical patients at Ipswich Hospital (not just day procedure as is typical elsewhere) is a remarkable effort to evaluate individual care, and improvements in systems have occurred as a result.

There are an increasing number of x-rays remaining unreported at Ipswich (around 20% currently) and Kingaroy (only reported by special request which is less than 5%). This poses some risk to the adequacy of care planning and its evaluation.

When patients are transferred to Ipswich from rural sites, there is no routine feedback to the sending clinicians unless they endeavour to pursue this themselves, which can be difficult. Consequently the evaluation of their care planning and immediate care delivery for the most at risk patients is greatly restricted, unless the patient returns to a local general practitioner or re-presents to hospital.

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

(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.

Mental Health

(i) The installation of video-conferencing facilities at Goodna Community Clinic be considered, in order to support clinical care of consumers admitted to inpatient facilities [Ipswich] and to strengthen continuing professional development activities.
(ii) The seclusion room on the Aged Care Inpatient Unit be considered for conversion into a snoezelen room [or similar].
(iii) Strategies be identified to further enhance and strengthen the implementation of research outcomes of the Queensland Centre for Mental Health Research, which now has an established international reputation.

Function: Clinical **Standard:** 1.1
Criterion: 1.1.3 Consumers / patients are informed of the consent process, understand and provide consent for their health care.

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

Surveyor's Comments:

There are appropriate policies and processes for consent for procedures/treatment, financial aspects and release of information. Various evaluation methods include patient satisfaction in relation to privacy and treatment information provision, participation in a statewide prospective audit of surgical consent and in-house record audits. A quality improvement activity reviewed at survey demonstrated a significant improvement in specific informed consent for epidural anaesthesia. There is a developing culture of consistent use of evidence-based risk information specific to each procedure in consent documents issued by Queensland Health. These documents include a statement that the procedure/treatment "may include transfusion" and the policy is to delete this if applicable to the consent of an individual. However, consistent with best practice regarding the use of blood products, a separate and specific consent for transfusion has been recently developed and is about to be implemented (refer also criterion 1.5.5). A Queensland Health policy document regarding invasive procedures provides that consent should be gained at least 24 hours prior to surgical procedures, unless an emergency situation requires otherwise. Consequently local improvements have been made to create a zero tolerance culture for "corridor consent" and audits are undertaken against the policy.

Although it was confirmed that the checks in place have resulted in 100% documentation of informed consent by the time a procedure is actually undertaken, a significant number of procedures do not achieve the organisational policy goal of being in place at least 24 hours prior to surgery (up to 28% in a survey covering two weeks from 23rd July) and this includes a number of cases that were booked elective procedures. There may be individual clinician practices that contribute to this result, with the correct process being undertaken in doctors' rooms, but delay in provision of the document to the hospital impairs the opportunity to confirm that consent is valid and correct and this poses some risk of last minute cancellation of the procedure if a patient is not adequately informed, a mistake has been made in the document, or perhaps the patient has a change of mind and needs time for further discussion.

At the Brisbane Youth Detention Centre, clinicians expressed a conflict with usual professional standards in relation to the gaining of consent from minors for immunisation procedures. This situation involves specific legal circumstances and public health imperatives that may outweigh the standard patient rights issues, so it is suggested that this be explored and staff can then respond accordingly.

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

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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Function: Clinical **Standard:** 1.1
Criterion: 1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.

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

Surveyor's Comments:

There is considerable evidence of evaluation of individual care and increasing evidence of the use of aggregated outcome evaluation which can be used to improve systems of care. Use has been made of patient satisfaction data to monitor and improve outcomes. Coders review record content and at Ipswich also attend grand rounds to exchange information with clinical staff. Incident data is analysed and aggregated with opportunities for learning distributed across the District. Compliments and complaints are widely used as a measure of outcome evaluation. High risk indicators (falls, pressure ulcers, medication incidents, infections in general, urinary tract infections, for example) are collated and analysed to varying extents across the sites according to the frequency of such events. Specific units and projects are comprehensively evaluated including the Fit for Surgery physiotherapy program in orthopaedics, the VTE project, palliative care management, rehabilitation goals achievement, special care nursery infant outcomes, midwifery care outcomes, MAPU case review, to name but a few.

All deaths are centrally reviewed, and feedback is given about opportunities to improve care or regarding further in-depth review of potential preventable deaths. Patient Safety and Quality Officers are now assigned to every facility and clinical unit, providing a valuable resource that is independent and provides advice about possible trends or broad system opportunities for improvement. There is variable multidisciplinary participation, particularly by doctors, across the rural sites and some meetings are recently begun or have lapsed for periods of time. Minutes of these meetings do not generally reflect sound analytical discussion with decisions about strategies to improve, and it is suggested that this be a focus of structure and effort for the clinical risk meetings. The meetings typically discuss incidents, readmissions, clinical indicators and complaints. Many rural sites could also benefit by the participation of a pharmacist in these clinical risk meetings, perhaps by teleconference (refer comments at criterion 1.5.1).

Departmental mortality and morbidity meetings at Ipswich are at various stages of evolution and have varying practices of transparency, which may impede participation and organisational improvement. It is suggested that heads of departments explore practice elsewhere at similar large facilities where it is common practice to have well documented, multidisciplinary robust discussion that leads to improvement without clinician defensiveness about indemnity issues or other barriers. A standard model could be considered as organisational policy based on appropriate professional advice of medical colleges and respected peers.

It was noted in action-based minutes that there are frequent occasions of issues being referred to clinical heads of units/departments by the Patient Safety and Quality Officers, which either receive no response or there is a lengthy delay in response. Further efforts in relation to clarifying accountability of heads of departments in relation to clinical governance matters could also be considered, as part of the proposed performance review system for medical staff as discussed under criterion 3.1.3.

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

(i) The analysis of aggregated data concerning outcomes of care be strengthened and the participation by medical officers in multidisciplinary review be increased, so that there is more effective development of strategies to improve patient outcomes.
(ii) A simple system for tracking the timeliness of Clinical Unit Director response to clinical indicator queries and other matters forwarded by the Patient Safety and Quality Unit be developed, with reporting at District safety and quality meetings where delays or failure to respond have occurred, so that appropriate clinical governance can be assured.

Mental Health
(i) An evaluation of the extent of integration between the rehabilitation service (The Park) teams and clinical units be undertaken with the objective of identifying additional strategies to strengthen care planning and delivery.
(ii) A review of patient transport needs such that all disabled consumers are able to participate fully in rehabilitation and other treatment programs be undertaken.
(iii) Housekeeping be included in a life skills program in the Medium Secure Unit for client self esteem.
(iv) Staff attitudes in the Adult Mental Health Unit be modified by training and/or recruitment of leaders who will make changes to bring workers up to a respectful client-based, recovery model of care.

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(v) Concerns expressed by clients in the Adult Mental Health Unit about boredom be reviewed and measures be put in place to address them.

Function: Clinical **Standard:** 1.1
Criterion: 1.1.5 Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.

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

Surveyor's Comments:

Policy, procedure and guidelines relating to discharge planning exist across the organisation. The survey team also noted the commitment by the clinical staff to the early identification of day of discharge and to the management of risk of delayed discharge. A range of evaluation strategies is utilised, including medical record audits of the content of discharge and medication summaries. Unplanned readmission rates are reviewed at Ipswich Hospital and at the smaller rural sites; review of individual cases of unplanned readmissions occurs.

A strong culture of interdisciplinary team work is evident across all sites within the limitations of available resources. Under the auspices of the Hand to Home program, Ipswich Hospital has consolidated a range of resources dedicated to discharge support to realign the acute hospital/community interface. Screening occurs in the Emergency Department at Ipswich to identify patients at risk of discharge delay and to prevent avoidable admissions. Admitted patients are then followed up on the wards by staff from the Hand to Home program, to enhance the coordinated approach to discharge in collaboration with hospital staff.

Liaison with a wide range of community, respite and support programs occurs including general practitioners, general practice nurses, Blue Care, Meals on Wheels, non-government organisations and local councils. Feedback from these agencies about the effectiveness of liaison is obtained through various mechanisms, much of this being informal comment. Follow up of at risk day surgery patients occurs per telephone, and written protocols have been developed for discharge requirements such as voiding and for discharge analgesia. The effectiveness of the patient and carer education system is largely evaluated through follow-up of individual patient compliance with treatment plans. Review of the level of formal evaluation systems and formal follow-up of improvement actions would be useful in each site to further enhance systems.

Other examples of excellent discharge initiatives include the use of local planning and flow charts, assessment for discharge, referral processes to community agencies and the range of options for post-acute care at Wondai and Kingaroy, the early discharge home or transfer to rural sites of post- natal patients from Ipswich, and the effective use of interdisciplinary teamwork at Boonah, Laidley and Esk. The Rural Rehabilitation Team also works in collaboration with the rural sites and participates in case conferences for complex patients.

However, it was noted at the rural sites of Boonah, Laidley and Esk that, whilst admission and exclusion criteria exist to guide procedures around transfers to Ipswich Hospital and acceptance of transfers from Ipswich Hospital, significant negotiation and debate about the appropriateness of transfers have been required at times. This lack of clarity has the potential to compromise patient safety. A recommendation has been made under criterion 1.1.1 in relation to the development of admission and exclusion criteria for rural sites, which is agreed to and well understood by all parties. Achievement of consistent criteria will enhance and streamline the patient transfer processes.

The potential for further learning within the rural sites exists in relation to clinical judgement of the need to transfer patients from rural sites to Ipswich Hospital. Valuable feedback could be derived if formal mechanisms are established to ensure that information is provided by Ipswich to the rural sites about the appropriateness of transfers, and/or the clinical outcomes of patients who are transferred to Ipswich. A recommendation has been made under criterion 1.1.2 in relation to this issue.

Surveyor's Recommendation:

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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

Surveyor's Comments:

Systems for ongoing care facilitate the support of patients with chronic illness. There are established processes for referrals to and liaison with multiple service providers, including general practitioners, Blue Care, non-government organisations, local government, aged care facilities, and other community providers.

Programs for education and ongoing support for people with diabetes and other chronic conditions are available locally across the organisation. For example, diabetes and heart failure programs are available at Laidley where previously patients had to travel to Ipswich. A significant focus on community awareness of services now available at Esk has resulted in increased referrals from the general practitioner of people with diabetes to the hospital, to access diabetes education programs. Ipswich Hospital, in liaison with local government, facilitates enhanced transport options to services through the provision of a shuttle bus from a car park situated some way from the hospital. Increased geriatrician support at Ipswich has enabled an enhanced support service to local general practitioners for care of the older person.

The community health team at Cherbourg is actively exploring ways to increase uptake of programs by delivering services in an accessible manner, and minimising the need for patient travel. It is noted that the incidence of severe chronic disease is significant within this community, and the survey team encourages the continued analysis of workload indicators to support business case requirements for future resourcing of services.

Readmission rates associated with chronic disease are reviewed at Ipswich Hospital, while the smaller rural sites are able to identify individuals who re-present frequently and review of care through interdisciplinary case conferencing occurs with these specific patients. Case studies indicate success in admission prevention for this group of patients in the rural areas.

Other examples of programs and practices observed which contribute to the ongoing care of patients with chronic illness include:-
* Chronic Disease Service at Ipswich Hospital including programs for congestive heart failure, lung health and diabetes;
* Collaborative program between Ipswich Hospital and the Division of General Practice's "Better Health Diabetes";
* Chronic disease programs at Boonah, such as the "Lighten Up" healthy eating program for diabetes;
* Living with Cancer Program at Laidley;
* Proactive approach at Kingaroy to identify geographic areas of high need for post-natal support;
* Diabetes education at Cherbourg;
*Collaborative approach at Kingaroy with non-government organisatons and local government to establish respite programs.

Surveyor's Recommendation:

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Function: Clinical **Standard:** 1.1
Criterion: 1.1.7 Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.

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

Surveyor's Comments:

The health service has in place policies and procedures which provide guidance to staff in managing end of life care and the management of the deceased patient. These guidelines are available both on the intranet and in hard copy. Ipswich Hospital has a ten bed Palliative Care Unit and a comprehensive palliative care service led by a palliative care physician. This service also conducts outpatient clinics and has an outreach component so that patients wishing to die at home are afforded this opportunity, either by staff of the health service or contracted out to other agencies, as they do at Esk. Rural hospitals in the District have dedicated patient rooms for palliative and dying patients, which provide for privacy, family involvement and comfort. The health service is congratulated on this initiative to ensure that all health services have an appropriate space to allow for dying with dignity. At Cherbourg Hospital the cultural needs of the indigenous people are respected, which allows them to perform their cultural practices for end of life situations. Many of the site facilities have active volunteer groups which donate furniture and equipment for these special rooms.

Education for staff involved in caring for end-stage of life situations is ongoing practice. The palliative care physician is very active in providing workshops and in-service for multidisciplinary staff on the subject of palliative care and its management. Nursing is also very proactive in this regard, with membership of palliative care networks and associations. There is a comprehensive induction program for staff when they join the ward team. Support processes to assist staff and carers are undertaken where possible, however, due to resource issues, referral to bereavement and counselling services outside the health service needs to be undertaken.

The in-patient unit at Ipswich has implemented a modified version of the Liverpool Clinical Care Pathway for palliative care patients. The whole team, including family, has to agree to the patient being placed on this pathway, and then information from this pathway is submitted for evaluation to the national palliative care data collection collaborative. Performance indicator data reports comparing to national average data submitted is then returned to the centre for quality improvement action if necessary. Documentation audits are undertaken in relation to variance with the pathway, care documentation and medication administration. Case conference occurs weekly with all members of the multidisciplinary team having input, and a monthly inter-agency meeting occurs. The unit takes part in clinical studies and is currently enrolled in pancreatic and medication use studies.

There is a statutory obligation in Queensland requiring all deaths to be audited by health facilities and data submitted to the Health Quality and Complaints Commission (HQCC). This process is both a learning tool and monitoring methodology to ensure that improvement in care can be detected. At Ipswich the palliative care physician audits death in the clinical unit. Peer review may be a more objective way of reviewing the case management.

Surveyor's Recommendation:

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Function: Clinical **Standard:** 1.1
Criterion: 1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.

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

Surveyor's Comments:

The quality of the content of patient records in areas other than mental health has improved following greater use of some excellent audit tools, and the monitoring of outcomes of audits. Performance improvement is being monitored through the use of benchmarks and indicators. Audits of care plan and discharge plan content have been carried out across the District, which now includes the former South Burnett District. The data trends presented were (in most instances) across two to three years and in many indicators showed considerable improvement during that time, as a consequence of improving practices and ongoing education of both staff and clinicians.This criterion is to ensure that medical records are maintained appropriately, so that the information kept within them is comprehensive and accurate. The organisation needs to have processes in place that ensure that this comprehensiveness and accuracy is occurring. Without accurate and comprehensive information, there is the risk that the organisation will not be able to provide appropriate care. In terms of The Park, the organisation has no systematic auditing process to help determine that the medical record content is sufficiently detailed to allow care delivery to be tracked, monitored and evaluated.

It was noted that in audits of mental health records, the trended data provided evidence of continued poor compliance with identification of 'at risk' clients and other information required to improve the safety of both staff and clients.

Advanced Completion in 60 Days (AC-60)
An AC-60 was conducted on the following recommendations from the In-Depth Review:
(i) The Park Campus develop a system for reporting the results of clinical record audits to clinical teams.
(ii) The Park Campus develop a system for reviewing any trends discovered from the clinical record audit and a plan be developed for improving performance in identified areas.
(iii) All mental health programs implement an audit of the quality of clinical notes for each clinical discipline.

Action Taken by Organisation to Address Recommendation
(i) The Park has reviewed the established audit processes and tools to ensure a linking system is in place for the collection of data. A system for reporting the findings/recommendations of the clinical chart audits has been developed and formalised in the following clinical chart audits:
* Health Information Service - Area Administrative Officer Clinical Chart Audit. Compliance of the audit looks at the administrative components of the medical record.
* Clinical Programs - Clinical Chart Audit. To ensure that clinicians, by discipline, comply with facility policy and professional standards regarding clinical charts.
* Clinical Initiatives - Care Plan Audit. Compliance of the audit measures the Individual Care Plan in the Medical Record.
* Medical Services - Limited Community Treatment Audit. Compliance with Mental Health Act 2000 and other legislation and standards.

All clinical chart audits have had proposals documented which outline the scope and procedure of work for each clinical chart audit. Documentation includes proposal, audit tool, flowchart, audit report and action plans.

(ii) A flowchart incorporating each clinical chart audit has been developed for The Park that links audit tools and outlines the process for reviewing any trends or patterns identified in the findings of each audit. This also incorporates the flow of communication and feedback from and to Executive and the clinical teams.

(iii) The Park - An audit of the quality of clinical notes has been implemented for each discipline. This can be evidenced through the proposal, flowchart, findings and audit summary report for the clinical chart audit.

IMHS - Audit reports are tabled at Executive meetings and findings/recommendations are referred to the appropriate discipline team leader.

Completion Due By:15 December 2008

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Responsibility: Health Information Manager

Surveyor's Comments
Having reviewed the range of audit processes in place, the service has developed a flow chart which demonstrates the flow of communications to appropriate clinical staff and committees, to ensure that the results of audits are communicated and acted upon. There is a process in place for escalation to the Executive Committee in the event that action is inadequate or unsuccessful.

The surveyors are confident that the processes in place will now address the shortcomings identified during the In-Depth Review.

The Conditional Survey team will need to confirm that the changes have been sustained, and this process will be facilitated if the District develops and collects some relevant performance indicators to demonstrate the effectiveness and sustainability of the changes.

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

Mental Health

Stage 2 (by August 2009)
(i) The effectiveness of the clinical record audit process implemented be evaluated.
(ii) West Moreton Health District complete an audit to ensure that all mental health services have a clinical record audit system in place and operational.

Function: Clinical **Standard:** 1.2
Criterion: 1.2.1 The community has information on, and access to, health services and care appropriate to its needs.

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

Surveyor's Comments:

A Health Service Plan 2007-2012 has been prepared addressing the strategic approach to clinical and community services planning, with a clear path forward for service development.

Surveyor's Recommendation:

Function: Clinical **Standard:** 1.2
Criterion: 1.2.2 Access and admission to the system of care is prioritised according to clinical need.

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

Surveyor's Comments:

The establishment of the Outpatient Central Referral Centre at Ipswich Hospital has enhanced patient access to the appropriate clinics. Bookings are prioritised with the relevant clinician. Other strategies adopted include:

1. the establishment of a fast track endoscopy service;
2. the consolidation of the Orthopaedic Physiotherapy Screening Clinic;
3. the establishment by Podiatry of a high risk foot clinic for diabetic patients;
4. the establishment of the Podiatry Screening Clinic and case management of patients by podiatry services, reducing waiting times at the orthopaedic clinic from six months to four weeks;

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5, intervention of babies with permanent hearing loss;
6. the assessment and subsequent streaming of antenatal patients, which has identified low risk obstetric patients suitable to be managed by the Midwifery Group Practice model of care;
7. the transfer of the management of patients with Type 2 diabetes to the community;
8. referrals to local optometrists to perform retinopathy screening for diabetic patients.

There has been a resultant reduction in the waiting lists, notably those who had had to wait longer than 12 months, particularly with the Faciomaxillary Clinic. Category One patients are seen usually within two weeks. The “failure to attend” rate has reduced. Waiting list audits are regularly performed to monitor the situation. Referral guidelines are being developed to expedite the prioritisation and appropriate access of patients to the relevant clinics. These strategies are commended.

Rural hospitals have implemented a series of improvements in response to recommendations from the State Coroner elsewhere in the Southern Area. This includes the adoption of and training in triage categorisation of emergency presentations that is best practice in emergency medicine. Also, systems have been set up to facilitate communication between doctors in the rural hospitals and the senior medical officer on duty in the Emergency Department at Ipswich Hospital, greatly improving the decision making and timeliness about transfers based on clinical need.

Recently there has been an extension of the clinic wait times involving the Child and Family Health Service (CAFHS) Young People’s Health Team outreach service affecting the timely review of young mothers and babies identified as ‘at risk’ due to domestic or financial risk, or maternal mood. The Day Stay Centre is experiencing increasing demand. The Occupational Therapy Service is ranked 10/16 of participating hospitals in reviewing stroke patients within 48 hours of admission.

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

A review of the staffing/resource levels be undertaken and strategies implemented to address the waiting times involved with the outreach service provided by the Child and Family Health Service Young People’s Health Team, Day Stay Centre and Occupational Therapy Service.

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:**

Surveyor's Comments:

Queensland Health has determined the role and function of its hospitals and the District operates within those parameters, ensuring that appropriate skills are maintained for each role, and that patients are treated in the most appropriate setting.

This criterion is an ACHS developmental criterion. Therefore, a surveyor rating is not applied to this criterion.

Surveyor's Recommendation:

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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

Surveyor's Comments:

There is widespread evidence that Ipswich Hospital has implemented evidence-based care. Examples include the implementation of the venous thromboembolism prevention program hospital-wide, and adoption of the "Liverpool Care Pathway" by the Palliative Care Unit. There is evidence that some of the care pathways have been evaluated.

The adoption of "Transforming Care at the Bedside" model of care by the Medical Business Unit at Ipswich Hospital has resulted in positive outcomes. These include discharge efficiencies with a reduction of patient outliers. There has been a reduction of complaints. Staff satisfaction rates have increased. Staff vacancies have been reduced from 45 full-time equivalents in 2006 to zero in 2008.

The establishment and consolidation of the Orthopaedic Physiotherapy Screening Clinic has seen selective patients being appropriately managed non-operatively, reducing the load on the orthopaedic service. This model of service is being adopted by other institutions in Queensland. Such an initiative is commended.

Surveyor's Recommendation:

Function: Clinical **Standard:** 1.5
Criterion: 1.5.1 Medications are managed to ensure safe and effective practice.

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

Surveyor's Comments:

It was noted that medication error minimisation systems, as proposed nationally, were in place in all facilities in the District using tools such as competencies assessment and reporting of errors in a non- threatening manner.

It was identified that there was a reporting/notification format through to the District Director of Pharmacy level, who reports on issues involving pharmacy and medication management. In each facility, reporting through PRIME, incident reporting on such issues as medication error rates, adverse reaction rates, errors in prescribing along with results of medication audits, provided valuable information on incidents and near-misses. At the time the PRIME reporting audit revealed a plateau in reporting, the focus on observational audits to monitor correct medication administration was introduced. The observational audits are based on the national handwashing audit tool which had been so successful.

Clinical risk management meetings were found to have matters relating to medication management on the agenda and action was taken to address issues raised.

Some examples of creative ways of safely managing medication administration in the ward areas at Ipswich were:
• Introduction of medication safety vests with the intention that on a medication round the administrator of medications was not to be disturbed;
• Door signage on the dangerous drug cupboard door indicating a count was in progress and not to enter.

The national medication chart has been introduced and audits of compliance identified some areas of non-compliance in low risk areas of the chart only. These charts are on a continuing review program. In the area of dispensing at Ipswich, as a result of the employment of additional staff in the pharmacy department, efficiency in the time to dispense discharge medications was noted.

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Access to mobile lap tops in the ward areas, especially in the medical business unit, has enhanced the service delivery. Access to electronic MIMS and guidelines for administration was found to be available in each area to ensure compliance with policy. The satellite pharmacy had created efficiencies, and standardised stock on shelf in all areas so as to minimise errors was noted as a significant risk minimisation initiative.

Drug calculation scenarios and self-directed learning packages provided evidence that every effort had been made to assist in accuracy of administration and medication management. Medication charts at Ipswich were found to be reviewed and improvements made as a result of audit findings. Errors, near misses and adverse drug reaction analyses and trending were also attended. The distribution of medications at Ipswich was managed by pharmacy and the service was evaluated and improved as required. The same could not be guaranteed in other hospitals of the District. Recommendations will be made to assist in overcoming this obvious deficit in the system.

In the smaller rural facilities the pharmacy is managed by nursing staff and there is a need for pharmacy support visits to each site to monitor operations, including stock control, and to audit the integrity of the discharge medication processes and record keeping. Drug refrigerators in rural facilities were not routinely fitted with alarms to identify loss of temperature.

At Kingaroy, it was apparent that the process for the administration and ongoing clinical management of patients on opioid maintenance, such as methadone and buprenorphine, could be enhanced with advice from Pharmacy and Alcohol, Tobacco and Other Drug Services (ATODS). Medication management in some of the mental health units was noted as less than ideal and this is addressed in the Mental Health In-depth Review Report.

This criterion is to ensure that medication practices are in place to ensure safe and effective practice. In terms of The Park, the organisation has no systematic auditing process to help determine that medication is managed safely and effectively. An audit of medications in the service is generally conducted only once a year. Additionally, the pharmacists on campus have little time to provide clinical pharmacy services on the ward, such as attending ward rounds or providing education to consumers or their carers.

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

(i) A pharmacy consulting service be provided to those rural facilities without a pharmacist and where the pharmacy service is provided by nursing staff.
(ii) The system for reviewing medication incidents and management practices be enhanced to ensure that there is always feedback to staff on outcomes of the reviews.
(iii) Specialist advice on appropriate protocols for the administration and ongoing clinical management of patients on opioid maintenance at Kingaroy be sought from Pharmacy or Alcohol, Tobacco and Other Drug Services.
(iv) Drug refrigerators be fitted with alarms to identify loss of temperature.

Mental Health

(i) The Park Campus develop a system for monthly auditing of medication in each program area.
(ii) The Park Campus develop a system for reviewing any trends discovered from the audit and developing a plan for improving performance in identified areas.
(iii) The Park Campus review the utilisation of pharmacy time to enable clinical input at ward level.

Risk Rating: Moderate

Risk Comments:

There is a moderate risk to patients in the absence of a robust audit of medication management.

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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 health care workers.

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

Surveyor's Comments:

The Infection Control District Management Plan Version 2.0 (August 2007) is based on the State plan and provides the overarching standard for the infection control program. The infection control program was guided by policy available on the hospital intranet site with the usage yet to be ascertained, although through communication with staff over the period of the survey, the survey team was reassured that staff did and could access the intranet site easily.

The change from controlling infections to prevention was the focus of the staff driving the program and they were supported by management as all recognised that where prevention is not possible, infections are managed effectively.

The District infection control program has support provided from the team at Ipswich Hospital with link staff on outlying sites. This team guides infection control management, conducts consultancies as required, evaluates clinical practice, provides surveillance and education (including ICMP), updates the infection control manual, oversees and monitors the business planning, is in charge of the annual reporting, the intranet update, and staff health (flu vaccination and MMR offer). Team meetings are held weekly for information sharing and networking.

There is effective management of patients with multi-resistant organisms so as to have minimal transmission or infections at Ipswich, with accommodation provided in the isolation area. The protocol for MRSA swabbing each Tuesday on the surgical ward was reported as effective in minimisation of the spread of infection, and the policy for the management of patients with MRSA on admission was mandatory.

There was evidence of a program available for the prompt and effective management of infectious outbreaks.

Pandemic influenza training occurs for all staff, with pre-reading and a video provided to the education program. Benchmarking results are published in CHRISP and the ACHS clinical indicator report. All are positive to sound practices for infection management District-wide. A review of antibiotic usage with a restriction policy was highlighted in the resident medical officer information handbook and at orientation. Pharmacy is involved in the monitoring of Vancomycin usage.

The hand hygiene campaign which commenced in 2004 has been very successful. Unit champions number 300 (10% of all staff). Volunteers, chaplains, work experience and students are all included in hand hygiene education, the flu vaccine program, ongoing education, and pandemic training. A review of the very important areas of CSSD, operating theatres, catering services and housekeeping provided evidence of adhering to policy. The use of single-use equipment was found to be in place in all hospitals throughout the district.

It was noted that in the nursing review of Surgical Services – Kingaroy Hospital - April 2007 *Central Sterilising and Supply Department Action Plan*, the priority 1 recommendations have been partially addressed with the washers ordered and the performance qualifications of the sterilisers attended, and temporary arrangements made to meet the recommendations.

Good procedures were noted to be in place at wards, and there is external storage to ensure that waste is identified and disposed of to ensure minimal risk to staff and external contractors. All staff consulted were aware of, and had undertaken, inservice on infection control procedures pertaining to waste management including the handling and transportation of soiled linen.

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

Alarm systems for refrigerators in outlying hospitals to denote a power loss be implemented.

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Function: Clinical **Standard:** 1.5
Criterion: 1.5.3 The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy.

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

Surveyor's Comments:

Assessment for pressure areas on admission, or when observed or reported as hospital acquired, was attended District-wide with a comprehensive awareness and prevention program. The assessments were undertaken across the District and guided by policy, with the program extending to the patient during surgical procedures in the operating theatres where pressure relieving devices were available.

Audit results are circulated and education is very willingly provided by a highly motivated team. A comprehensive and extensive equipment register is available and well maintained, and a replacement program for ageing/damaged equipment is apparent.

Changes in services which indicate improvement were dedicated resources (staff and equipment) to minimise the incidence of pressure ulcers and effectively manage pressure ulcers when they do exist, education to the general public and, in the Emergency Department, the purchase of safer trolleys, better suited for nursing elderly patients along with education of staff in the safe management of patients in the Emergency Department with mobility problems. Improvement was noted in the storage of mattresses and pressure relieving devices. *Waterloo Mondays* is an innovative program for regularly and routinely revisiting the pressure ulcer assessments.

The full time position of stoma/wound and pressure ulcer management at Ipswich Hospital has a District focus and a network with regional/national hospitals, domiciliary services, nursing homes, general practitioner pracices and the Flying Doctor. Distance consultation via photos of problem wounds and stomas (with consent) on email is well utilised.

Pressure ulcer statistics validated through PRIME for ACHS clinical indicators six monthly were found to be positive for sound assessment throughout the District. The guidance from Queensland Health is prescriptive and has been well adhered to in all facilities.

Surveyor's Recommendation:

Function: Clinical **Standard:** 1.5
Criterion: 1.5.4 The incidence of falls and fall injuries are minimised through a falls management program.

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

Surveyor's Comments:

Evidence was found of the implementation of the standard falls prevention strategies and auditing processes in Ipswich and the outlying facilities. Falls documentation and assessment and falls injury data are reviewed, and analysis is conducted and reported at unit levels on a regular basis. As a result of the very comprehensive education and awareness program a decrease in falls has been recognised.

The District program was found to be guided by a State policy with a local “draft” policy available and still under review. The falls assessment tool is still in its infancy and is used in all areas of the hospital, except the children’s ward, where it is considered not relevant. A mobility assessment program in the Emergency Department is used to identify those patients who are at high risk of falling.

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The District roll out of the Ipswich program with a dedicated coordinator is yet to be attended although, in the interim, the sites are adhering to policy. At ward levels it was recognised that a resource person was dedicated to promote falls risk assessment.

There was evidence of the development of falls reduction and promotion resources in self-directed learning packages and a day set aside to revisit the program annually, April Falls day (1 April).

To prevent falls from occurring, brochures and health promotion (refer to criterion 2.4.1) from Queensland Health are circulated to patients, carers and staff. Check lists for compliance and emphasis on safe footwear (brochures) were available and distributed. Prevention of injury from a fall is evident in the risk minimisation initiative called the "Bee Safe" program. This 5 bees program has been very effective in spreading the message. On review of the menu and the content, it was apparent that optimising nutritional status is recognised as a standard strategy for falls prevention, along with maintaining a safe environment.

The audits to determine compliance with the falls program are positive and provide evidence of success. The opportunity to benchmark results over time, given the sound platform now present, is apparent.

Surveyor's Recommendation:

Function: Clinical **Standard:** 1.5
Criterion: 1.5.5 The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.

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

Surveyor's Comments:

The pathology service is responsible for the collection, prescription, safety and appropriateness of blood component therapy. This service is also responsible for the analysis and reporting on disposal rates of blood products.

The link to appropriateness would be enhanced by the review of utilisation and performance indicators as provided by Auslab on wastage. A policy is in place to cover the transport, storage, ongoing monitoring and management of blood. The consent process, until recently, has been through the generic hospital-wide consent forms. The introduction of a statewide consent for blood form is to be introduced (refer to criterion 1.1.3). Evidence of evaluation of the safety and appropriateness of blood component therapy was not apparent, although the tools and data were available on the system.

Staff in all areas of the hospitals District-wide who administer blood and blood products are guided by policy and are assessed for competency.

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

(i) A blood management system which monitors and reviews the prescribing of blood and blood products to ensure appropriate practice be developed.
(ii) An education program for clinical staff on appropriate practices for prescribing blood and blood products be developed and implemented.
(iii) The maximum blood ordering schedule (MBOS) dated 1995 be updated.

Risk Rating: Low

Risk Comments:

The system for the prescription and use of blood and blood products does not provide the level of monitoring and review which would be expected in a contemporary system. There is nothing to suggest that practices are

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inappropriate but neither is there evidence to demonstrate that practices are appropriate. Without appropriate monitoring and review there is an element of risk which is considered, at this stage, to be low.

Function: Clinical **Standard:** 1.5
Criterion: 1.5.6 The organisation ensures that the correct patient receives the correct procedure on the correct site.

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

Surveyor's Comments:

Throughout the District, the correct patient, correct procedure, correct site and ensuring intended surgery (EIS) program was found to be very comprehensive and effective. Systems and processes were found to be in place to minimise the risk of error. Pre-operative policies and compliance with the national protocol were found to have been introduced, with education and awareness programs ongoing. The identification of patients, pre-operative polices and compliance with national protocol including the mandatory “time out” policy in the operating theatre and procedure rooms was introduced with education for all parties involved.

Evidence was found that there was compliance on paper and in practice with policies at Kingaroy and Ipswich where surgery occurs. Additionally, the District compliance audit at State level (reported in CRISP) provided reassurance of positive compliance for the District. The PRIME reporting system is used to report non-compliance with the policy and the use of the root cause analysis module was available to review non-compliance and improve. A local compliance audit using the State audit tool will again be conducted (observation audit) in September. The time for the State audit is yet to be confirmed. The District will contribute to the statewide (Queensland Health) project on applying EIS in the oral health setting in September.

The survey team was reassured that there was 100% compliance with ensuring intended surgery.

The photo identification included in the referral documentation for methadone patients was one example of the correct patient, correct procedure other than the intended surgery model. Additionally, a process was introduced for patient identification with a coloured arm band applied early in the Emergency Department at triage so that the patient is properly identified and, in so doing, minimising the risk of an incorrect procedure, test or intervention especially for the aged. Much good work had occurred in this very important area of safe care and services.

Surveyor's Recommendation:

Function: Clinical **Standard:** 1.6
Criterion: 1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service

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

Surveyor's Comments:

Queensland Health is committed to community and consumer input into health service planning and operations. It has produced a ‘toolkit’ of effective ways to facilitate such input. The health service demonstrates its commitment to consumer input through its action to engage consumers in various ways and at different levels within the organisation.

At the governance level, the organisation has set up two Health Community Committees which represent the north and south areas of the District. The role of these committees is to monitor the safety and clinical performance of health services, as well as feed into the system community input and wishes. Minutes of these meetings reflect information on activity and performance within the District, but do not reflect any discussion by members or decisions made by the committees. Such information may be beneficial and should be considered. Consumer input and

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feedback occur via a range of involvements such as participation on the Patient Safety and Quality Council and the Occupational Health and Safety Committee, and involvement in strategic planning days, along with consultation when developing the demand management strategy for the District. Other mechanisms for consumer input are reference and focus groups, local liaisons with community representatives in smaller centres such as Boonah, Laidley and Esk and centres in the South Burnett area. Liaisons with indigenous people in Cherbourg were positive. The maternity service has extensive community involvement in assisting them to develop and promote their new model of maternity care.

Feedback mechanisms, such as patient satisfaction surveys and their evaluation, along with complaints management processes, are used to ensure valuable consumer input. The organisation is currently awaiting results from their latest organisation-wide patient satisfaction survey for feedback from the public on their perceptions of their hospital experiences. The survey, undertaken in February 2006, indicated that strategies should be developed to elicit feedback from the patients at the hospital level on their degree of satisfaction. An action plan on such strategies was subject to a recommendation in the last Organisation-Wide Survey, but it does not appear to have eventuated.

Feedback from the public in the form of compliments and complaints is registered and data collected and provided to management and the Health Community Committee. The complaint management system aims to provide feedback and close off complaints within 35 days.

Evaluation of the input by consumers could be strengthened to give management an overall picture of the degree of involvement, the outcome of that involvement, and feedback to the community on the extent of community involvement. Acknowledgement of the involvement does occur at special recognition ceremonies at the various hospital and community facilities within the District.

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

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.

Mental Health

(i) Data collection be reviewed by consumer consultants to record outcomes, strengths and weaknesses (Rehabilitation Team at The Park) so that their service and performance can be evaluated and opportunities for improvement identified.
(ii) Consultants in the Adult Mental Health Unit be provided with training to enable them to explain adult guardian and official visitor services.

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

Surveyor's Comments:

Queensland Health produces a poster and pamphlet outlining the rights and responsibilities of consumers of the public health system. This document was published in 2002, and there does not appear to have been any revision or revised document since then. The pamphlet now contains inaccurate information and it does not refer to the Health Quality and Complaints Commission, which is a right for consumers of the health system to access when they have a concern about clinical care. Health services have code of conduct training, and information kits and pamphlets in order to guide their behaviour as well. There is a system for capturing complaints by consumers, and each health facility has a designated person or team to take complaints and manage the process of recording the complaints on the PRIME incident reporting system. Action is then taken to address the concerns within a 35 day turn-around period where possible. There seems to be good compliance with ensuring that clients and patients were aware of the rights and responsibilities issue either by posters on desks, counters or walls, pamphlets in admission packs and bedside lockers, and reference to rights embedded in the surgical consent forms.

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

Queensland Health be approached to review and republish its Rights and Responsibilities pamphlets and posters in order to ensure that the content is current.

Mental Health

The integrated mental health service's inpatient program policy on informing consumers/patients of their rights and responsibilities be reviewed to include the involvement of clinical staff in this process and the documentation of the process in the health record.

Function: Clinical **Standard:** 1.6
Criterion: 1.6.3 The organisation makes provision for consumers / patients from culturally and linguistically diverse backgrounds and consumers / patients with special needs.

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

Surveyor's Comments:

There is a Queensland Health 'toolkit' which includes Guidelines for Use of Interpreters. There is a procedural guideline document for use in managing cultural and linguistic issues. The District has appointed a coordinator for multicultural awareness, with one position at Ipswich Hospital and another at 'The Park'. These positions manage the interpreter services, and have resulted in improved coordination of interpreters and reduced costs as a result of booked interpreters being notified of cancellations in advance. It is hoped that the installation of the ISIS information system will result in improved data collection and evaluation.

The District has a number of groups which are culturally diverse, these being the indigenous, Samoan and Vietnamese communities. Liaison with the various groups assists in meeting their needs. Information sessions for staff on multicultural and interpreter services are provided. Information is included in orientation programs. As new facilities are built, the signage is constructed in accordance with standards to assist multicultural ethnic groups with international symbols and also the visually impaired.

In the special needs area, the maternity unit holds a monthly memorial service for bereaved parents or those who have lost an infant through miscarriage. This has been widely appreciated by those with the special need to grieve. The unit is congratulated for this service. Equipment to assist with the bariatric patient has also been purchased. Evaluation is basic, and further development of evaluation which measures whether the organisation is meeting the needs of those with cultural diversity and special needs consumers would enhance this service.

Surveyor's Recommendation:

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FUNCTION SUMMARY: SUPPORT

The West Moreton South Burnett Health Service utilises a District-wide approach to improving care and service delivery outcomes, which is coordinated through the Patient Safety and Quality Unit. The surveyors noted a high level of leadership and support from the District Executive and the Patient and Safety Quality Unit team for clinical and administrative staff undertaking a variety of improvement projects, which are referred to in the body of the report.

In general, quality activity projects appear to be aligned to strategic and operational priorities. It is suggested that a review be undertaken to ensure that this is the case across the District. The surveyors observed that with some activities there is a need to ensure that the quality cycle is completed. Staff undertaking improvement activities demonstrated commitment and spoke enthusiastically about their involvement, confirming that quality improvement is an essential part of the organisational culture. Staff are congratulated for their efforts and achievements. With the forthcoming amalgamation, the organisation has sound systems in place to sustain continuous quality improvement.

Whilst advocacy for risk management is evident in some areas of the organisation, there appears to be little clinical support across the District. The organisation will need to enlist clinician support in the promotion of quality improvement that has a risk focus. Local application of Queensland Health policies, PRIME and the complaints database ensure that information is available District-wide, with PRIME reports presented at relevant clinical meetings. Compliance with relevant legislation is evident with the inclusion of rural health facilities in the mortality audit, and the implementation of a three tier process.

Patient safety, quality improvement and complaints management are included in the District orientation program. Adherence to the principles of open disclosure is demonstrated, with some senior staff completing open disclosure education and a plan is in place for other staff to undertake education. The process for patients/clients to offer compliments and register concerns is well managed and improved with the establishment of Complaints Coordinators at Kingaroy Hospital which enables patients/clients to receive direct feedback.

The Human Resources Department (HRD) has stabilised under a permanent leadership/management structure for the past 12 months, after a protracted time of instability associated with the amalgamation of the new District. The surveyors were impressed with the enthusiasm and dynamic approach taken by the current HRD, particularly in response to, arguably, the major challenge to the organisation, namely the recruitment and retention of clinicians across the District, so as to maintain service provision. The HRD, in concert with Nursing support, has facilitated an array of creative and innovative programs and schemes that have been successful in recruiting and retaining staff in a very competitive market. The organisation is congratulated on these programs, which include local implementation of Queensland Health's Rural Return to Nursing Program, the On-boarding Project to provide a nurtured entry and ongoing support to new recruits from overseas and interstate, the Grow Your Own Health Employees, TAFE program at Cherbourg, which is targeting increased employment of indigenous health workers, and Health Employment Multicultural Equity and Diversity Project attended by 80 staff. Over and above these projects are the organisation's pervasive family friendly flexible work options which are clearly appreciated by both professional and support staff.

The development of a comprehensive workforce plan is a major objective of the HRD and to this end a special project officer has been employed to coordinate its development, which will have a time line of two years. The surveyors were impressed with the extensive preparatory work and research already undertaken to ensure that the plan is not a token exercise. A recommendation will be made to expedite this important planning process.

The HRD recently developed a new template for Performance Appraisal Development (PAD) and a roll out of training for managers was undertaken up until February 2008. Evidence provided to the surveyors indicated that this is one area that needs to be energised and assertively promoted as the current take up of PAD is relatively poor, with the notable exception of the Nursing Department at Ipswich Hospital which has an exemplary profile of successfully implementing the system. The surveyors were made aware of related issues concerning departmental access to the current registration and scope of practice of all health professionals, access to training, supervision and mandatory inservice for medical staff, particularly junior medical officers, and the implementation of the policy "Clinical Performance Concerns - Management of Senior Medical Staff". A number of recommendations are made to address these matters.

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The surveyors noted that the District does not have a comprehensive and viable learning and development plan, although some departments have exceptional, locally developed programs in place. An impressive recent initiative has been the allocation of nurse educator positions or sessions at rural sites. Generally, however, attendance at mandatory training is less than optimal, apart from fire training, and child protection is an undeveloped issue with respect to staff education. It was further noted that the functioning of the General Clinical Education Committee, which oversees the education and supervision of certain categories of the medical workforce, could be improved. Again recommendations have been made to ensure that each of these issues is appropriately reviewed and addressed.

The surveyors congratulate the District for ensuring that there is a comprehensive range of staff support systems in place across the District, the most notable being the Employee Assistance Service (EAS), provided by an external contractor, and the inhouse Workplace Equity and Harassment Officers (WEHOs), of which there are ten scattered across the District. These support services are the subject of regular review and evaluation and are clearly valued by staff, judged on their uptake. Much the same can be said of the workplace relations systems, which demonstrate their effectiveness by the relatively high level of staff morale noted and the good industrial climate pervading the District.

Data and information are captured effectively via a range of corporate systems, support care, and service improvement. The reports and data quality are evaluated through satisfaction surveys, benchmarking and audit tool application. In some of the rural services there has been an absence of feedback in the form of clinical indicators or other data that could be used to evaluate care outcomes. This has recently been rectified and staff were already using the outcome data provided. The recruitment of medical staff will also facilitate participation in clinical indicator monitoring.

Information technology services are part of Queensland Health's Shared Services. The integration of two Districts, West Moreton and South Burnett, has required the information technology and information management systems and their overall management to integrate. There was evidence across the District that this was being done in a manner that was supporting management and service delivery. An issue of varying access to personal computers across the District was noted and it is recommended that steps be taken to establish staff/personal computer ratios for use across the District.

Overall this standard has been comprehensively addressed but the recent integration of two districts into one has caused some inconsistency which will be addressed in time.

A number of staff were involved in health promotion strategies, and the survey team was encouraged by the innovation that has been shown and commitment to improving health and services in some challenging situations.

There was evidence that the Population Health Service contributes to a number of interventions as well, which provides overarching support across the District and a framework for process, while still allowing changes to the model to reflect community needs.

It was evident that the Population Health Service focuses on primary prevention strategies, while the Health Service District focuses on secondary and tertiary interventions. Some key initiatives which were noted for their achievements, notwithstanding others, were the national bowel and breast cancer screening programs, enhancing the health of mothers, infants and children such as the Cherbourg Health pregnancy project, promoting healthy weight by supporting the lighten up to a healthy lifestyle and living strong programs, vaccination and immunisation programs, Cherbourg's program for the management of diabetes, the commencement of regular health promotion segments on the local radio to increase knowledge and awareness of health issues and related service options in Cherbourg, mobile women's health service to improve the uptake of pap smears in more remote areas, evidence-based programs for chronic conditions and monitoring rate of re-presentation by the community health nurses, and the SNAP project, which is a general health screening and early intervention model. Cherbourg was also noted for its consumer participation in the development of its strategies.

It is suggested that staff involved in the implementation of these health promotion initiatives be more involved in the development of performance indicators, and associated collection and analysis of data to further inform clinical outcomes and service planning.

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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: EA **Surveyor rating:** MA

Surveyor's Comments:

A variety of patient safety and quality improvement activities is demonstrated throughout the District.

A number of different templates are utilised for recording minutes of meetings. A single standardised outcome-based template would ensure consistent quality across the District. Whilst the development of the QASAR database has improved the recording and reporting of improvement activities, staff evaluation of this tool would identify areas for improvement.

The development of the Venous Thromboembolism and the Falls Prevention Programs prior to extending District-wide is an excellent initiative. Improved patient and staff satisfaction has been identified with the implementation of the clinical handover process. The reduction of the number and severity of hospital acquired pressure ulcers has been achieved through improved incident reporting, auditing and staff education. The Birth and Beyond Program offers women the opportunity to receive antenatal and postnatal care at home or community centre. A multidisciplinary team ensures that 'at risk' patients are reviewed, with all necessary investigations carried out prior to admission. The surveyors noted that there are no existing performance indicators for the Department of Medical Imaging. It is suggested that relevant indicators be developed to monitor, review and evaluate service.

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

(i) A standard, outcome-based template be developed for recording minutes of meetings, to improve the quality of minute taking across the District.
(ii) An analysis of the QASAR database be undertaken to identify users' perceptions, needs and level of satisfaction and make improvements as required.

Mental Health

A systems approach to the mental health sector quality improvement activities be developed, including the many current audits, to be applicable for a specified time frame, developed in consultation with staff and consumer staff members and evaluated for progress on a regular basis.

Function: Support **Standard:** 2.1
Criterion: 2.1.2 The integrated organisation-wide risk management policy and system ensure that clinical and corporate risks are identified, minimised and managed.

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

Surveyor's Comments:

The District utilises the Queensland Health risk management system and QHRisk, to manage risk but there are opportunities to improve its implementation across the District. Risk identification is reactive through using specific incidents to identify opportunities to develop risk reduction strategies. A proactive approach to identifying risks should be explored with (where necessary) staff training to assist in risk identification. The District's risk register which exists in QHRisk identifies, almost exclusively, risk at a District level. Risk identification and registration would be enhanced if responsibility was devolved throughout the organisation's structure, beginning with clinical and corporate business units and working down through wards and administrative units. QHRisk and PRIME are difficult to locate on the intranet and input to these systems may increase if they are easy to locate. A review of the location of the links/icons to these programs may simplify staff access and promote a shared responsibility and management of risk, complaints and incidents.

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There is little apparent medical clinician leadership in risk management, which is reflected in the poor attendance of consultant medical staff at the District Patient Safety Committee, the District Drug and Therapeutic Committee, and the General Clinical Education Committee. The District Patient Safety Committee has no medical consultant membership and clinical issues are referred by the chairman (EDMS) to the Medical Advisory Council, however, there is no standing agenda item on the Medical Advisory Council for clinical incidents/complaints, nor are the minutes of the Patient Safety Committee tabled at the Medical Advisory Council.

Staff across the West Moreton South Burnett Health Service District mental health sector are aware of their responsibilities for managing risk and do so through communication and consultation. The risk management policy is District-wide, executive endorsed, addresses clinical and corporate risks and is available to staff electronically. The policy is based on the Hunter Valley framework and is detailed and in parts specific about processes.

The current risk management framework identifies risks, analyses, evaluates and treats them but there is a lack of evidence of site specific monitoring, review on a regular basis and communication of reassessment to the relevant site staff, committees and persons responsible as articulated in the policy *West Moreton South Burnett Health Service District Clinical Governance Operational Plan* and the *Risk Management Plan*. The risk register is centrally managed and again, access or full engagement by site-specific staff is not demonstrated.

There are specific committees for clinical risk management but the evidence of effective functioning or impact of the committees was not demonstrated. The corporate risk management system is inclusive of all sites but the interface between sites and the District process is not clearly demonstrated as providing effective bottom-up and top-down communication and follow-up.

The many audits, both clinical and corporate, completed across the sites are compliance directed and there was little evidence of a collective approach to the coordination of, purpose of and outcomes that improved safety or quality. Staff did report that they could initiate an action related to risk, had some control over response to an identified risk but were unsure of who in the risk management framework held overall responsibility for any incident follow-up.

The recommendations for root cause analysis and HEAPS (local investigations) are recorded in PRIME and do come to the Patient Safety Committee, however, there is not a demonstrated control over the actioning, timeframes and outcomes from them, with little if any detail recorded in minutes and an inability of staff, either directly involved or management, to articulate what was the outcomes of many of the HEAPS/root cause analysis recommendations. A system for the tracking of recommendation progress was not established.

There is an explainable reliance on the central patient safety process for monitoring but the effectiveness of the interface of District with the integrated mental health service, Kingaroy, Goodna and The Park was not established.

Trending and reporting of incident data occur and is reported to staff but there was, again, an ad hoc approach to engaging staff in understanding or using the aggregate data to improve care.

The following issues were notable:
The home visiting safety policy - *Home Visiting in the Community – PROWMSB20080258,* for mental health service community staff does not provide a formal requirement for completion or formal recording of home visiting risks for individual clients. There is an ad hoc approach by some teams to utilising the alert process to inform colleagues of identified risks. The policy is also not inclusive enough, for example, the recording of staff exposure to cigarette smoke/dogs.

<u>Advanced Completion in 60 Days (AC-60)</u>
An AC-60 was undertaken on the following recommendations from the In-Depth Review:
(i) An audit of the current control and tracking of the progress of the recommendations from root cause analysis and HEAPS be undertaken in the mental health service, and the focus be on ownership by site staff and leaders as well as the District system with the development of an identified pathway of open, two-way communication.
(ii) A formal and inclusive home visiting risk assessment process be put in place in the mental health service and evaluated.

<u>Action Taken by Organisation to Address Recommendation</u>
(i) An audit has been completed in relation to the monitoring and progress of RCA and HEAPS recommendations. This audit identified deficits in the RCA and HEAPS recommendation process. In response, the RCA and HEAPS process has been revised to include:
* Flowchart now includes the defined sequence of events and reporting processes which must occur for each

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RCA/HEAPS with particular reference to improved flow of communication for the Mental Health Service.
* An electronic and paper checklist has been implemented to monitor the progress of each RCA/HEAPS recommendation for completion and closure of the clinical incident.
* Feedback mechanisms to clinical teams have been revised and occur at Patient Safety Rounds, Mental Health Patient Safety and Quality Committee and relevant Mental Health Services committee meetings (ie Work Improvement Groups, Business Unit Management Committee)

Appointment of a Patient Safety Officer with the Mental Health portfolio, with a direct reporting line to the District Director Patient Safety and Quality and situated in the District Patient Safety and Quality Unit. The Officer is responsible for the management of the RCA/HEAPS reviews.

(ii) The District Home Visiting policy has been reviewed and endorsed at the District Executive Committee on the 14 November 2008 and is accessible on the District Intranet Site. The risk assessment tool has been widely consulted and reviewed to include environmental risks (cigarette smoke/dogs/weapons). An evaluation of the tool is underway and results will be available for the surveyors in December 2008.

Completion Due By: 15 December 2008
Responsibility: Executive Director Mental Health Service WMSBHSD

Surveyor's Comments
A database of all Root Cause Analysis and HEAPS recommendations since 2008 has been compiled, their implementation tracked, and those which have not been implemented have been identified and are being followed up.

A system is now in place which will ensure that all recommendations are communicated to the relevant personnel and tracked for implementation.

A District-wide home visiting policy has been developed and implemented and is shortly to be evaluated for effectiveness through a new audit tool.

The Conditional survey team will need to confirm that the changes have been sustained, and this process will be facilitated if the District develops and collects some relevant performance indicators to demonstrate the effectiveness and sustainability of the changes.

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

(i) The role of clinical leadership in peak committees which consider risk be reviewed to ensure that there is sound medical input into the risk management system.
(ii) A proactive, multidisciplinary approach be developed for the identification of risk to enhance the existing system, which relies heavily on incidents to identify risk.

Function: Support **Standard:** 2.1
Criterion: 2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.

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

Surveyor's Comments:

Processes are in place to ensure that there is systemic analysis of incidents and complaints, with results reported at relevant committees. The inclusion of all HEAPS SAC 2 events for review has made this process more robust.

Whilst business units hold risk management meetings to review incidents and complaints, the surveyors noted that incidents/complaints are not a fixed agenda item for all departmental meetings. It is suggested that all departments include incidents and complaints as a standing agenda item.

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A number of senior staff have attended open disclosure training and a plan is in place for other senior staff to undertake this training.

Brochures and posters detail the process for patients/clients to give compliments and raise concerns. Responsibility for the management of complaints and clinical incidents has been delegated across the District. The appointment of Complaints Coordinators at Kingaroy Hospital and a dedicated phone number for client accessibility is an excellent initiative. A high majority of complainants receive feedback within the policy timeframe.

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

Mental Health

(i) The requirements for client follow-up and support post-incident be reviewed and formalised.
(ii) The Peer Support Program be evaluated for effectiveness of staff participation rates as measured against its aims and objectives.
(iii) An evaluation of the rate of incident reporting, clarification of incident types and an assessment of staff understanding and use of the PRIME system be undertaken.
(iv) The current complaint management process be broadened to capture first line complaints from all sources.

Function: Support **Standard:** 2.2
Criterion: 2.2.1 Human resources planning supports the organisation's current and future ability to address needs.

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

Surveyor's Comments:

Prior to the appointment of the current Director of Human Resources, human resources leadership was fragile as there was a lengthy period when the position was filled on a temporary basis and the status quo was being maintained. In the past year, the amalgamated District Human Resources Department has been subject to a restructure and the Director has initiated a change management process using multiple projects (eg Health Employment Multicultural Equity and Diversity Project, the "Untapped" Migrant and Refugee Labour Market Workforce Partnerships Initiative) and has devolved recruitment to the business unit. There are plans endorsed by the District Executive to establish a Strategic Recruitment Unit within the Human Resources Department, and for the latter to have a focused planning and policy function. Once the restructured Human Resources Department is bedded down, the priority issue will be the development and implementation of the District workforce plan that will have a timeframe of approximately two years. This process has begun with a major presentation to the executive, outlining the current workforce issues confronting the organisation and the strategies to be included in the plan to address these issues. A Workforce Strategy Project Officer has been appointed to coordinate the development of the plan, and workforce issues have been included in the District 2008/09 Operational Plan, the progress of which is regularly reviewed by the executive. This component has the status of an interim workforce plan, and includes the Human Resources Department providing a viable human resources service and ongoing support to the smaller rural facilities, and promoting a multi-faceted staff retention strategy. The latter includes "emotional intelligence" training of Nurse Unit Managers and clinical nurses and a progressive needs assessment across all facilities, resulting in incrementally improved staffing mix/establishment for many services (eg new oral health therapist, upgrading of radiographers to be recruited, increased employment opportunities for health workers from a culturally and linguistically diverse background).

The interim workforce plan is informed by the Southern Area Health Service Workforce Plan 2007-2012, which was extrapolated from the Queensland Health Peoples Plan 2007-2012. The key elements of these policies being implemented by the District are the creation of a positive workplace culture through empowerment of departmental managers, the minimisation of bureaucratic barriers, and attracting and retaining people.

Consultation with a range of staff representative groups (eg consultative network involving industrial associations, Public Hospitals Oversights Committee, Medical Workforce Strategy Committee) about the major elements of the interim and proposed workforce plans has been undertaken.

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Consultation with the allied health departmental heads indicated that as a result of protracted negotiations with the District Executive, agreement had been reached to fund and establish a new position of Director of Allied Health Services to sit on the District Executive. The organisation is encouraged to promptly recruit to this position as soon as the recently announced amalgamation with the Toowoomba and Darling Downs Health Service District is finalised.

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

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).

Function: Support **Standard:** 2.2
Criterion: 2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.

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

Surveyor's Comments:

The District has well established protocols in place for the recruitment, selection and appointment of new staff that are based on Queensland Health templates and guidelines. With the devolution of responsibility to departments for their respective staff recruitment and appointments, the organisation's Human Resources Department has developed a recruitment pack that contains guidelines and forms that departments are to access when they recruit staff. This information pack has been subject to regular evaluation and refinement. Professional departments (medical, nursing, allied health) ensure that recruited staff have their necessary licences, registration, qualifications, skills and experience and, prior to final offer, the Human Resources Department checks that all procedures have been appropriately followed.

The work of the Nurse Support Unit in facilitating an optimal recruitment and retention service for nursing staff is very impressive, and the surveyors congratulate the staff of this unit for their sensitive, respectful and creative approach to this endeavour.

The Ipswich Hospital Foundation has developed a policy and orientation program for volunteers which has been endorsed by the executive. The surveyors noted that volunteers provide an invaluable fund raising and health promotion service to the organisation, particularly in the smaller rural communities and their contribution is highly valued by the District.

The organisation has a very impressive day long orientation program for all new appointees and this is facilitated by a comprehensive orientation manual, which is regularly updated and evaluated. The surveyors noted that the orientation process had recently been revised and refined to focus on core and mandatory requirements.

The District has identified a number of performance indicators which reflect the effectiveness of current recruitment, selection and appointment systems. These include criminal record check turnaround (benchmark 72 hours), utilisation of agency nurses and number of medical vacancies. The organisation is congratulated on the success of its recruitment of overseas medical staff through the "Area of Need" program, and for its participation in the Queensland Country Relieving Doctors Program. The latter includes the provision of an information kit (compact disc and relevant information regarding protocols and clinical support) and was developed as part of the Southern Area project on emergency department medical workforce. The surveyors noted a local outcome of this strategy at Kingaroy Hospital which now has in place its full medical establishment of seven doctors.

The District recruitment system has recently been adapted by using the internet to advertise positions, and plans are in place to utilise You Tube for targeted recruitment.

The Human Resources Department has collaborated with departments to review their respective staff establishments when there are indications that the current staffing mix or complement is not meeting service needs. Examples of this process include the establishment of an administrative officer position for triage on the afternoon to evening shift at Ipswich Hospital Emergency Department, the recruitment of casual physiotherapists to work after hours and on

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weekends in the intensive care unit, increase in the number of staff surgeons at Ipswich from two to three, and the employment of assistants in nursing in the acute setting of the Child and Family Health Service.

The District is congratulated on successfully initiating a comprehensive range of creative recruitment strategies which includes:
i. The Rural Return To Nursing Program;
ii. The On-boarding Project to facilitate a nurtured entry into the service for new staff from overseas and interstate;
iii. The Grow Your Own Health Employees Program at Cherbourg which provides a TAFE diploma course in nursing for local indigenous people;
iv. The Health Employment Multicultural Equity and Diversity Project.

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

Mental Health

(i) The equity of access of allied health students to current under and post-graduate placements be reviewed together with the impact of any inequity on future allied health workforce recruiting.
(ii) The effectiveness and sustainability of the current preceptorship program be evaluated with a focus on its ability to support students in what is a multidisciplinary service model.

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:** SA

Surveyor's Comments:

The Performance Appraisal Development (PAD) system has been recently reviewed and updated in consultation with staff representatives and industrial associations. The outcome has been the development of new templates for position descriptions, now called role descriptions, and a revised protocol which includes sections for the employee to receive both positive feedback from management on their performance over the past year and to identify their goals for the coming year, and to provide management with their record of attendance/participation in mandatory training. The PAD protocol facilitates a two-way negotiating process between employee and management and, apart from providing the opportunity for the employee's role description to be updated, also includes a "career coaching" component whereby the training requirements/needs of the employee are identified and an agreed annual educational/training schedule is documented. This component ensures that the employee's goals and educational program are aligned with the needs and goals of the organisation.

An electronic database (Lattice) is maintained and documents when an employee has participated in the PAD process. Queensland Health monitors this database and provides the organisation with a status report with respect to the local implementation of PAD. The latest report indicates a less than satisfactory uptake and this is in part due to rural services not recording PADs in Lattice. A recommendation will be made to address the issue of less than optimal uptake of PAD in all departments other than Nursing at Ipswich Hospital, which has an exemplary record in this regard. The surveyors noted that some departments did not acknowledge that PAD was mandatory.

The surveyors noted further that there was relatively poor attendance of medical staff at educational inservices and mandatory training sessions. It is noted that some health services ensure that medical staff have "protected time" for their education and training, ie they do not need to be on call during these sessions. A recommendation will be made to address this specific issue.

The District has recently evaluated and updated its complaints policy and associated protocol, which reflects and meets the requirements of the Queensland Health Complaints Policy. It is required to report on all non-clinical complaints or reported concerns about staff, which usually involve alleged breaches of the code of conduct and/or professional code of practice, to Queensland Health and to provide regular reports on the local complaints management process and its outcome. Staff under investigation are also provided with regular reports to ensure that the process is fair and transparent.

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The surveyors had access to the District Policy and Procedure "Clinical Performance Concerns-Management of Senior Medical Staff" which was updated in August 2008. It was noted that the policy required that the clinical concerns triage meeting annually review the revised procedure. The surveyors suggest that this review process be formalised and that a report of the review be forwarded to the District Executive to oversee and ensure that the evaluation is robust and transparent.

Professional departments (medical, nursing, allied health) have systems in place which ensure that all clinical staff employed maintain their professional registration. There is an issue, however, in some rural services where Site Managers are not formally advised of the registration status and scope of practice of junior medical officers rostered for a ten week rural relief term when general practitioners are on leave or positions are vacant. In many instances these doctors do not have access to on-site medical supervision. It is possible that this situation places both the patient and junior medical officer at some risk from less than optimal clinical judgement.

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

(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.

Risk Rating: Moderate

Risk Comments:

Some of these recommendations have the potential to be a low to moderate risk to the organisation, both with respect to patient safety and corporate reputation, if they are not implemented. It is important that the District address each of these recommendations to ensure that service provision is of optimal quality and that patient safety is a primary organisational objective.

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:** SA

Surveyor's Comments:

The District does not have a coordinated, comprehensive learning and development plan. There is a plethora of learning opportunities organised by departments to upskill their staff and these initiatives are impressive. The interim "Workforce Plan" contains some educational programs but these are focused on workforce-related issues.

The organisation's generic Learning and Development Department is minimally resourced and is located within the Human Resources Department. This mini-department arranges a number of training/educational programs (eg monthly one day orientation, monthly one day recruitment and selection training, bi-monthly cultural awareness training, PAD training up until early 2008) and coordinates a range of educational initiatives, including assistants in nursing traineeships, indigenous enrolled nurse cadetships, work experience students, the Administrative Officer Professional Program, Working Together Clinics, the Certificate IV in Business (Frontline Management) TAFE course run at Ipswich Hospital and the processing of SARAS (Study and Research Assistance Scheme) applications. The latter is a scheme whereby staff can apply for financial or other assistance to enrol in external courses.

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The organisation's Nurse Education Department offers an extensive array of nurse educational programs which are tailored to the needs of nurses in various departments. These are developed in response to either legislative or credentialling requirements, or informal channels of feedback from units. In all cases, upskilling of nurses is the objective. An impressive recent initiative at rural sites is the allocation of nurse educator positions or sessions to provide enhanced and increased training in mandatory and other courses for all staff based at these sites.

It was noted that the General Clinical Education Committee which oversees the education and training of post-graduate medical students and international medical graduates did not hold monthly meetings between September 2007 and May 2008 and that the Manager Medical Education position was vacant for the seven months until an appointment was made in May 2008. It was further noted that attendance by consultant and junior medical staff was poor when the meetings did occur. The surveyors regard these issues as unsatisfactory as they compromise the accreditation status of medical students.

Child protection training and management of related issues in the rural centres could be significantly improved. It is suggested that the District establish a mechanism to increase awareness of child protection issues to address this need. The surveyors identified a further training need, namely in evaluation methodology for projects and programs that are established or developed locally. It is suggested that the Learning and Development Department conduct a needs assessment as part of its development of a generic staff development plan.

The surveyors were provided with a profile of attendance at the organisation's mandatory training program and it was noted that participation was not optimal, apart from that for fire safety training. The District has a policy and procedure on "Mandatory Training" but at this time there is not a formal organisational response to encourage improved attendance at these sessions.

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

(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).

Mental Health

A review of the District Mental Health Education Service provision to all sections and disciplines of the mental health sector be undertaken and a plan of action be developed for equitable delivery of education including the resource capacity to deliver.

Risk Rating: Low

Risk Comments:

The issues are assessed as having low risk potential to the organisation's reputation and patient safety.

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

Surveyor's Comments:

There is an Employee Assistance Service (EAS) provided by an external contractor. The service contract is reviewed every six months for its utilisation and effectiveness using several performance indicators, and is assertively promoted across the organisation by the placement of posters and brochures in prominent positions (staff rooms).

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The EAS is also utilised as part of performance development programs in special cases, eg when a staff member is referred for a course in anger management.

Another employee support system is the appointment of selected staff as Workplace Equity and Harassment Officers (WEHOs). There are ten of these staff within the District and each has attended a three day training course and is mentored. They are staff who volunteer to undertake this additional responsibility in addition to their normal duties, which range from those of a District Manager to those of a registered nurse. Any member of staff can access a WEHO when they are rostered on duty. They report directly to the District Manager and a representative from the Human Resources Department attends all report-back meetings, at which de-identified issues are discussed.

The new PAD system has been specifically developed to motivate staff by acknowledgement of their personal contribution to the organisation. Every three years, the organisation contracts the University of Queensland to conduct a staff satisfaction survey which generates an action plan to address any areas of concern identified in the survey.

In early 2008 a group program for 110 managers on "Working Better Together" was conducted. The objective was to encourage managers to identify potential issues in the workplace before they became major problems. Feedback from the workshop became the basis of an action plan for the executive to implement that would hopefully raise the morale of staff across the organisation. Another initiative to nurture staff was arranging a train-the-trainer workshop on emotional intelligence for 85 managers.

The District has in place a two tier industrial consultative committee structure whereby each facility holds regular consultation meetings between management and union representatives concerning local or facility issues, and any unresolved issue is reported to the District Consultative Committee for resolution. This system is reviewed annually by the stakeholders and has been deemed an effective approach to establishing a cooperative workplace environment. The surveyors noted that an impressive contingency plan has been developed based on risk management, for the management of foreseeable industrial action that involved certain staff groups refraining from their allocated work for periods of time.

Flexible working hours, including nine day fortnights, a "working from home" option for eligible employees and breast feeding at work for mothers returning to work from maternity leave are available.

A number of performance indicators are in place to evaluate both staff support services and workplace relations, ie time lost in industrial disputes, staff satisfaction index, episodes of utilisation of the EAS.

The organisation is encouraged to benchmark its indicators on workplace relations to complement the current benchmarking of EAS indicators with comparable organisations.

Surveyor's Recommendation:

Function: Support **Standard:** 2.3
Criterion: 2.3.1 Records management systems support the collection of information and meet the organisation's needs.

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

Surveyor's Comments:

The standard of record management has benefited from a high level of effort in this area. The organisation has invested in the records management system and introduced improvements such as providing a ‘runner’ position, a Lamson Tube, H-record, and 24 hour staffing coverage for the department. The outcome has documented improvements in record accessibility and a reduction in lost charts. Performance improvement processes are carried out through the use of: satisfaction surveys, audit tools and outcomes evaluated against industry standards.

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At the Ipswich Hospital, there have been a number of improvements made in the area of patient record integration across the local services. There is also a flagging system to advise of charts held at other sites. While some of the rural services have also advanced the integration of patient records, others were found to be lacking record integration and flagging processes. Ensuring that all the relevant information is available to clinicians when making care-based-decisions is critical.

The standardisation of clinical forms is a priority for the District but is still a work-in-progress. It was noted that multiple forms and an apparent lack of control over the development of forms was causing concern, especially in the rural hospitals.

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

(i) The work to date on the integration of patient records across services and the flagging of records held at other sites be continued across the District.
(ii) The District's standardisation of clinical forms project continue to be implemented.

Function: Support **Standard:** 2.3
Criterion: 2.3.2 Information and data management and collection systems are used to help meet the strategic and operational needs of the organisation.

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

Surveyor's Comments:

Clinical documentation improvements have resulted from ongoing education of clinicians through a range of initiatives, such as coders attending grand rounds and meeting regularly with nurses and allied health staff.

There is an information strategic plan in place. Policies direct data collection and utilisation. There was linkage of data linkages and an excellent program of ongoing staff education.

External reviews of coding accuracy are undertaken and the subsequent recommendations are actively implemented. Audit reports indicated that the coding was of high quality and accuracy overall.

The data collected is evaluated. The satisfaction of management is audited and findings acted upon.

Surveyor's Recommendation:

Function: Support **Standard:** 2.3
Criterion: 2.3.3 Data and information are used effectively to support and improve care and services.

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

Surveyor's Comments:

The information management team is commended for the way in which it effectively and efficiently manages the huge amounts of information gathered via systems such as EDIS, ORMIS, HIBISCUS and many others and, via Transition 2, provides reports required by management and staff across the organisation in their strategic accountabilities.

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The quality of data and reports is monitored via business systems using benchmarks and key indicators. Access to data is managed via formal delegation processes. Customer satisfaction audits are undertaken annually. Ad hoc requests are managed via a request form and team evaluation processes.

Staff competency is managed via on-line education tools, competency-based training, processing manuals and check lists.

Surveyor's Recommendation:

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

Surveyor's Comments:

The statewide Information Technology Unit (ITU) is responsible for hardware, hubs, licensing and the network, and for integrity and support. There is a State Information Technology Plan (ITU). The ITU is also responsible for managing the phone system contract. The risk and crisis management systems are managed corporately but local needs are included. The ITU's District responsibility has been impacted upon in recent years by the integration of the two Districts and corporate information technology changes.

There is a District Information Technology Governance Committee which meets monthly. Its membership includes three senior clinicians. A staff satisfaction survey and an information technology training needs analysis survey is carried out annually. All personal computers are replaced every three years. Hibiscus is upgraded three times a year.

An excellent innovation, the Intellipos, has been implemented and its swipe card capability has streamlined the processing of clients at the patient kiosk and the staff dining room.

At Laidley, an electronic media resource room "the Hub" has been created adjacent to the ward area. It provides access to teleconferencing, personal computers, videoconferencing and fax equipment. This is a great resource for clinical and administrative consultation, eg twice weekly clinical case review which involves off-site pharmacy, allied health and senior medical officer at Ipswich. The development and use of "the Hub" is commended.

While the District strategic plan has elements of information technology, there appear to be significant issues emerging in relation to staff access to Novell applications, finance and human resource enterprise systems. There has also been an explosion in the growth of requests for mobiles and personal computers. Access and equity appear to be issues across the District with mental health, community health and the hospitals operating with different rules for personal computer/staff ratios. It seems that a planned approach addressing the local issues, including a budget and benchmarking of information technology service provision would enhance the resolution of the problems.

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

A District information technology plan (supporting the Queensland Health plan) be developed to address the local issues of information technology provision.

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Function: Support **Standard:** 2.4
Criterion: 2.4.1 Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation.

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

Surveyor's Comments:

There was evidence that the Queensland Government's Population Health Service contributes to the West Moreton South Burnett District's health prevention, promotion and protection program through the Southern Area Population Health Service. A multidisciplinary and multi-strategy approach is utilised to implement programs that are aligned with Queensland Health's strategic and statewide services plans and other related population health outcome and quality plans. The Health Indicators report provides the District with the ability to understand issues in the geographical locations. The Population Health Service focuses on primary prevention strategies, while the Health Service District focuses on secondary and tertiary interventions. Some key initiatives include the promotion of healthy eating and increasing the consumption of fruit and vegetables, national bowel and breast cancer screening programs, enhancing the health of mothers, infants and children such as the Cherbourg Health pregnancy project, promoting healthy weight by supporting the lighten up to a healthy lifestyle and living strong programs, and supporting vaccine service providers with expert advice and professional development, and undertaking surveillance of vaccination rates and systems. Feedback of vaccination programs is provided to the Health Service District so that comparisons with the national immunisation target of 95% can be made. These immunisation rates are trended over the last five years and compared across the District.

Other initiatives that were identified across the District include Cherbourg's program for the management of diabetes, and the commencement of regular health promotion segments on the local radio to increase knowledge and awareness of health issues and related service options. Cherbourg was also noted for its consumer participation in the development and review of these strategies, some of which were outlined in the 10 point plan.

Additionally, a mobile women's health service was established to improve the uptake of pap smears in more remote areas. This has resulted in a positive community response. A falls prevention program is currently underway. One strategy is the monitoring of older people who have had falls at home and referring them to relevant services, such as tai chi, for managing arthritis and improving core stability, occupational therapy services or rehabilitation, and subsequently monitoring if there is a reduction in falls. Community health nurses are running evidence-based programs for chronic conditions and monitoring the rate of re-presentations. Those patients who re-present are referred for individual or groupwork programs, as appropriate to their care needs. This has also been introduced to nurses in general practitioner practices, and initial data indicates that this has resulted in a reduction in re-presentations. A further research project with a health promotion framework is the SNAP project in the community, linked to research at Ipswich Hospital. This is a general health screening and early intervention model for individuals in the workplace, and referrals to appropriate health interventions/health promotion projects are made. This has resulted in improved health status for a range of indicators thus far.

It is suggested that staff involved in the implementation of these health promotion initiatives be more involved in the development of performance indicators and associated collection and analysis of data, to further inform clinical outcomes and service planning.

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

A suite of key performance indicators be established in consultation with relevant staff, to capture the outcomes of the health performance initiatives across the District and trend them over time.

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Function: Support **Standard:** 2.5
Criterion: 2.5.1 The organisation's research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research

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

Surveyor's Comments:

The survey team was impressed with the outstanding research programs of the Queensland Centre for Mental Health Research (QCMHR). The Centre is a demonstrated national and international leader in mental health research, having gained international recognition through publication in national and international peer-reviewed journals, citations in texts and journals, and multiple collaborations with international partners. Research outcomes are influencing health policy at State and national level, and there is demonstrated evidence of improvements in health care.

QCMHR research achievements include:

* development and implementation of a new national model of employment support for people with schizophrenia, through the adoption of an inter-sectoral collaboration between mental health service and employment services, thus advancing the vocational rehabilitation of people with schizophrenia;
* implementation of a program of workplace screening for depression and related disorders, wherein, in collaboration with 52 industry partners, 270,000 employees have been screened in workplaces across Australia and followed up to facilitate access to treatment.

There are pockets of excellent research being done in the District including the service areas of audiology (neonatal screening), speech pathology (in the Barrett Adolescent Centre which is focused on patients with eating disorders), and Child Health CAFHS (open plan drop-in centre).

The survey team noted that staff have a limited knowledge of research being conducted in the District, other than the research being conducted in their services/departments. It is suggested that the District develop a communication strategy to inform the organisation of the research programs and projects being conducted in the District, and the demonstrated improvements in health care being achieved. This will facilitate the growth and development of a culture of research in the District, and enable services/departments to synergistically build upon the gains already made.

In the absence of evaluation of research governance within the District, performance under this criterion cannot be rated higher than MA at this time.

Surveyor's Recommendation:

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FUNCTION SUMMARY: CORPORATE

Strategic and operational planning is very well done. Using Queensland Health's Strategic Plan 2007-12 and its statewide Health Services Plan 2007-12 as the launching platform, the District has developed its Operational Plan and its Health Services Plan 2007-12. Clinical units and major services have developed their own business plans, guided by Queensland Health objectives and District strategies. Progress towards achievement of the objectives is monitored during the year and strategies modified as necessary.

The Director-General of Queensland Health is the governing body of the District but day to day management is delegated to the District Manager. For the purposes of the survey, the District Executive has been considered to be the day to day governing body, recognising the ultimate authority of the Director-General. Documented terms of reference have been established for the District Executive and all other committees, although not all terms of reference are as robust as they may be. There is an annual self-evaluation of all committees and changes to terms of reference are recommended to the executive. Again, this is not always done as robustly as it could be and there are recommendations made around this. Wherever appropriate, time limited committees are established for specific purposes. The deliberations of committees are minuted and decisions remain on the agenda until actions are complete but in line with previous comments, the quality is not universally good and there are recommendations made for improvement.

Strong financial management systems are evident, with financial performance regularly evaluated and improved. Delegations are specific to positions and are regularly reviewed and updated. Compliance with delegations is monitored against rules incorporated into electronic purchasing systems. Budget development is zero based and staff are involved in the development, monitoring and management of their budgets.

The survey team was surprised to note that, in the light of Queensland's experience in another District, systems to define the scope of practice for clinical professionals and for the introduction of new interventions and new technology were not as robust as contemporary standards would dictate. Recommendations have been made to bring performance in these areas to an appropriate standard.

Contracts with external providers are negotiated and managed on behalf of the District by Shared Services.

Since the amalgamation of the two component Districts, opportunity has been taken to evaluate the system for developing, managing and reviewing policies and procedures and a new, improved system has been implemented. Policies have been risk rated and they are being reviewed and rewritten according to priority. This is a work-in-progress and there still remains much to do.

Safety management systems ensure safety and wellbeing for consumers/patients, staff, visitors and contractors. The amalgamation of the occupational health and safety unit with the fire service unit has created a single District unit that has responsibility for all safety management systems within the health service. Much work has been undertaken in the past 12 months to provide support and advice from Ipswich to the rural health services in safety management. Boonah, Laidley and Esk Hospitals have developed good links with the District unit and this has contributed to the implementation of District initiatives and a reduction in staff incidents.

An asbestos register is maintained across the District, however, there has not been an action plan developed which prioritises action to address risks at Laidley and Esk.

The Ipswich medical imaging department has been reviewed following the previous survey to seek solutions to the ongoing problems of space in the waiting area for non-inpatients and inpatients. There is still the opportunity to further review how best to manage inpatients who remain waiting for transfer back to ward areas.

While signposting across the District generally meets needs, there is the opportunity to further improve signposting to the emergency department at Kingaroy. Where the function of a facility has changed, the District should also ensure that signposting is updated to reflect current usage. This is required at the Sacred Heart oral health facility which has changed from a clinic to an administration unit.

It was noted that the new facilities at Wondai provide an excellent residential facility for the immediate district for aged persons. Currently the facility has capacity for additional residents and may provide an opportunity for residents of the older Farr Home facility to be given the option to move into the Wondai facility. Patient areas at Wondai meet residents' needs, however, a review of the current administrative area may provide an opportunity for improvement to the space and work area for administration staff.

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Safe work practices were generally displayed across the District and this practice could be reinforced in the Kingaroy maintenance workshop, with safe practice posters and procedures prominently displayed.

The need for a full fire inspection of all facilities has been noted in other areas of this report. Fire training is evident and while the generic program is effective, the size and complexity of the various work areas would benefit from a tailored fire training package for hospitals, community health settings and remote sites, eg oral health.

Security of staff is acknowledged by management and much has been done to minimise risks to staff. Video surveillance is prominent and, where applicable, dedicated security staff are employed. For the smaller rural centres, particular at Laidley Hospital, Laidley oral health facility and Wondai, security measures should be reviewed and action taken to reduce risks.

Keys are generally well secured, however, there is general access to master keys at Kingaroy and this should be reviewed to ensure that inappropriate access to keys in minimised.

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Function: Corporate **Standard:** 3.1
Criterion: 3.1.1 The organisation provides quality, safe care through strategic and operational planning and development.

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

Surveyor's Comments:

The District has diligently translated the Queensland Health strategic and clinical directions into a District Operational Plan and a District Clinical Service Plan, developed its strategies for implementing the resultant objectives and encouraging business and clinical units to develop their business plans to operationalise the District plans. This has been particularly well done. It is felt that operationalising the plans could be improved by setting milestones for review during the year to ensure that progress is more effectively monitored. At present, the plans specify the body of work to be achieved in the space of the year and, whilst progress is monitored mid-year, there is no established measure against which that progress can be evaluated until the end of the year. A draft demand management strategy has been developed to facilitate management as predicted increases in demand eventuate.

Planning has been undertaken with wide consultation involving staff, community and external stakeholders, utilising data modelling to inform decisions.

As an example of the internal planning process, the nursing division has developed its plan for the 2008-9 year following a consultative process involving both managers and staff within the context of the District plan. The plan addresses increasing demand, workforce requirements, risk management, work/life balance, education and development, models of practice and finance and resources. A workload management tool was developed in June 2008.

Surveyor's Recommendation:

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

Surveyor's Comments:

The organisational structure of the District was reviewed and revised following the Districts' amalgamation. The Executive Committee, as the day to day governing body, has been restructured recently following evaluation of its functioning since the amalgamation. The executive has formal terms of reference and evaluates its performance annually. Community input is facilitated through the District Community Council. Its members sit on appropriate District committees including the Patient Safety and Quality Council to provide a community perspective to deliberations. Effective links are maintained with the Division of General Practice and good relationships were demonstrated.

There are established terms of reference and membership for all committees, a requirement that they evaluate their performance annually and there is a template for the recording of minutes but it is not in universal use across the District. In a number of cases, and particularly in Mental Health, terms of reference do not provide for clear direction in relation to expected outcomes and evaluation of effectiveness, whilst minutes do not clearly reflect decisions taken and the impact of implementation leading to evidence of continuous improvement. Minutes can provide a rich source of verification of various aspects of care and service provision and, hence, need to be recorded in a way which reflects this. The use of first names and/or initials only in minutes should be eliminated and replaced by either using the position held or full names (initials supported by an explanatory key are an acceptable alternative). Evaluation of meeting effectiveness was sometimes observed to be as limited as an evaluation of attendance. Terms of reference

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should include the criteria to be used for assessing effectiveness. A simple way of achieving this is to have a committee set its objectives for the year and evaluate performance against those objectives at the end of the year.

Queensland Health maintains a system-wide approach to delegations which are regularly reviewed and updated as necessary. There are controls in place through finance, purchasing and human resource systems to monitor compliance. Queensland Health's Integrated Resource Manual provides the operating and management requirements for staff and facilities which, in other jurisdictions, may appear in by-laws. These are regularly updated. Performance requirements for the District are incorporated into the District Manager's performance agreement.

There is a rigorous system for financial management. Accounting services are a shared service but financial management is provided within the District. Staff are involved in the preparation of their budgets and are then expected to manage within the allocated budget. Good information systems provide a wealth of financial information to District and unit management. Data is converted into easily interpreted information, trended, analysed and modelled to facilitate good financial management. Compliance with the Financial Management Act, including financial controls, is evaluated and certified annually.

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

(i) A suitable mechanism for the evaluation of the effectiveness of committees be developed and appropriate measures for evaluation be included in each committee's terms of reference.
(ii) Minutes be recorded to a standard which provides a clearly identifiable decision trail and the status of issues under discussion.
(iii) The use of abbreviated names within minutes be eliminated and replaced with a system which ensures that individual participants are clearly identifiable.

Function: Corporate **Standard:** 3.1
Criterion: 3.1.3 Processes for credentialing and defining the scope of clinical practice support safe, quality health care.

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

Surveyor's Comments:

The surveyors noted that there are rigorous processes in each professional discipline in the District to ensure credentialling and currency of registration with the respective registration authority.

Allied Health
There are rigorous processes to check credentialling and registration at time of appointment. It is noted that there is no registration authority for some craft groups (eg Social Work) and that membership of the professional association is non-mandatory.

It was noted that in some allied health disciplines checks of registration were not being done until some days after the registration renewal date on 1 July. It was also noted that in some allied health disciplines the responsibility for credentialling was a shared responsibility between the service manager and Director, and in others the responsibility rested with either the Director or service manager. It is suggested that responsibility for credentialling of allied health staff be standardised, and responsibility assigned to the Director of the respective allied health discipline, and that checking of registration renewal occur prior to 30 June each year.

Nursing
The surveyors noted that nursing administration has implemented rigorous processes around appointments and initial credentialling, and that there are systems for monitoring registration, education and competencies.

Junior and Senior Medical Staff
There are robust processes to check credentials and registration with the Queensland Medical Board, using the Queensland Medical Board public access register.

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It was noted that evidence of current registration was missing from the files of two junior medical staff, which was not in accordance with the District policy (untitled). It is suggested that an internal audit process of personnel files be introduced in Medical Administration to ensure evidence of currency of registration of junior medical staff.

The survey team noted that the District has implemented a policy/procedure 'Credentials and Clinical Privileges for Medical Practitioners' and has a system for credentialling and clinical privileging of medical practitioners (other than junior medical staff), which is facility-specific and relates to the Service Capability Framework of the facility and/or health service. The surveyors noted, however, that there is currently no policy/procedure or system for defining the scope of clinical practice for medical practitioners, in particular for proceduralists, which defines those procedures which the consultant can or cannot perform.

The surveyors noted that there is no system or policy/procedure for credentialling and defining the scope of clinical practice of registrar or senior medical officer staff, with the exception of obstetric and gynaecology registrars where there is a robust process for credentialling and competency assessment of obstetric and gynaecology registrars to conduct unsupervised after-hours LUSCS. The clinical leadership of the Director Obstetrics and Gynaecology and high level of consultant engagement in this process, and the commitment to providing after-hours supervision for registrars and junior medical staff is commended.

The survey team recommends that a process of credentialling and defining the scope of clinical practice for registrar and senior medical officers be implemented as a priority for all registrars and senior medical officers who are performing interventional procedures. This will provide a framework for managing requests from registrars to perform procedures, as with the recent request by a surgical registrar to perform a laparoscopic appendicectomy.

The survey team noted that there is a District policy 'Introduction of New Equipment or Consumables for Surgical Services' however, there is no policy or system for the safe introduction of new interventions/services. The surveyors recommend that a policy and system for the safe introduction of new interventions/services be implemented as a priority, and that the scope of clinical practice of a clinician be reviewed prior to new services or interventions being introduced. The implementation of this system will provide a framework to appropriately manage applications from clinicians to perform new procedures, as with the recent request by a consultant to perform laparoscopic banding.
It is noted that there is a performance appraisal and development framework for consultant medical staff, however, few consultant staff have completed performance appraisals. This system of performance monitoring needs to be linked to the system of credentialling and defining the scope of clinical practice, in order that a consultant's scope of clinical practice can be varied where indicated.

The surveyors noted that there is no policy or system for performance management of junior medical staff, and that management of poorly performing junior medical staff has been identified as a key risk for the organisation.

The survey team noted that there is currently no process of formal communication to key stakeholders of the clinical privileges and scope of clinical practice of medical staff including consultant, general practitioner/visiting medical officer, registrar and senior medical officers. As a consequence, these staff are required to contact individual staff including the Executive Director Medical Services and Directors of Business Units to provide this information. It is recommended that a communication strategy be implemented which enables key stakeholders to have direct access to this information.

The surveyors noted that at Kingaroy there has been a long-standing medical workforce shortage of anaesthetist and obstetrician consultant staff, and that currently a general practitioner/visiting medical officer who has clinical privileges as a generalist obstetrician and anaesthetist is rostered to concurrently cover two rosters and provide after-hours cover, as both the on-call anaesthetist and obstetrician. It is the understanding of the surveyors that the general practitioner/visiting medical officer only performs epidural anaesthesia and not general anaesthesia in this situation. The surveyors noted that the District conducted an internal review of maternity services at Kingaroy in May 2007, and that as a result of this review several risk management strategies have been implemented, including screening of high risk pregnancies and transfer to higher level care, whilst concerted endeavours have been made to recruit additional obstetric and anaesthetist staff. The surveyors understand that a new consultant anaesthetist is expected to be appointed in 8-12 weeks and that the general practitioner/visiting medical officer will then only cover the after-hours obstetric roster.

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Advanced Completion in 60 Days (AC-60)

An AC-60 was undertaken on the following High Priority Recommendations from the Organisation-Wide Survey:
Stage 1:
(i) A system be implemented for defining, monitoring and communicating the scope of clinical practice for all consultant, general practitioner/visiting medical officer, registrars and senior medical officers in the District, which specifically includes medical staff working in The Park Centre for Mental Health and registrars performing electro-convulsive therapy procedures.
(ii) A system of performance management for junior medical staff, and consultant and general practitioner/visiting medical officer medical staff be implemented, which is linked to the system of credentialling and defining the scope of clinical practice, and ensures that all consultant and general practitioner/visiting medical officer medical staff have an annual performance appraisal.
(iii) A system of performance management for junior medical staff be implemented, which is linked to the system of credentialling and defining the scope of clinical practice.
(iv) A policy be developed and a system implemented for the safe introduction of new interventions, which includes review of a clinician's scope of clinical practice prior to the introduction of new interventions.
(v) The systems developed in response to recommendations (i) and (ii) be implemented in at least two clinical services and an action plan developed for their implementation across the whole District.

Stage 2 :
(i) The organisation demonstrate that the scope of clinical practice and performance management systems developed in Stage 1 have been implemented across the whole District.

Action Taken by Organisation to Address Recommendations

Actions undertaken:
(i)
* The WSMB District Credentials and Clinical Privileges for Medical Practitioners Policy/Procedure has been revised to fully reflect the requirements in the Credentialing and defining the Scope of Clinical Practice for medical practitioners in Queensland - a policy and resource handbook v1.0 April 2008.
* Credentialling application forms have been revised to reflect the current Credentialing and defining the Scope of Clinical Practice for medical practitioners in Queensland – a policy and resource handbook v1.0 April 2008.
* A database has been developed which monitors and identifies all Senior Medical Officers and Visiting Medical Officers in the district and outlines their credentialling status.
* A district credentialling and clinical privileges intranet site has been created and published for all credentialling resources and to communicate the process for credentialling.
* The WMSB District Service Capability Framework has been revised and links with the district and Queensland Health credentialling policy and is accessible on the WMSB District intranet site.
* Registrars (except Psychiatric Registrars who perform ECT) have been excluded from the credentialling process as supported and referenced in the ACHS EQuIP 4 Update (No 4, October 2008) which states on page four of this document that credentialling of junior medical officers/registrars in training programs is not required by the ACHS standards, however organisations must provide evidence that junior medical officers are provided with appropriate levels of supervision at all times, by either the organisation or a college and that their scope of practice is defined, with inclusion and exclusion criteria readily available to other members of staff and clearly displayed. Please refer to Rec. No. (iii) below.
* Mental Health Medical Officer Consultants and Registrars that perform ECT have applied for credentialling. These applications are for review at the Credentialling committee meeting on the 9 December 2008.
(ii)
* The Senior Medical Officer Performance Appraisal and Development (PAD) form has been revised to incorporate additional credentials and clinical privileges sought in the coming 12 months. The PAD also incorporates additional complex/interventional procedures or equipment that a medical officer may wish to conduct/use in the coming 12 months at their current facility.
The PAD links with the revised WMSB District Credentialling policy/procedure and the revised WMSB District New Interventional policy/procedure. All three documents are now linked and appropriately make reference to each other.
* A referee report form and supervisors report form have been implemented to ensure all medical officers are subject to ongoing performance management. These reports may be called on if there are concerns about a clinician.
* The Terms of Reference for the Credentialling and Clinical Privileges committee have been revised to ensure a system of credentialling for medical officers is more robust and aligns itself with state and federal credentialling standards. The committee now allows for performance management of Senior Medical Officers as access to reports such as complaints, surgical complications and concerns about a clinician are able to be discussed in this forum.
(iii)
* In accordance with state and national directives, the Ipswich Hospital Junior doctor Medical Education program will undergo a full accreditation survey in March 2009 (date to be confirmed). The accreditation will be undertaken by the

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Postgraduate Medical Education Council of Queensland (PMCQ), who are the accreditation authority for the Medical Board of Queensland.
PMCQ is responsible for ensuring that all health care facilities employing junior medical officers (PGY1, PGY2, and PGY3 and above not involved in a vocational training program) adhere to set standards in relation to supervision, assessment, evaluation, education provision, and general working conditions. In accordance with the requirements of the recently released new state and nationally supported accreditation standards, Ipswich Hospital is currently undertaking a comprehensive review of all policies, processes, and practices relating to these standards. This process will ensure that all junior doctors employed within Ipswich Hospital are appropriately supported, supervised, assessed, and educated.
The draft policies and guidelines will form the basis for junior doctor education, supervision and assessment in Ipswich Hospital and will be implemented at the beginning of 2009, for review by PMCQ in March 2009 as part of the full accreditation process. These include:
> Assessment Interview Process flow sheet
> Guidelines for Junior Medical Officers Assessment handbook
> Clinical Supervisors handbook for supervising Junior Medical Officers
> End Term Assessment form management flow chart for Junior Medical Officers
> Guidelines for completing Junior Medical Officer Assessment forms
> Junior Doctor Assessment Policy
> Protected Learning Time Policy for Junior Medical Officer
> Supervision of International Medical Graduates
> Supervision of Junior Medical Officers.

(iv)
District policy/procedure on New Interventional Procedures has been reviewed. The revised policy/procedure has been approved by District Executive and is accessible on the district intranet site. This policy/procedure links and references the revised WMSB District Credentials and Clinical Privileges for Medical Practitioners Policy/Procedure.

(v)
Recommendation (i) has been implemented across the district. This can be demonstrated through an up to date credentials database for Senior Medical Officers and Visiting Medical Officers for the district. Recommendation (ii) has been addressed through all new medical officer applicants and re-applicants now completing the new application form as documented through a revised credentialling process flow chart. Terms of reference for credentialling committee have been revised to ensure a system of credentialling for medical officers is more robust and aligns itself with state and federal credentialling standards.

Surveyor's Comments
The District has established and implemented a system for defining, monitoring and communicating scope of clinical practice across the District and this is available to staff on the intranet, thus satisfying both stages of the recommendation.

A revised senior medical staff performance and appraisal document is linked to credentialling and the processes for the introduction of new procedures or technology.

The District is in the process of undertaking a review of all policies, processes and practices relating to the supervision, management and education of junior medical staff. This will culminate with an accreditation review by the Postgraduate Medical Education Council of Queensland in early 2009, at which time these policies and practices will be finally reviewed and implemented.

A revised policy on the introduction of new interventions and technology has been approved and is available on the intranet.

The Conditional survey team will need to confirm that the changes have been sustained, and this process will be facilitated if the District develops and collects some relevant performance indicators to demonstrate the effectiveness and sustainability of the changes.

Surveyor's Recommendation:

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Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Corporate **Standard:** 3.1
Criterion: 3.1.4 External service providers are managed to maximise quality care and service delivery.

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

Surveyor's Comments:

External services are contracted by Shared Services on behalf of the Health Service Districts; the District, itself, does not negotiate or manage contracts. There is an operating level agreement between the District and Shared Services covering the responsibilities of the parties and performance requirements.

Preparatory to preparing contracts, the matters which are important to the end users are identified so that contracts can be assured of meeting the end user's needs. In negotiating contracts, Shared Services require contractors to have a system of quality assurance such as ISO accreditation or HACCP and to be legislatively compliant. Performance indicators are determined, included in contracts and monitored during the currency of the contract. There are annual reviews of longer term contracts undertaken with the end users. Whilst the District is required to manage the contractor, assistance is provided by Shared Services for dispute resolution. District specific contractor handbooks (including safety responsibilities) and induction requirements are referenced in contracts.

Surveyor's Recommendation:

Function: Corporate **Standard:** 3.1
Criterion: 3.1.5 Documented corporate and clinical policies assist the organisation to provide quality care.

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

Surveyor's Comments:

On amalgamation of the two former Districts a rationalisation of policies and procedures was necessary. The District has taken this as an opportunity to review and update its system for creating, managing and reviewing policies. A mapping process has been undertaken to identify a currently relevant suite of policies and procedures and to archive those no longer considered relevant. They have been risk rated and work is proceeding on their development. In the meantime, existing policies remain in place until replaced with the updated version.

The system provides for policies and procedures to be evidence-based, to reference current issues, Australian, industry and professional standards, legislation, codes of ethics and codes of practice and the evidence upon which they are based. A District Standards Committee oversees this work. Review dates are determined and appear on the policy or procedure. A comprehensive system for disseminating information about new or changed policies is in place, including email, posters and *Polly the Policy Parrot*. Education is provided for significant policies or significant change and, where appropriate, sign off is required to ensure that the information has been received.

It was noted during the survey that the policy and procedure applying to home visiting by staff does not adequately address the specific needs of those working in rural and remote areas, for example, when outside mobile phone coverage. It would be appropriate to review the policy to ensure that it adequately meets needs.

There is a system in place to monitor new or changed legislation and services offered by the Private Hospitals Association of Queensland and the Office of the Queensland Parliamentary Counsel are utilised for keeping abreast of changes. Legislative compliance is monitored by internal audit and the Health Quality and Complaints Commission. Staff were advised by the survey team of commercial services which are available to refine the compliance monitoring function.

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

The policy and procedure relating to home visiting by staff be reviewed to ensure that it adequately covers the needs of those working in rural and remote areas, for example, when outside mobile phone coverage.

Mental Health
The system for ensuring implementation of and compliance with new or amended legislative requirements be documented, including a mechanism for evaluation, and included in the policy management process to enable its evaluation and improvement where necessary.

Function: Corporate **Standard:** 3.2
Criterion: 3.2.1 Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.

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

Surveyor's Comments:

Risk assessments are undertaken at each site and there are sufficient lifting aids and appliances within each site to minimise risk. Where risks are identified, an action plan is in place to minimise impact. Generic manual handling training programs are in place and provide a sound general package to staff. The manual handling training package could benefit from further development and have packages tailored to specific work areas. It was identified in Ipswich Hospital that administration staff could benefit from a tailored package focused on document and office equipment movement. Administrative staff based at Sacred Heart dental unit would benefit from a full assessment of the dental record storage system and the potential manual handling risks associated with the current storage compactus.

A Radiation Safety Officer has been appointed and has responsibility to oversee all facets of radiation safety across the District. A report in April 2008 reviewed all aspects of safety and rated the radiation safety at a high standard. A radiation safety management plan is in place which ensures that consumer/patient exposure to radiation is minimal. There is a sound mechanism for feedback from the District radiographers to registered nurse operators at Boonah, Laidley and Esk Hospitals. This feedback should be extended to Kingaroy to ensure that professional development of staff includes raising awareness of radiation safety issues.

Material safety data sheets are readily available across all hospital sites and chemical storage is safe and contained in secure areas. Boonah, Laidley, Esk and Kingaroy Hospitals all have access to Chemalert systems which ensures that all information is current and relevant to practice. These same procedures should be further extended to The Park where material safety data sheet information was not readily available and chemicals were stored in patient rooms.

Policy and procedures are in place and supported through an identified and trained group of occupational health and safety representatives. Systems are evaluated and improvements identified and actioned.

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

(i) A manual handling program be developed at Ipswich to address specific needs of administrative staff, ie lifting, moving clinical records, moving computers, lifting boxes of copy paper.
(ii) The storage facility for patient records at Sacred Heart oral health unit be evaluated for compliance with manual handling principles.
(iii) Resources be assigned at Laidley and Esk to prioritise actions to address issues in asbestos reports.
(iv) The Radiation Safety Officer provide professional development to local staff at Kingaroy to increase awareness of radiation safety issues.

Mental Health
(i) The bathroom and laundry chemicals used in the Extended Treatment and Rehabilitation Unit be reviewed with a view to replacing hazardous materials with non-hazardous alternatives to enhance client safety.

Organisation Wide Survey - Survey Team Summary Report

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(ii) Where bathroom and laundry chemicals are in use material safety data sheets be displayed at the point of use and staff and, where relevant, patients be educated in the application of the material safety data sheets.
(iii) The overall safety system be more systematically evaluated for effectiveness and improvements be made as necessary.

Function: Corporate **Standard:** 3.2
Criterion: 3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

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

Surveyor's Comments:

Plant and equipment are operated and maintained by a well organised District team. The team is made up of a composition of employees and external contractors who are all subject to the policies and procedures of the health service. A District-wide preventative maintenance program ensures that plant and equipment is maintained in good working order and that procedures are in place to ensure that repairs are identified and actioned in a timely manner.

An energy management system is in place in Ipswich, and this has resulted in efficiencies in energy usage and a resultant decrease in energy expenditure.

Mental health medical records are archived in a building adjacent to Dawson House known as the Dawson House Annexe. Whilst the building has suitable fire protection, the security of the building is minimal with unprotected glass windows and the records are exposed to sun. Steps should be taken to ensure that these records are stored so as to protect and preserve the records.

Part of the intent of this criterion is to ensure that all buildings (and utilities) owned or used by a health care organisation are managed and operated to support a safe health environment. The criterion addresses in a broader sense how the organisation maximises the safety, comfort and needs of the community it serves. The focus of this AC-60 recommendation and the accompanying subservient recommendations is the Barrett Adolescent Centre (BAC) located within The Park – Centre for Mental Health. Many of the patients admitted to the BAC have extensive histories of recurrent, severe self-harm and suicidal behaviours often associated with abuse and trauma. As a statewide service and the only facility capable of providing care for this high acuity group of patients, the BAC does not have a choice about the mix of patients they will admit. The surveyors noted that as the redevelopment of The Park site progressed BAC lost access to other buildings, eg nearby auditorium, high dependency unit and medical centre for the management of patients with eating disorders. This compounded the problems and placed greater strain on the patient accommodation, notably the ward environment.

The level of risk associated with the BAC patient accommodation and treatment areas has been identified over a long period of time, with reviews conducted in 2003-2004 and in 2006. In addition, internal reviews have been instigated following various critical incidents over the period from 2003 to the present time. Evidence in BAC and hospital records demonstrates an increasing level of incidents often associated with serious outcomes for both patients and staff. This has led to a high level reliance on continuous observation as a patient safety strategy. Recommendations to address the associated staffing issues are included under criterion 2.1.2 in the in-depth review report.

Whilst there has been a decision to rebuild the facility, the timeframe for this to occur remains unclear and is reported as not likely to be for another two or three years.

The current situation needs to be addressed immediately with interim measures to address and mitigate the risks associated with:
1. Requirement for containment for high acuity patients and to provide for protection from self-harm or harm to others;
2. Accommodating physically fit seriously ill adolescents in a non-purpose built environment which it has been agreed in various reports is entirely unsuitable to their needs.

A further comprehensive review was conducted in March 2007 and a range of improvements recommended to enable the unit to continue to provide a safe patient and staff environment, pending the capital works program to rebuild the facility. This report reiterated the findings of previous reports and could provide a useful basis for addressing the immediate risk issues.

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Advanced Completion in 60 Days (AC-60)
An AC-60 was conducted on the following High Priority Recommendations from the In-Depth Review:
Stage 1:
(i) Written confirmation of approval be obtained (with necessary budget allocation) to immediately make the necessary environmental modifications to the Barrett Adolescent Unit to reduce risk to acceptable levels and improve patient and staff safety.
(ii) Documented evidence of approved plans and work schedule for the environmental modifications be provided, with designated timeframes for completion.

Action Taken by Organisation to Address Recommendation
Stage 1:
(i) Written approval with appropriate budget allocation has been obtained for the environmental modifications to Barrett Adolescent Unit to reduce risk and improve patient safety. The environmental modifications include:
* Removal and replacement of glass with Perspex in identified areas of the unit has been completed.
* The front entrance door will be replaced with an aluminium frame and toughened glass. Scope of work has been developed and installation of the new door is to be completed by 05 Dec 08.
* High Dependency Unit (HDU) plans have been drawn up and are progressing through the building approval process. Associated plans are currently being drafted in relation to the under slab, sewerage and drainage services and the ducted air conditioning. Once plans are finalised they will be submitted for approval through Project Services. Fixtures such as lighting, doors, door frames, hinges associated with the project have been ordered. Project scheduled to be completed April/May 2009.

(ii) The evidence of the documented plans and the work schedules of environmental modifications is available from Building and Engineering Maintenance Services. The Park Service Manager and Service Improvement Coordinator also have access to copies of the plans and work schedules. Timeframes for the completion of the environmental modifications project are scheduled to be completed April/May 2009. The scope of work for all of these modifications outlines the requirements/specifications of the work and the timeframes for the work to be completed.

Stage 2:
(ii) Corporately there has been a decision to relocate Barrett Adolescent Unit to another site. Negotiations are underway for the unit to be relocated and developed at Metro South Health Service District (Redlands). This is supported by documented evidence - "Report of the site evaluation sub-group" Site options paper for the redevelopment of the Barrett Adolescent Centre - October 2008 available through the District Chief Executive Officer's office.
Completion Due By: 15 December 2008
Responsibility: Executive Director Mental Health Service WMSBHSD

Surveyor's Comments
A budget allocation has been made for the temporary works. The design has been completed and final approval is awaited from Council for the plumbing works. In the meantime, some works have been completed and others are underway. Completion of the project is anticipated in April/May 2009. The rating remains at SA pending the completion of the Stage 1 works.

A site for the relocation of the unit has been agreed between the two relevant District Managers. Consultation with stakeholders is to be undertaken in the New Year. Funding is available and the project will proceed to the design stage as soon as the site is confirmed. The surveyors were encouraged by the progress to date.

The Conditional survey team will need to confirm the completion of the temporary building works to address the deficiencies in the building and will need to verify that continuing progress has been made towards the relocation of the facility. If both aspects are confirmed, the High Priority Recommendation can be closed and the criterion re-rated to MA.

Surveyor's Recommendation: **HPR:** Yes

(i) Action be taken to ensure that inpatients in the medical imaging waiting area at Ipswich are returned to the ward immediately after their procedures, or structural changes be made to ensure that comfort and dignity is maintained.
(ii) Signposting at Sacred Heart Oral Health (administration/dental records) be changed to reflect the changed role from clinic to administration building.
(iii) The decommissioning of Farr Home and the relocation of residents to a more suitable aged care residential facility be considered (Kingaroy).

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
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(iv) Safe work practices/safety rules be readily available for workshop staff at Kingaroy to assist in the promotion of a safe workplace.
(v) The current workplace administration floor space at Wondai be reviewed with a view to increasing the workplace size.
(vi) Refrigerators/freezers at Boonah, Laidley and Esk be fitted with temperature monitoring capacity.
(vii) Archived medical records in the mental health and oral health services be stored in a safe manner, free from exposure to sunlight and security risks.
(viii) Signposting for access and entry to the emergency department at Kingaroy be reviewed.

Stage 2 (August 2009)
(i) The immediate works identified in Stage 1 to reduce risk to acceptable levels be completed.
(ii) The rebuilding of the Barrett Adolescent Unit be expedited to enable care and services to be provided for adolescent patients in a purpose-built facility which facilitates a safe health environment and maximises the safety, comfort and needs of the community.

Risk Rating: Extreme

Risk Comments:

The surveyors assessed the risk as in the extreme category ie (likelihood – almost certain and consequences high) based on the history of incidents, near misses and root cause analysis investigations, discussions with clinicians working in the unit and observation of the area first hand by surveyors from both the in-depth review and organisation-wide survey teams. The rating was subsequently reduced to SA and a High Priority Recommendation assigned.

Function: Corporate **Standard:** 3.2
Criterion: 3.2.3 Waste and environmental management supports safe practice and a safe environment.

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

Surveyor's Comments:

Waste management services across the District comply with industry standards and there are good initiatives at Ipswich with recycling of waste water. Recycling of packaging at Ipswich is limited to cardboard and given the extent of recyclable material from a facility of this size, a review should be undertaken to assess further opportunities to expand the recycling program. Improvement of waste management practices at The Park would benefit from inclusion in staff orientation and in-service packages.

Good signage for waste material storage is displayed throughout the facilities. Secure external storage facilities are in place with access to approved external waste contractors.

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

(i) The capacity to implement a comprehensive recycling program at Ipswich be reviewed.
(ii) Waste management procedures in the mental health service be included in staff orientation packages and in-service programs.
(iii) Action plans be developed in the mental health service for implementing improvements following routine waste management audits.

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Organisation: West Moreton South Burnett Health Service District
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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

Surveyor's Comments:

The organisation provided evidence of full fire inspections of Esk, The Park, Boonah, Laidley, Kingaroy, Wondai, Nanango, Cherbourg and Murgon facilities. Action plans have been developed and identified works have been completed, or are progressing towards completion. Inspections and action plans of those facilities have been developed within the current EQuIP cycle. At the time of survey a fire inspection was underway at Ipswich Hospital and was due for completion in the coming months. There was no evidence of planned fire inspections for Oral Health facilities at Collingwood Park or Sacred Heart facilities.

Staff are trained in emergency preparedness and this is demonstrated by the sound knowledge that staff displayed during the survey period. New emergency exit plans have been developed at Ipswich Hospital.

Advanced Completion in 60 Days (AC-60)
An AC-60 was undertaken on the following recommendations from the Organisation-Wide Survey:
(i) Ipswich fire inspection be completed and there be a documented plan to implement the recommendations from that fire inspection.
(ii) Oral Health facilities at Collingwood Park and Sacred Heart undertake a full fire inspection by an authorised external provider and there be a documented plan to implement the recommendations of those fire inspections.

Action Taken by Organisation to Address Recommendations
Actions undertaken:
(i) Ipswich Hospital Building Survey report was received from Queensland Fire and Rescue Service (QFRS) on 20 October 2008. A documented action plan was developed to address all requirements to be addressed within 28 days as per Australian and Queensland legislation and standards. Key stakeholders at Ipswich Hospital met on 28 October 2008 and allocated tasks as identified in the Action Plan.
Tasks have been given a high priority to be completed by Building Engineering and Maintenance Services at Ipswich Hospital. All other recommendations have been given a priority to be completed. A follow-up compliance inspection is being arranged with QFRS between the 24 and 27 November 2008.

(ii) A Queensland Fire and Rescue Service (QFRS) Building Inspection was conducted on all West Moreton South Burnett Health Service District Oral Health facilities (including Collingwood Park and Sacred Heart). A report was subsequently received from QFRS for all facilities and the facilities which require actions to address identified issues from QFRS was placed into documented action plans. Documented action plans for Collingwood Park and Sacred Heart have been developed to address the identified issues. A follow-up compliance inspection is being arranged with QFRS between the 24 and 27 November 2008.
Completion Due By: 15 December 2008
Responsibility: District Director Clinical Support Services

Surveyor's Comments
The fire inspections for the Ipswich campus and the dental facilities have been completed and action plans were prepared and implemented.

All Queensland Fire and Rescue Service requirements have, subsequently, been completed and the Fire and Rescue Service has certified that all requirements have been met.

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

(i) Progress be hastened in replacing existing emergency exit plans with new exit plans in ward areas of Ipswich hospital.
(ii) The District fire training program be further developed to include site/unit specific content that reflects the uniqueness and needs of each work location.

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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

Surveyor's Comments:

Staff in at risk areas have access to monitoring equipment and security personnel as appropriate. Aggressive Behaviour Minimisation training is in place.

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

(i) The security risks facing staff when working alone at night in the emergency departments at Laidley and Esk be monitored to ensure that personal safety is maintained.
(ii) A safety review be undertaken of all non-hospital sites to ensure that staff working in small teams in isolated sites have a secure workplace with appropriate communication systems in place if needed in an emergency (Oral Health).
(iii) The security of staff working in the Laidley Oral Health facility be reviewed.
(iv) The personal duress alarm system at Wondai be reviewed with a view to determining its functionality and future use.
((v) General and master keys for the Kingaroy facility be located and maintained in a locked key cabinet with limited staff access.

Rating Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Clinical				
Criterion	Description	Organisation's self-rating	Surveyor Rating	HPR
Crit. 1.1.1	The assessment system ensures current and ongoing needs of the consumer / patient are identified.	MA	MA	
Crit. 1.1.2	Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.	MA	MA	
Crit. 1.1.3	Consumers / patients are informed of the consent process, understand and provide consent for their health care.	MA	MA	
Crit. 1.1.4	Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.	MA	MA	
Crit. 1.1.5	Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.	MA	MA	
Crit. 1.1.6	Systems for ongoing care of the consumer / patient are coordinated and effective.	MA	MA	
Crit. 1.1.7	Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.	MA	MA	
Crit. 1.1.8	The health record ensures comprehensive and accurate information is recorded and used in care delivery.	MA	MA	
Crit. 1.2.1	The community has information on, and access to, health services and care appropriate to its needs.	MA	MA	
Crit. 1.2.2	Access and admission to the system of care is prioritised according to clinical need.	MA	MA	
Crit. 1.3.1	Health care and services are appropriate and delivered in the most appropriate setting.	MA		
Crit. 1.4.1	Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.	MA	MA	
Crit. 1.5.1	Medications are managed to ensure safe and effective practice.	MA	SA	
Crit. 1.5.2	The infection control system supports safe practice and ensures a safe environment for consumers / patients and health care workers.	OA	MA	
Crit. 1.5.3	The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy.	MA	MA	
Crit. 1.5.4	The incidence of falls and fall injuries are minimised through a falls management program.	EA	MA	
Crit. 1.5.5	The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.	MA	SA	
Crit. 1.5.6	The organisation ensures that the correct patient receives the correct procedure on the correct site.	MA	MA	
Crit. 1.6.1	Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service	MA	MA	
Crit. 1.6.2	Consumers / patients are informed of their rights and responsibilities.	MA	MA	
Crit. 1.6.3	The organisation makes provision for consumers / patients from culturally and linguistically diverse backgrounds and consumers / patients with special needs.	MA	MA	

Rating Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Support				
Criterion	Description	Organisation's self-rating	Surveyor Rating	HPR
Crit. 2.1.1	The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.	EA	MA	
Crit. 2.1.2	The integrated organisation-wide risk management policy and system ensure that clinical and corporate risks are identified, minimised and managed.	EA	MA	
Crit. 2.1.3	Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.	MA	MA	
Crit. 2.2.1	Human resources planning supports the organisation's current and future ability to address needs.	MA	MA	
Crit. 2.2.2	The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.	MA	MA	
Crit. 2.2.3	The continuing employment and performance development system ensures the competence of staff and volunteers.	MA	SA	
Crit. 2.2.4	The learning and development system ensures the skill and competence of staff and volunteers.	MA	SA	
Crit. 2.2.5	Employee support systems and workplace relations assist the organisation to achieve its goals.	MA	MA	
Crit. 2.3.1	Records management systems support the collection of information and meet the organisation's needs.	MA	MA	
Crit. 2.3.2	Information and data management and collection systems are used to help meet the strategic and operational needs of the organisation.	MA	MA	
Crit. 2.3.3	Data and information are used effectively to support and improve care and services.	MA	MA	
Crit. 2.3.4	The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).	MA	MA	
Crit. 2.4.1	Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation.	MA	MA	
Crit. 2.5.1	The organisation's research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research	OA	MA	

Corporate				
Criterion	Description	Organisation's self-rating	Surveyor Rating	HPR
Crit. 3.1.1	The organisation provides quality, safe care through strategic and operational planning and development.	MA	MA	
Crit. 3.1.2	Governance is assisted by formal structures and delegation practices within the organisation.	MA	MA	
Crit. 3.1.3	Processes for credentialing and defining the scope of clinical practice support safe, quality health care.	MA	MA	
Crit. 3.1.4	External service providers are managed to maximise quality care and service delivery.	MA	MA	

Rating Summary Report

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Crit. 3.1.5	Documented corporate and clinical policies assist the organisation to provide quality care.	MA	MA	
Crit. 3.2.1	Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.	MA	MA	
Crit. 3.2.2	Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.	MA	SA	Y
Crit. 3.2.3	Waste and environmental management supports safe practice and a safe environment.	MA	MA	
Crit. 3.2.4	Emergency and disaster management supports safe practice and a safe environment.	MA	MA	
Crit. 3.2.5	Security management supports safe practice and a safe environment.	MA	MA	

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.1
Criterion: 1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.

High Priority: No

Recommendation:

(i) Compliance with the use of assessment documentation tools be improved.
(ii) Clearly documented, practical, easy reference admission and exclusion criteria be developed for each rural facility based on the site capability framework, so that front line staff can make consistent timely decisions about transfer out and that tertiary acceptance is more transparent.

Mental Health

(i) An evaluation of the mental health consultation/liaison nurse role and workload in the emergency department of the Ipswich Hospital be undertaken.
(ii) The quantity and quality of office space and computer access available to all community mental health teams be reviewed.
(iii) A review of office security and sound-proofing at South Burnett Community Mental Health be undertaken.
(iv) The allocation of specific, rather than pool, vehicles to the Ipswich Rural Community Mental Health Team be considered so that assessment tools and other requirements [including those for physical examination, such as sphygmomanometers] can be stored in the vehicles.
(v) Consumer transport needs be reviewed in order to facilitate their access to assessment and other clinical services in South Burnett.
(vi) Access to assessment and other clinical services for South Burnett consumers in the older age group be reviewed.

Function: Clinical **Standard:** 1.1
Criterion: 1.1.2 Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.

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.

Mental Health

(i) The installation of video-conferencing facilities at Goodna Community Clinic be considered, in order to support clinical care of consumers admitted to inpatient facilities [Ipswich] and to strengthen continuing professional development activities.
(ii) The seclusion room on the Aged Care Inpatient Unit be considered for conversion into a snoezelen room [or similar].
(iii) Strategies be identified to further enhance and strengthen the implementation of research outcomes of the Queensland Centre for Mental Health Research, which now has an established international reputation.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
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Function: Clinical **Standard:** 1.1
Criterion: 1.1.3 Consumers / patients are informed of the consent process, understand and provide consent for their health care.

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).

Function: Clinical **Standard:** 1.1
Criterion: 1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.

High Priority: No

Recommendation:

(i) The analysis of aggregated data concerning outcomes of care be strengthened and the participation by medical officers in multidisciplinary review be increased, so that there is more effective development of strategies to improve patient outcomes.
(ii) A simple system for tracking the timeliness of Clinical Unit Director response to clinical indicator queries and other matters forwarded by the Patient Safety and Quality Unit be developed, with reporting at District safety and quality meetings where delays or failure to respond have occurred, so that appropriate clinical governance can be assured.

Mental Health
(i) An evaluation of the extent of integration between the rehabilitation service (The Park) teams and clinical units be undertaken with the objective of identifying additional strategies to strengthen care planning and delivery.
(ii) A review of patient transport needs such that all disabled consumers are able to participate fully in rehabilitation and other treatment programs be undertaken.
(iii) Housekeeping be included in a life skills program in the Medium Secure Unit for client self esteem.
(iv) Staff attitudes in the Adult Mental Health Unit be modified by training and/or recruitment of leaders who will make changes to bring workers up to a respectful client-based, recovery model of care.
(v) Concerns expressed by clients in the Adult Mental Health Unit about boredom be reviewed and measures be put in place to address them.

Function: Clinical **Standard:** 1.1
Criterion: 1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.

High Priority: No

Recommendation:

Mental Health

Stage 2 (by August 2009)
(i) The effectiveness of the clinical record audit process implemented be evaluated.
(ii) West Moreton Health District complete an audit to ensure that all mental health services have a clinical record audit system in place and operational.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.2
Criterion: 1.2.2 Access and admission to the system of care is prioritised according to clinical need.

High Priority: No

Recommendation:

A review of the staffing/resource levels be undertaken and strategies implemented to address the waiting times involved with the outreach service provided by the Child and Family Health Service Young People's Health Team, Day Stay Centre and Occupational Therapy Service.

Function: Clinical **Standard:** 1.5
Criterion: 1.5.1 Medications are managed to ensure safe and effective practice.

High Priority: No

Recommendation:

(i) A pharmacy consulting service be provided to those rural facilities without a pharmacist and where the pharmacy service is provided by nursing staff.
(ii) The system for reviewing medication incidents and management practices be enhanced to ensure that there is always feedback to staff on outcomes of the reviews.
(iii) Specialist advice on appropriate protocols for the administration and ongoing clinical management of patients on opioid maintenance at Kingaroy be sought from Pharmacy or Alcohol, Tobacco and Other Drug Services.
(iv) Drug refrigerators be fitted with alarms to identify loss of temperature.

Mental Health

(i) The Park Campus develop a system for monthly auditing of medication in each program area.
(ii) The Park Campus develop a system for reviewing any trends discovered from the audit and developing a plan for improving performance in identified areas.
(iii) The Park Campus review the utilisation of pharmacy time to enable clinical input at ward level.

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 health care workers.

High Priority: No

Recommendation:

Alarm systems for refrigerators in outlying hospitals to denote a power loss be implemented.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.5
Criterion: 1.5.5 The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.

High Priority: No

Recommendation:

(i) A blood management system which monitors and reviews the prescribing of blood and blood products to ensure appropriate practice be developed.
(ii) An education program for clinical staff on appropriate practices for prescribing blood and blood products be developed and implemented.
(iii) The maximum blood ordering schedule (MBOS) dated 1995 be updated.

Function: Clinical **Standard:** 1.6
Criterion: 1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service

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.

Mental Health

(i) Data collection be reviewed by consumer consultants to record outcomes, strengths and weaknesses (Rehabilitation Team at The Park) so that their service and performance can be evaluated and opportunities for improvement identified.
(ii) Consultants in the Adult Mental Health Unit be provided with training to enable them to explain adult guardian and official visitor services.

Function: Clinical **Standard:** 1.6
Criterion: 1.6.2 Consumers / patients are informed of their rights and responsibilities.

High Priority: No

Recommendation:

Queensland Health be approached to review and republish its Rights and Responsibilities pamphlets and posters in order to ensure that the content is current.

Mental Health

The integrated mental health service's inpatient program policy on informing consumers/patients of their rights and responsibilities be reviewed to include the involvement of clinical staff in this process and the documentation of the process in the health record.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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.

High Priority: No

Recommendation:

(i) A standard, outcome-based template be developed for recording minutes of meetings, to improve the quality of minute taking across the District.
(ii) An analysis of the QASAR database be undertaken to identify users' perceptions, needs and level of satisfaction and make improvements as required.

Mental Health

A systems approach to the mental health sector quality improvement activities be developed, including the many current audits, to be applicable for a specified time frame, developed in consultation with staff and consumer staff members and evaluated for progress on a regular basis.

Function: Support **Standard:** 2.1
Criterion: 2.1.2 The integrated organisation-wide risk management policy and system ensure that clinical and corporate risks are identified, minimised and managed.

High Priority: No

Recommendation:

(i) The role of clinical leadership in peak committees which consider risk be reviewed to ensure that there is sound medical input into the risk management system.
(ii) A proactive, multidisciplinary approach be developed for the identification of risk to enhance the existing system, which relies heavily on incidents to identify risk.

Function: Support **Standard:** 2.1
Criterion: 2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.

High Priority: No

Recommendation:

Mental Health

(i) The requirements for client follow-up and support post-incident be reviewed and formalised.
(ii) The Peer Support Program be evaluated for effectiveness of staff participation rates as measured against its aims and objectives.
(iii) An evaluation of the rate of incident reporting, clarification of incident types and an assessment of staff understanding and use of the PRIME system be undertaken.
(iv) The current complaint management process be broadened to capture first line complaints from all sources.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Support **Standard:** 2.2
Criterion: 2.2.1 Human resources planning supports the organisation's current and future ability to address needs.

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).

Function: Support **Standard:** 2.2
Criterion: 2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.

High Priority: No

Recommendation:

Mental Health

(i) The equity of access of allied health students to current under and post-graduate placements be reviewed together with the impact of any inequity on future allied health workforce recruiting.
(ii) The effectiveness and sustainability of the current preceptorship program be evaluated with a focus on its ability to support students in what is a multidisciplinary service model.

Function: Support **Standard:** 2.2
Criterion: 2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.

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.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
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.

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).

Mental Health

A review of the District Mental Health Education Service provision to all sections and disciplines of the mental health sector be undertaken and a plan of action be developed for equitable delivery of education including the resource capacity to deliver.

Function: Support **Standard:** 2.3
Criterion: 2.3.1 Records management systems support the collection of information and meet the organisation's needs.

High Priority: No

Recommendation:

(i) The work to date on the integration of patient records across services and the flagging of records held at other sites be continued across the District.
(ii) The District's standardisation of clinical forms project continue to be implemented.

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).

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.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Support **Standard:** 2.4
Criterion: 2.4.1 Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation.

High Priority: No

Recommendation:

A suite of key performance indicators be established in consultation with relevant staff, to capture the outcomes of the health performance initiatives across the District and trend them over time.

Function: Corporate **Standard:** 3.1
Criterion: 3.1.2 Governance is assisted by formal structures and delegation practices within the organisation.

High Priority: No

Recommendation:

(i) A suitable mechanism for the evaluation of the effectiveness of committees be developed and appropriate measures for evaluation be included in each committee's terms of reference.
(ii) Minutes be recorded to a standard which provides a clearly identifiable decision trail and the status of issues under discussion.
(iii) The use of abbreviated names within minutes be eliminated and replaced with a system which ensures that individual participants are clearly identifiable.

Function: Corporate **Standard:** 3.1
Criterion: 3.1.5 Documented corporate and clinical policies assist the organisation to provide quality care.

High Priority: No

Recommendation:

The policy and procedure relating to home visiting by staff be reviewed to ensure that it adequately covers the needs of those working in rural and remote areas, for example, when outside mobile phone coverage.

Mental Health
The system for ensuring implementation of and compliance with new or amended legislative requirements be documented, including a mechanism for evaluation, and included in the policy management process to enable its evaluation and improvement where necessary.

Function: Corporate **Standard:** 3.2
Criterion: 3.2.1 Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.

High Priority: No

Recommendation:

(i) A manual handling program be developed at Ipswich to address specific needs of administrative staff, ie lifting, moving clinical records, moving computers, lifting boxes of copy paper.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

(ii) The storage facility for patient records at Sacred Heart oral health unit be evaluated for compliance with manual handling principles.
(iii) Resources be assigned at Laidley and Esk to prioritise actions to address issues in asbestos reports.
(iv) The Radiation Safety Officer provide professional development to local staff at Kingaroy to increase awareness of radiation safety issues.

Mental Health
(i) The bathroom and laundry chemicals used in the Extended Treatment and Rehabilitation Unit be reviewed with a view to replacing hazardous materials with non-hazardous alternatives to enhance client safety.
(ii) Where bathroom and laundry chemicals are in use material safety data sheets be displayed at the point of use and staff and, where relevant, patients be educated in the application of the material safety data sheets.
(iii) The overall safety system be more systematically evaluated for effectiveness and improvements be made as necessary.

Function: Corporate **Standard:** 3.2
Criterion: 3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

High Priority: Yes

Recommendation:

(i) Action be taken to ensure that inpatients in the medical imaging waiting area at Ipswich are returned to the ward immediately after their procedures, or structural changes be made to ensure that comfort and dignity is maintained.
(ii) Signposting at Sacred Heart Oral Health (administration/dental records) be changed to reflect the changed role from clinic to administration building.
(iii) The decommissioning of Farr Home and the relocation of residents to a more suitable aged care residential facility be considered (Kingaroy).
(iv) Safe work practices/safety rules be readily available for workshop staff at Kingaroy to assist in the promotion of a safe workplace.
(v) The current workplace administration floor space at Wondai be reviewed with a view to increasing the workplace size.
(vi) Refrigerators/freezers at Boonah, Laidley and Esk be fitted with temperature monitoring capacity.
(vii) Archived medical records in the mental health and oral health services be stored in a safe manner, free from exposure to sunlight and security risks.
(viii) Signposting for access and entry to the emergency department at Kingaroy be reviewed.

Stage 2 (August 2009)
(i) The immediate works identified in Stage 1 to reduce risk to acceptable levels be completed.
(ii) The rebuilding of the Barrett Adolescent Unit be expedited to enable care and services to be provided for adolescent patients in a purpose-built facility which facilitates a safe health environment and maximises the safety, comfort and needs of the community.

Function: Corporate **Standard:** 3.2
Criterion: 3.2.3 Waste and environmental management supports safe practice and a safe environment.

High Priority: No

Recommendation:

(i) The capacity to implement a comprehensive recycling program at Ipswich be reviewed.
(ii) Waste management procedures in the mental health service be included in staff orientation packages and in-service programs.
(iii) Action plans be developed in the mental health service for implementing improvements following routine waste management audits.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Corporate **Standard:** 3.2
Criterion: 3.2.4 Emergency and disaster management supports safe practice and a safe environment.

High Priority: No

Recommendation:

(i) Progress be hastened in replacing existing emergency exit plans with new exit plans in ward areas of Ipswich hospital.
(ii) The District fire training program be further developed to include site/unit specific content that reflects the uniqueness and needs of each work location.

Function: Corporate **Standard:** 3.2
Criterion: 3.2.5 Security management supports safe practice and a safe environment.

High Priority: No

Recommendation:

(i) The security risks facing staff when working alone at night in the emergency departments at Laidley and Esk be monitored to ensure that personal safety is maintained.
(ii) A safety review be undertaken of all non-hospital sites to ensure that staff working in small teams in isolated sites have a secure workplace with appropriate communication systems in place if needed in an emergency (Oral Health).
(iii) The security of staff working in the Laidley Oral Health facility be reviewed.
(iv) The personal duress alarm system at Wondai be reviewed with a view to determining its functionality and future use.
((v) General and master keys for the Kingaroy facility be located and maintained in a locked key cabinet with limited staff access.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.1.2.1
Function: Clinical **Standard:** 1.1
Criterion: 1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.

High Priority: No

Recommendation:

1. The Emergency Department when fully staffed implement a policy which requires authorisation for at least known high risk patients to be discharged by a senior doctor.

2. The timeliness of registrars attending the Emergency Department be monitored and reviewed.

3. The Health Service consider the formation of a Medical Emergency Team.

Mental Health

4. Formal processes be established to ensure that nursing handover (at The Park) occurs in an appropriate manner to facilitate the transition of clinical information which maximises and enhances consumer care.

Action:

1. Identified high risk patients (chest pain, abdo pain, headache, paediatrics) to be reviewed by a Senior Doctor before discharge by an intern or RMO from the Emergency Department Ipswich Hospital - completed.

2. The right of admission procedure circulated to all ED medical staff and hospital registrars which allows for patients who have not been reviewed within two hours to be admitted to the wards - completed.

3. Medical emergency team proposal on resus committee agenda - proposal considered at all levels - not proceeding - insufficient evidence that this achieves improved outcomes. Policy to be developed for patient criteria requiring medical/surgical registrar consultation. Currently researching the MEWS - Medical Emergency Warning System for possible application.
Mental Health

4. ET&R Clinical Project completed. WPG developed; Tool and process for transfer of information from clnical teams to staff developed; Entry and discharge processes reviewed; All processes and tools used in clinical handover reviewed - changes relating to content, responsibilities for, and roles; Project outcomes communicated to all staff. Electronic conveying of clinical information between Nurse Unit Managers and After Hours Nurse Managers on a daily basis - communication across all shifts in relation to changes to acuity. Joint policy developed between Ipswich Hospital and The Park for handover of information of patients assessed, treated or discharged at or from IH & The Park. (Nursing Executive / Clinical Program Areas - Completed) **Mental Health**

4. Clinical Program areas reviewing handover process and implementing practices. ET&R currently trialling intended changes. Work Practice Guidelines being established.

Completion Due By: June 2007

Responsibility: Nursing Executive / Clinical Program Areas

Organisation Completed:

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Surveyor's Comments: **Recomm. Closed:** Yes

1. The Director of the Emergency Department (ED) has implemented a policy which requires that all identified high risk patients (chest pain, abdominal pain, headache, paediatric) are reviewed by a senior medical officer prior to discharge by a junior medical officer. The policy is included in orientation for junior staff and monitored by reference to incident data. There have been no reported incidents of this nature since implementation of the policy.

2. The 2005 Right to Admission policy allows ED senior medical officers to transfer stable patients to the wards and the policy has been reinforced by orientation of registrars. The formation of the Medical Assessment and Planning Unit (MAPU) has had significant impact on the journey of medical patients through the hospital. Some delays still occur with surgical registrars having competing commitments in theatres or outpatients but the Right to Admission policy addresses this at least for stable patients.

3. The formation of a Medical Emergency Team has been considered with evidence explored and so the recommendation is closed. Alternate strategies to address identification and early management of deteriorating patients is currently being explored by the Resuscitation Committee.

Recommendation: OWS0206.1.3.1
Function: Clinical **Standard:** 1.1
Criterion: 1.1.2 Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.

High Priority: No

Recommendation:

1. The Pharmacy Department at Ipswich Hospital adopt rural support strategies that ensure regular visits to the Boonah, Esk and Laidley Health Services.

2. The newly implemented clinical practice guidelines be evaluated to ensure the effectiveness of this change and that the process is beneficial for both patient management and clinical outcomes.

3. A system be developed to track patient information documents that are developed in-house, and that all these be dated so that accurate up to date data is ensured. A process of formal review including level of language and understandability to the text be conducted.

4. The Patient Management process be looked at from a strategic view with policy development that allows those staff in charge of decisions to clearly understand the actions that are required when all available resources have been used.

5. There be a structured continuing education program in the Emergency Department and the wards of Ipswich Hospital with protected time for staff participation.

Mental Health

6. A review of the current (15 desk space) open office plan in the Extended Treatment & Rehabilitation Unit be undertaken, to ensure that there is lockable space for information, appropriate desk allocation and regard for the provision of confidential conversations and/or discussions.

7. A review of the workspaces at Goodna Community Health be undertaken to ensure that staff and clients are provided the safest environment.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Action:

Mental Health

6. Review undertaken and changes being implemented are:

New office on verandah of Gunnii House
Review of OT test room locations
WPH&S Environmental audit conducted
Office furniture and additional computers ordered.

1. Telepharmacy for rural sites & I-Pharmacy intervention implemented and completed across rural facilities - completed.

2. Evaluation of the efficacy of clinical guidelines be conducted and patient outcomes reflect effectiveness of the guidelines (June 2007 - DDON) in progress.

3. Completed and implemented policy and procedure for development, publication and evaluation of patient information. Audit results demonstrate compliance - completed.

4. MBU, CAFHS and SBU have established bed management strategies and have developed a formalised escalation process in times of crisis.

5. Nursing structured continuing education program has been actioned; training examples include: the nurses role in triage, communication, role and functions within ED, skill development and upskilling. Formalised medical structured continuing education and training program has been actioned; examples include upskilling, doctors are supernumerary for 10 weeks when converting from SHO to PHO level. An office within ED has been converted to a dedicated medical training room with scenario based training and real life simulations - completed.

Mental Health

6. Office space project completed - report finalised.

(ET&R Work Improvement Group / BU1 Management Committee - Completed)

7. Review work space for staff at Goodna in conjunction with Goodna Community Health (as per IMHS Strategic Plan 2006-2011) - June2007 Service Manager IMHS.

Completion Due By: December 2006

Responsibility: ET&R WIG / BU1 Management Committee

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

1. Pharmacy services are in place at rural sites. The teleconference model at Laidley is working well there to increase clinical input. This model could be extended to other sites. The absence of on-site visits still has an impact on the risks for medication management being undertaken solely by nurses, and a new recommendation has been made under criterion 1.5.1 in the current report.

2. Clinical guidelines are progressively being implemented based on models of best practice from reputable sources. Local evaluation is also being undertaken in various indirect and direct ways sufficient to address the intent of the recommendation.

3. Processes for the introduction of patient forms have been formalised, with master templates of approved documents available on the intranet. Auditing of records by the Health Information Manager tracks compliance.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

4. Escalation processes have been developed using a traffic light system for the Emergency Department and Intensive Care Unit at Ipswich, with "pull" systems from the wards and transit/discharge lounge areas in each ward assisting patient flow along with other strategies such as the MAPU.

5. The Emergency Department now provides two education sessions per week plus teleconference to rural sites. Various nurse educator positions have been increased across all sites and opportunities for education in core competency increased. Junior medical officers report difficulty in accessing education at times, and this is the subject of comment under criterion 2.2.4 in the current report.

6&7. The organisation has demonstrated completion of review of these facilities with appropriate renovations completed.

Recommendation: OWS0206.2.4.2
Function: Clinical **Standard:** 1.1
Criterion: 1.1.3 Consumers / patients are informed of the consent process, understand and provide consent for their health care.

High Priority: No

Recommendation:

1. In the light of the outcomes of the Queensland Patient Satisfaction Survey a targeted audit be conducted of consumer awareness of the Patient Rights and Responsibilities information at Ipswich Hospital.

Mental Health

2. With the appointment of a consumer position for the Integrated Mental Health Service a similar model be implemented as currently exists at The Park with the ability for consumers to have access to information from consumers on their rights and responsibilities at all points of care.

Action:

1. Subsequent review of the Queensland Health Patient Satisfaction Survey. Latest survey specifically asks about patient rights and responsibilities (awaiting results). All area have patient rights and responsibilities brochures and posters in place.

Mental Health
2. Developed the role for Consumer Consultant around the recovery principles as per IMHS Strategic Plan 2006-2011; Established a Consumer & Carer Advisory Group - completed.

Completion Due By: Feb 2008

Responsibility: Quality and Safety Officer PSQU

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

1. Further audit has taken place and thus this recommendation is closed. Results are not yet known, but the current information available was noted to be out of date and is the subject of a new recommendation under criterion 1.6.2.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.1.3.2
Function: Clinical **Standard:** 1.1
Criterion: 1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.

High Priority: No

Recommendation:

Mental Health

Ongoing review be undertaken of the level of seclusion within the Mental Health Service and strategies be implemented to ensure that the service performs at an industry standard based on best practice.

Action:

Mental Health
The Park

- Project and research commissioned to review issues related to seclusion use across all clinical programs at The Park. Priority areas in High Security, Medium Secure & Dual Diagnosis. The Park - Seclusion and Restraint Reduction Plan developed (2007)
- Benchmarking of seclusion use included in Statewide Benchmarking of Medium Secure services.
- Workgroup established in Medium Secure to identify and implement strategies to reduce seclusion use.
- Evaluation project has been established to assess the efficacy of these
- Beacon site for Prevention and Reduction of Seclusion and Restraint.
- Policies reviewed.

IMHS

- Seclusion review program implemented in IMHS by the CN for Clinical Risk Management. Significant decrease in seclusion rates has resulted through the implementation of the Seclusion Action Plan. There has been participation in the clinical collaborative for seclusion and restraint and the Seclusion Committee meets monthly

Completion Due By: Ongoing

Responsibility: Clinical Steering Committee / SERU / Seclusion & R

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

The organisation has demonstrated review of its seclusion practices and implemented strategies to reduce the usage of seclusion.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.1.4.1
Function: Clinical **Standard:** 1.1
Criterion: 1.1.5 Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.

High Priority: No

Recommendation:

1. An organisation-wide approach to discharge planning be developed including appropriate review of cases where there are problems.

2. At Laidley Hospital a record flagging or alert system be developed as a matter of priority to support effective discharge planning from the hospital to community and reduce the potential for miscommunication and/or unplanned clinical outcomes.

Action:

1. On hold until State Discharge Planning policy rollout. Hand to Home response team implemented at Ipswich Hospital which has integrated the roles of post acute wounds and health maintenance into a single service. This service manages the whole hospitalisation by case management from preadmission to up to 4 weeks post discharge. Ipswich Hospital is to be one of the pilot sites for Qld Health Enterprise Discharge Summary.

2. Address as part of District strategy to address the need for an integrated record across Ipswich Hospital, Rural Health Services and Community Health Service. Community Health Service dispatch the medical record to rural facility and upon completing admission or presentation, the medical record is returned to Community Health. Pilot site for electronic discharge summary to commence in 2008.

Completion Due By: Ongoing

Responsibility: Director HIM

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

1. The organisation uses the Queensland Health Policy on Discharge Planning as the overarching guide to processes and practices across all sites. Systems are in place appropriate for each site for interdisciplinary review of patients who represent post discharge, or who have frequent readmissions. Identification of patients who are potentially at risk of delayed discharge occurs on admission and appropriate interventions are actioned. The Hand to Home program at Ipswich Hospital has been created in order to consolidate the range of resources dedicated to discharge support and to realign the acute/community interface. The survey team noted the commitment by the clinical staff across all sites to the review of patients where there are potential or actual problems with discharge.

2. All clinical services, including community health and diabetes education, now document in the patient medical records at Laidley Hospital rather than maintaining separate files as was the case at the previous survey. These practices have achieved consolidation of all patient information in one file and have obviated the need for the development of a flagging system to enhance communication.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.4.1.1
Function: Clinical **Standard:** 1.1
Criterion: 1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.

High Priority: No

Recommendation:

1. Priority be given to developing a system to ensure timeliness of access of all members of the health care team (acute care, mental health, community health) to all parts of the health record at the point of access of the patient / client to the service, to ensure comprehensive health assessments and improved clinical outcomes.

2. The process for reviewing the results and addressing the recommendations arising from the regular Medical Record Audits be more formalised and that there is clear documentation of the ways the recommendations are being addressed and the quality loop closed.

Action:

1. Review current medical records across the district and seek a streamlined approach to patient records (June 2007 - Director HIM).

2. Documentation audit is formally conducted as a clinical audit process with feedback loop. Results tabled Patient Safety and Quality Council on an annual basis - completed.

Completion Due By: June 2007

Responsibility: Director HIM

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

A concerted effort has been made by the Medical Records Department to address the recommendations from the previous survey. Performance improvement is being monitored more effectively through the use of benchmarks and indicators There was evidence that there is an ongoing process for the integration of medical records and the flagging of other records for patients across the District.

Recommendation: OWS0206.1.1.1
Function: Clinical **Standard:** 1.2
Criterion: 1.2.1 The community has information on, and access to, health services and care appropriate to its needs.

High Priority: No

Recommendation:

1. A strategic approach be adopted to clinical service planning. This approach should reflect the needs of the community and projected service demands.

2. Podiatry resources be increased at Ipswich Hospital to address the foot health needs of diabetic patients.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

3. The resource levels of occupational therapy, speech pathology and nutrition and dietetics be increased at the Boonah, Esk, and Laidley Health Services.

Action:

1. Health Services Plan 2008-2012 developed and in progress. The Ipswich Hospital Demand Management Strategy is currently being developed - to identify how the facility will cope with the growth in demand over the next 10 years.

2. Appointment of Director of Podiatry – West Moreton South Burnett Health Service District. Increase of podiatry position 0.3FTE to 1.0FTE for Ipswich Hospital. New position and service created based at Kingaroy/Wondai to service South Burnett Area for district; development of new position description.

3. Current financial constraints prevent an increase in current resources - for review in next financial year.

Completion Due By: August 2007

Responsibility: DMS

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

1. A Health Services Plan 2008-2012 has been developed for clinical service planning.

2. A Director of Podiatry appointment to Ipswich Hospital was made in 2007, an increase from 0.3. A high risk foot clinic has been established which runs concurrently with the diabetes clinic. It is noted that a podiatrist position has also been established at South Burnett.

3. A Rural Rehabilitation Outreach Service has recently been established, and has provided dedicated resources of an occupational therapist and a speech pathologist, in addition to a physiotherapist, to Boonah, Esk and Laidley Health Services. Whilst the primary focus is rehabilitation, the focus is not exclusively rehabilitation, and the service has enabled access to occupational therapy and speech pathology services, and has improved continuum of care, facilitated early discharge and integrated acute and rehabilitation care.

Recommendation: OWS0206.1.1.3
Function: Clinical **Standard:** 1.2
Criterion: 1.2.2 Access and admission to the system of care is prioritised according to clinical need.

High Priority: No

Recommendation:

1. Waiting lists for outpatient clinics be reviewed, and further strategies developed to help reduce waiting times for appointments.

2. Further consideration be given to the provision of an emergency operating room at Ipswich Hospital for urgent obstetric and surgical cases.

3. Consideration be given to designation of a separate waiting area for Emergency Department paediatric patients.

4. Develop an appropriate interim care diversional therapy / activity program at the Laidley Hospital that is appropriately resourced.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
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5. Enhance the interim care program at Esk Hospital by furnishing and decorating the special support ward and allocating and training staff to deliver an appropriate diversional therapy program, consistent with residential aged care standards.

Action:

1. Review of OPD clinic processes for managing waiting lists and waiting times - in progress. Allocation of a NUM for 0.21 FTE to implement the Outpatient Referral Program.

2. Establish 6th Theatre - Business Case for a staffing establishment and equipment; Created a dedicated emergency session daily; Provided adequate elective list capacity to accommodate the increased community demand; Provided adequate elective lists without diminishing the private lists of the VMOs; Reduced number of cases performed after hours.

3. Refurbished current waiting environment and separate children's fenced area installed - completed.

4. Implementation of a diversional therapy program at this facility - Business case submitted to Ipswich community health NO6 through the hands to home project for funding for this position.

5. Seek support of District Executive to fund diversional therapy training; EOI for staff to undergo training; Implement training program; Review special support ward environment and implement recommendations - in progress.

Completion Due By: June 2008

Responsibility: DDON/DMS

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

1. The outpatient booking processes have been reviewed and streamlined. An Outpatient Central Referral Centre has been established. All bookings are reviewed in conjunction with the relevant clinician and prioritised. Strategies adopted include the transferring of the management of patients with Type 2 diabetes to the community, the referral of diabetic eye reviews to local optometrists who would perform retinopathy screening, the establishment of a fast track endoscopy service and the consolidation of the Orthopaedic Physiotherapy Screening Clinic. There has been a resultant reduction in the waiting lists, particularly those who have had to wait longer than 12 months, and with the Faciomaxillary Clinic. Category One patients are usually seen within two weeks. The failure to attend rate has reduced. Waiting list audits are regularly performed to monitor the situation. Referral guidelines are being developed to expedite the prioritising and appropriate access of patients to the relevant clinics.

2. A dedicated emergency theatre session has been established daily.

3. A fenced off area with appropriate play equipment has been established in the waiting room of the Emergency Department.

4. Nurses at Laidley Hospital have implemented an activities program established by a diversional therapist.

5. A nurse at Esk Hospital has commenced an activities program and is undergoing formal training in diversional therapy, with a view to undertaking a dual role.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
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Recommendation: OWS0206.2.4.1
Function: Clinical **Standard:** 1.6
Criterion: 1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service

High Priority: No

Recommendation:

1. A formal evaluation of all of the current consumer participation activities be undertaken and a district wide consumer plan be developed in consultation with consumers and staff of the various units of WMHSD.

Mental Health

2. Formal measures of consumer satisfaction be implemented consistently throughout the mental health services.

3. The level of consumer participation be increased in the Integrated Mental Health

Service through the allocation of dedicated resources to ensure consumers and carers have access to similar consumer services regardless of the entry point into services.

4. Consumer participation and representation at The Park have strong links with the establishment of consumer participation practice in the Integrated Mental Health Service.

Action:

1. Consumer Participation Toolkit completed and approved through District Executive.

Mental Health

2. Integrated Consumer Satisfaction Survey conducted Oct/Nov 07. Action plan to be developed from results of survey. Benchmarking between the 2 services. (Consumer Services - The Park / IMHS Consumer Consultant / CAG / SERU - April 08). Monthly surveys conducted in inpatient unit. Participation in trial of proposed national satisfaction measure (Consumer Perceptions of Care)

3. Consumer Consultant appointed. Consumer Liaison Officer position in the process of being established, currently filled in a temporary capacity. Established CAG. Consumer and Carer Representatives members of relevent management committees. Consumer Action Plan developed. Training program developed for volunteers. (Service Manager - Completed).

4. Communication strategies and supportive network developed between Consumer Consultant and Liaison Officer and IMHS Consumer Consultant to enable effective information sharing across services.. Proposal for integration of consumer services (The Park / IMHS) including Consumer & Carer Representative program, CAG, Consumer Consultant and Liaison roles. (Consumer Consultants The Park & IMHS - Ongoing)

Completion Due By: June 2007

Responsibility: Service Development / Consumer Services / SERU / C

Organisation Completed:

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Surveyor's Comments: **Recomm. Closed:** Yes

It would appear that no formal evaluation of consumer participation activities or a consumer plan have been developed as a result of the last recommendation. As a result of amalgamation with another District since the last Organisation-Wide Survey and its associated impact on realigning services, a new recommendation has been made.

Mental Health
The organisation has demonstrated measures for ongoing consumer satisfaction surveys, as well as increased level of consumer participation and representation within the mental health service.

Recommendation: OWS0206.2.3.1
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.

High Priority: No

Recommendation:

The District further extend and strengthen comprehensiveness of information reported to the District Council, Patient Safety and Quality Council and other areas within the organisation.

Action:

Development and implementation of the Clinical Governance Operational Plan which outlines reports for different forums across the district.

Completion Due By: March 2007

Responsibility: Director PSQU

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

Actions taken have met the requirements of this recommendation.

Recommendation: OWS0206.2.3.1
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.

High Priority: No

Recommendation:

The District further extend and strengthen comprehensiveness of information reported to the District Council, Patient Safety and Quality Council and other areas within the organisation.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
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Action:

Completion Due By:

Responsibility:

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

Actions taken have met the requirements of this recommendation.

Recommendation: OWS0206.6.1.1
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.

High Priority: No

Recommendation:

1. Implement a quality register and make information available to WMHSD staff via the intranet.

2. Explore increased opportunities for external benchmarking.

Action:

1. Developed quality activities register (QASAR) for multi- user access across the district. QASAR installed on server for multi user access. QASAR training in progress across district.

2. PCOC (Palliative Care Outcomes Collaborative) in progress, AROC (Australasian Rehabilitation Outcomes Collaborative) to be implemented, and APOP (Acute Pain Outcomes Project) in place. Venous Thrombo Embolism Prevention Program benchmarks with Princess Alexandra Hospital. Falls Prevention Program part of an action research program. Orthopaedic Physiotherapy Screening Clinic provides benchmarks for the statewide implementation.

Completion Due By: July 2007 - completed

Responsibility: PSQU

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

Actions taken have met the requirements of this recommendation. The question of benchmarking is entirely a matter for the District as it pursues its quality journey.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.2.2.2
Function: Support **Standard:** 2.1
Criterion: 2.1.2 The integrated organisation-wide risk management policy and system ensure that clinical and corporate risks are identified, minimised and managed.

High Priority: No

Recommendation:

1. The organisation ensure that all recommendations arising from root cause analyses are addressed and that a register of outcomes of actions arising from these recommendations is maintained.

2. The reporting and follow-up of adverse events and incidents be expanded to include "near misses".

Action:

1. Further development of the Queensland Health PRIME incident reporting system now captures all RCA recommendations. Reports available from QHERS - Queensland Health Electronic Reporting System. Overdue reports now tabled at Patient Safety & Quality Council.

2. Implemented District Wide HEAPS training that emphasises near miss reporting and established patient safety walk rounds- completed.

Completion Due By: Completed

Responsibility: Completed

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

Whilst near misses are now reported and actioned, the follow-up of root cause analyses in mental health is still not undertaken to an appropriate standard, and there is a further recommendation in relation to this within the current report. This recommendation is therefore closed.

Recommendation: OWS0206.3.1.1
Function: Support **Standard:** 2.2
Criterion: 2.2.1 Human resources planning supports the organisation's current and future ability to address needs.

High Priority: No

Recommendation:

Develop an organisational wide workforce plan that addresses the projected staffing requirements across disciplines of WMHSD.

Action:

District Wide Workforce Plan - WMSBHSD in progress.

Completion Due By: Dec 2008

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Responsibility: Director HRM

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

This recommendation has been addressed in part by the development of an interim workforce plan. A Project Officer has been employed to coordinate the development of a comprehensive workforce plan that includes projected staffing. The timeframe for achieving this objective is two years. A new recommendation will be made in the current report which subsumes this recommendation , which is now closed.

Recommendation: OWS0206.3.1.2
Function: Support **Standard:** 2.2
Criterion: 2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.

High Priority: No

Recommendation:

1. The District develop and implement a system to confirm identification of staff being appointed to the District Services. Proof of ID may include an original passport, drivers license, medicare card being sighted and copied with the signed copy being kept in the employee's personnel file.

2. The system of reviewing credentials and granting privileges be further refined in the areas of registrar and GP clinical practice.

Action:

1. Criminal History checks have been implemented for all new employees with documents used to confirm identification, such as a birth certificate, drivers licence or passport - completed.

2. Division of General Practice conduct a credentialling for GPs within private sector. Obstetric and Gynaecology registrars are credentialled for conducting unsupervised after hours LUSCS - completed. Credentialling policy updated to meet HQCC standards.

Completion Due By: June 2007

Responsibility: Director HRM

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

1. This recommendation has been appropriately addressed by the introduction of mandatory criminal record checks for all new staff appointments. These checks involve confirmation of identification via a birth certificate, passport or Medicare card, and the recommendation is now closed.

2. This recommendation has not yet been fully addressed and will be reframed and included in the current report, and accordingly is now closed.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
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Recommendation: OWS0206.3.1.3
Function: Support **Standard:** 2.2
Criterion: 2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.

High Priority: No

Recommendation:

The District Performance and Development process be actively implemented in all sites in the organisation to increase the level of compliance across the organisation.

Action:

Evaluated current system for recording of PAD. Current difficulties in capturing and reporting of data - awaiting a state-wide solution - to be rolled out in the near future (SABA).
District Wide policy on requirements of each manager/ supervisor to conduct PADs. PAD process simplified and circulated - training sessions provided for revised process.

Completion Due By: June 2007

Responsibility: Director HRM

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

A new Performance and Development (PAD) system has been developed by the Human Resources Department and this is being progressively rolled out across the organisation. The surveyors noted that compliance was still not 100% or near it, and a new recommendation to address this issue is included in the current report. This recommendation is now closed.

Recommendation: OWS0206.2.1.1
Function: Corporate **Standard:** 3.1
Criterion: 3.1.1 The organisation provides quality, safe care through strategic and operational planning and development.

High Priority: No

Recommendation:

Mental Health

1. The Mental Health strategic plans be developed and implemented across sites, with clear review mechanisms in place. To ensure accountability a reporting structure on progress at a District level continue to be developed.

2. There be a clear focus and subsequent articulation on the desired level of integration of services for The Park and the Integrated Mental Health Service.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Action:

Mental Health
1. Strategic & Operational Planning complete. First review proposed early 2007. Organisational Structure and reporting framework reviewed. Amendments made to The Park's Governance Document reflecting outcome of review.

2. West Moreton Health Service Patient Safety and Quality Committee established. The DMHES has been established and is progressing the integration of aspects of mental health education, orientation, mandatory training & rotation of graduate placements.**Mental Health**

1. Strategic & Operational Planning completed. Business Planning 2008-09 commenced - incorporated into District Plan. Organisational structure and reporting framework reviewed. Amendments made to The Park's Governance Document reflecting outcome of review.

2. West Moreton South Burnett Mental Health Service Patient Safety & Quality Committee reviewed. The District Mental Health Education Service established and is progressing the integration of aspects of mental health education, orientation, mandatory training and rotation of graduate placements. Proposal for integration of consumer services (The Park / IMHS) including Consumer & Carer Representative program, CAG, Consumer Consultant and Liaison roles. (Completion Date: Feb 07 / Responsibility of: DD WMSBMHS.

Completion Due By: April 2007

Responsibility: EMC / Service Development / Business Units

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

The organisation has demonstrated the development and implementation of mental health strategic plans across all sites and an articulation of the level of integration of services for The Park and integrated mental health service.

Recommendation: OWS0206.2.1.3
Function: Corporate **Standard:** 3.1
Criterion: 3.1.2 Governance is assisted by formal structures and delegation practices within the organisation.

High Priority: No

Recommendation:

1. Allied Health Seniors meeting should identify ways to collectively address pressing issues including rural health model of care, workforce planning, resource allocations in the rural health services, workload management, supervision models, clinical risk management and competency assessment.

2. Review the position of allied health chairperson to improve credibility and sustainability at District Executive level, and fund the incumbent at minimum 0.2 EFT so that appropriate leadership and clinical backfill can be provided.

3. The District research and develop a rural and primary health model to ensure consistency and equity of resources, especially for allied health, at the Boonah, Esk and Laidley Health Services.

Action:

1. Evaluation of Allied Health Meeting and Terms of Reference to address pressing issues. Meeting for Allied Health

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
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Seniors has commenced with Terms of Reference drawn up to reflect recommendations - completed.

2. Position of Allied Health Chairperson reviewed and time allocated to meet the demands of the role. A new position of District Director of Allied Health Services is currently under consideration.

3. Addressed as part of Health Services Plan 2008-2012.

Completion Due By: Completed

Responsibility: Completed

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

1. In addition to the development of Terms of Reference for the reconstituted allied health seniors Meeting, this recommendation has been further addressed by the temporary appointment of an Allied Health Workforce Development Officer, who has not only mapped the resource base of allied health staff across the District, identified issues of inequality of access and reinforced the need for the appointment of the position of Director of Allied Health Services at the District Executive, but also developed a business case for funds to establish a rehabilitation outreach service as an alternative service delivery model to address the inequities of access.

2. The establishment of a position of Director of Allied Health has been endorsed by the District Executive but recruitment has been delayed during the negotiations for a statewide industrial agreement for allied health staff, and will now be further delayed by the staff freeze pending the amalgamation with the Toowoomba and Darling Downs Health Service District.

3. The District has established a multidisciplinary Allied Health Outreach Team based at both Ipswich and Kingaroy Hospitals, as a new model of service delivery to better address the needs of the rural communities.

Recommendation: OWS0206.2.1.5
Function: Corporate **Standard:** 3.1
Criterion: 3.1.5 Documented corporate and clinical policies assist the organisation to provide quality care.

High Priority: No

Recommendation:

1. There be a system for monitoring staff access to and compliance with policies and procedures.

Mental Health

2. Policies and procedures be reviewed to ensure consistency within the Mental Health Services.

3. A system be developed to provide back-up policy and procedure documentation in the event of the electronic system being unavailable.

Action:

1. Reviewed Doc Cube system and developed a district wide strategy for a user friendly and efficient system through the development of district website for improved access for staff - in progress (Marketing - June 2008). All policies and procedure identified across the newly amalgamated district. Merging and archiving of no longer relevant or

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
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duplicitous documents has commenced. A structure for managing policies across the district has been drafted and is currently awaiting executive approval.

Mental Health

2. All Policy documents being reviewed and where practicable, integrated across both services. Review of process for development and review of policies completed. (August 08 - Service Development The Park / PS&Q Officer IMHS)
3. Policy documents in the form of hard copy and CD held by Service Development at The Park. Hard copy access provided to AH Nurse Managers. As Policies & Procedures are reviewed also being published to the WMSBHSD Intranet site. (Service Development - Completed)

Completion Due By: Ongoing

Responsibility: Service Development

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

1. A project officer has been appointed to implement a revised policy and procedure framework following the amalgamation of the Districts. This is a work in progress and will need to be reviewed at the next Periodic Review. An improved system for monitoring compliance with policies and with legislation was suggested to staff during the Organisation-Wide Survey.

Mental Health
2&3. The organisation has demonstrated consistency of its policies and procedures within mental health services. There is now a system to provide backup of policy and procedure documentation to the electronic system.

Recommendation: OWS0206.5.1.1
Function: Corporate **Standard:** 3.2
Criterion: 3.2.1 Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.

High Priority: No

Recommendation:

1. District Management review and evaluate the current Risk Register and Balanced Scorecard to ensure they meet not only the needs of Queensland Health, but of all the facilities within the District Health Service.

2. District Management extend the monitoring and evaluation of the delivery of support services through the Queensland Health Shared Service arrangements, particularly with respect to financial management, procurement, workplace health & safety and injury management.

3. Expertise within the Ipswich Hospital workplace health & safety team and injury management team be more accessible to all hospitals / services within the District.

4. A review of policies / procedures be initiated to more effectively support safe practice and a safe environment at The Park, with appropriate emphasis to be placed in identifying risks and preventing injuries to staff and clients.

5. District Management ensure that policies related to child protection, particularly at the Barrett Adolescent Unit be reviewed to confirm that there are appropriate protocols to protect children against abuse from children, as well as staff or visitors.

Recommendations from Previous Survey

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6. IMHS staff be regularly reminded of the need to carefully assess and manage clients who are potentially suicidal or who self harm.

7. Where at risk clients are not deemed sufficiently at risk to be placed in the High Dependency Unit, close observation of these clients be maintained and documented evidence be provided to demonstrate practices.

8. Management at The Park more strongly support and encourage staff participation in the Workplace Safety Committee.

9. A workplace health and safety officer, be nominated for Laidley Hospital.

10. Maintenance delegations (expenditure levels) be reviewed to ensure managers have sufficient authority to efficiently and effectively manage safety issues at the local level.

Action:

1. Reviewed risk register. Undertaken a district wide strategic planning process for the balanced scorecard. Implementation of QH Risk Management System provides access for directors across the district to lodge and manage their own risks.

2. Restructure of Shared Service Providers with return to the district of OHS, HRM with remaining functions to held offisite (whole of government initiatives).

3. O H & S structure reviewed and more resources applied to better meet district needs.

4. Policies, Procedures and Work Practice Guidelines continue to be monitored and reviewed in line with National, State and District risk management and child safety guidelines and requirements. Manual Handling (Object Handling) training conducted and competency assessments undertaken for all operational staff . (Service Development / WPH&S Officer / Business Units - Ongoing)

5. All staff in Barrett Adolescent Unit have undertaken Child Safety Legislation training. All staff are required to have a blue card prior to commencing employment in the unit. Child Safety mandatory reporting DVD shown to all staff and new staff captured at orientation; attendance is recorded. Children's Commission representative visits regularly for consumer feedback. Written report of visit provided. (Completion Date: Dec 06 / Responsibility of: Adolescent Unit / Service Development / PEP

6. Strengthened service capacity to deal with patients who are potentially suicidal or who self harm & ensure appropriate follow up for those people who are identified as having an increased risk. Reviewed handover to review risk. Review processes in clinical reviews. Failure to Attend Policy developed and implemented.

7. Maintain current management practices for high risk clients on the open ward (Ongoing - Nurse Unit Manger, Mental Health Unit).

8. Election of WPH&S Representatives across the District. Training provided to newly elected representatives and will be provided continuously. Attendance at meetings has increased. Meetings provide an opportunity for problem solving to occur between experienced members and new members. Flyers identifying OH&S Representatives in areas displayed in all units. (WPH&S Officer / Service Manager - Completed)

9. Manager Operational Services is the Laidley hospital WHSO.

10. Financial delegations have been reviewed.

Completion Due By: Ongoing

Responsibility: Service Development / WPH&S Officer / Business Uni

Organisation Completed:

Recommendations from Previous Survey

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Surveyor's Comments: **Recomm. Closed:** Yes

1. The risk register and balanced scorecard have been reviewed and evaluated. These documents form the basis of a Queensland whole of state approach to risk management and there is evidence that District risks are identified, and action plans developed within the statewide framework.

2. Queensland Health Shared Service arrangements have been reviewed and consistent with that review, occupational health and safety and human resource management functions are now located within the District structure. This has seen an improvement in service support to operational areas.

3. The outcome of action from recommendation 2 (above) for occupational health and safety has seen the formation of a District unit, which has provided sound support to hospital operational units. Comments within this current survey report will identify the need to further support non-hospital sites within the district.

4. Policies and procedures within The Park unit have been reviewed within a risk reduction framework.

5. Policies are now in place to reduce the risk of child abuse within the unit. Redevelopment of the unit to provide a more appropriate setting for the adolescents is the subject of a High Priority Recommendation in this report.

6. Assessment and client management of at risk clients is in place.

7. Completed.

8. Staff actively participate in the Workplace Safety Committee.

9. Workplace health and safety officers have been trained and are in place throughout the District, inclusive of Laidley.

10. Delegations schedules throughout the District have been implemented and staff education has been completed to ensure that Managers are aware of their delegated authority.

Recommendation: OWS0206.5.1.2
Function: Corporate **Standard:** 3.2
Criterion: 3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

High Priority: No

Recommendation:

1. The planned relocation of the generator and the completion of electrical upgrades at Esk Hospital be expedited.

2. The completion of the planned renovations of the toilet / bathroom facilities at Boonah Hospital be expedited.

3. A review of the facilities / infrastructure at Laidley Hospital be initiated to assess safety and security risks and meet modern service delivery needs.

4. District Management pursue the redevelopment of the Barrett Adolescent Unit at The Park so that care can be provided in a modern facility designed to meet service delivery needs and support safe practice and a safe environment.

5. A review be conducted on current systems for testing of electronic detection devices, pagers, radios to confirm that they are fully functional; and report results to the workplace safety committee.

Recommendations from Previous Survey

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6. The waiting area available for both inpatients and outpatients in the Medical Imaging Services, Ipswich Hospital be reviewed with respect to the comfort and privacy of patients, and action be taken for improvements needed.

7. Appropriate consultation be undertaken with the Rurals with respect to the planning of any refurbishments, the prioritisation of refurbishments (and any subsequent delays), and the procurement of goods and services.

Action:

1. Installed generator and switchboard upgraded.
2. Renovations completed.
3. Annual Security audit conducted and completed. Submission to Capital Assets committee for Duress and ED Alarms funding. ED Plan to upgrade security and duress submitted. Upgrade to backdoor entry completed.
4. Redevelopment of Barret Adolescent Unit remains a priority. Funding identified as part of the new Mental Health Plan. User Group established and meeting. Feasibility on a location for redevelopment is progressing through the Area Managers. Interim actions undertaken to enhance service delivery include:
: All hanging points identified and rectified.
: Sensory room created
: Improved quiet room
: Created a bedroom to suit need of a specialised client.
Identified improvements are prioritised and will progress.
5. Radios and pagers are repaired on request from the users. Duresses - aged mental care unit, adult mental health unit tested daily; special care nursery tested weekly; all duresses tested monthly; Duress system at The Park tested by random selection at every shift.
6. Some improvement made from review of waiting room area conducted with consumer input, awaiting additional funding and re-structure as part of the Demand Management Strategy.
7. Reviewed to reflect needs of rural facilities with BEMS manager. Boonah Hospital currently undergoing structural changes to improve aged care facilities.

Completion Due By: Completed

Responsibility: Completed

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

1. Generator and associated electrical work has been completed.

2. Toilet/bathroom facilities at Boonah have been completed.

3. Security audit has been completed. This recommendation has been closed and will be replaced with a recommendation focused on the safety of staff working alone at night . This new recommendation will be reported under criterion 3.2.5.

4. The recommendation in its current form has been closed and replaced by a new recommendation within the main body of this report, to better reflect the current circumstances.

5. Systems for testing and maintenance work on duress devices are appropriate.

6. The recommendation in its current form has been closed and replaced by a new recommendation within the main body of this report, to better reflect the current circumstances.

7. Rural facilities are consulted on refurbishment projects and remain active throughout the process.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
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Recommendation: OWS0206.1.1.2
Function: Corporate **Standard:** 3.2
Criterion: 3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

High Priority: No

Recommendation:

1. Signage at Esk from Brisbane Valley Highway be improved to ensure that those who are not familiar with the area can more easily locate the hospital.

2. Signs at the front of the Esk Hospital be upgraded.

Mental Health

3. Signage at the entrances to The Park be amended to include information on the nearest facility for hospital emergency services.

Action:

1. Reviewing current signage using consumer input (Apr 2007 - DRHS Esk).
2. Upgraded current signage.

Mental Health

3. Major road works have commenced at both entrances to The Park and redevelopment by QPS of the old facility. Erecting / replacing signage at this time would be ill-advised. Review at completion of roadworks. (Completion of roadworks - Service Manager)

Completion Due By: Review at completion of road works

Responsibility: Service Manager

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** Yes

1. Public road signage has been improved.

2. Signage at Esk Hospital has been upgraded.

3. Signage at The Park will be upgraded when the new traffic works are completed.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
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Recommendation: OWS0206.5.1.4
Function: Corporate **Standard:** 3.2
Criterion: 3.2.4 Emergency and disaster management supports safe practice and a safe environment.

High Priority: No

Recommendation:

1. The practical lessons from the fire emergency at Ipswich Hospital be documented and shared across all facilities.

2. Outstanding fire safety works commenced at The Park be completed.

3. The current no smoking policy in residential units at The Park be enforced and any relevant client/staff education be undertaken.

4. Staff at Goodna participate in fire safety training and conduct an annual mock evacuation.

5. The workplace layout for community services at Goodna be reviewed and the egress routes made clear/accessible.

6. The fire safety audit tool designed by the Fire Safety Officer at Ipswich be implemented District-wide.

7. Evacuation signs at Laidley be reviewed and replaced, as required, to facilitate safety.

Action:

1. Sent to all facilities to share with their staff and requested they save on shared drives. Included Mock purple and Code Purple action plans.

2. Works from the Bourne Report progressing with all required documentation related to amendments to the Fire & Engineering report forwarded for sign off. (Service Manager / Coordinator Fire Prevention & Security / District Fire, Security & Safety Advisor - Jun 08)

3. Anti-Smoking Legislaton reveiwed by the Smoking Committee. Facility policy reviewed. Nominated smoking areas created in all clinical areas. Staff trained in smoking cessation guidelines. Signage displayed in all areas. NRT implemented for staff and consumers. Inhalers, lozenges and patches available to consumers. Physical environments reviewed in all clinical areas and changes made to conform with policy requirements. Line Manager responsible for ongoing monitoring and compliance. Smoking inlcuded in assessment areas for benchmarking in ETR, Dual Diagnosis, and Medium Secure. (Smoking Committee / Clnical Business Units / DMHES - Completed.

4. Completed and now included on annual timetable within district.

5. Bins were removed from the rear stairwell and evacuation egress routes have been erected. A mock evacuation was conducted on 29.11.06.

6. Fire safety audit tool implemented and in place.

7. Replacement of evacuation signs at Laidley Hospital has been completed.

Completion Due By: Completed

Responsibility: Completed

Organisation Completed:

Recommendations from Previous Survey

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Surveyor's Comments: **Recomm. Closed:** Yes

1. This has been done and the Ipswich unit shares information across the District as emergency exercises are completed.

2. The Park has undergone a fire inspection, an action plan has been developed and works completed.

3. No smoking policy is consistent with Queensland Health policy.

4. Goodna staff participate in fire training and evacuation exercises.

5. Workplace safety has been reviewed and action taken to address egress concerns.

6. Ipswich unit shares information and audit tools.

7. Signage at Laidley has been upgraded.