Report of the ACHS National Safety and Quality Health Service (NSQHS) Standards Survey

ACT Health

Canberra, ACT

Organisation Code: 81 00 04

Survey Date: 19-23 March 2018

Advanced Completion: 3-5 July 2018

ACHS Accreditation Status: **ACCREDITED**

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About The Australian Council on Healthcare Standards

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

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

The principles upon which all ACHS programs are developed and the characteristics displayed by an improving organisation are:

- a customer focus
- strong leadership
- a culture of improving
- evidence of outcomes
- striving for best practice.

These principles can be applied to every aspect of service within an organisation.

What is Accreditation?

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

How to Use this Survey Report

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

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

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

1 Survey Team Summary Report

Consists of the following:

Standard Summaries - A Standard Summary 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 Standard and comments are made on activities that are performed well and indicating areas for improvement.

Ratings

Each action within a Standard is rated by the organisation and the survey team with one of the following ratings. The survey team also provides an overall rating for the Standard. If one core action is Not Met the overall rating for that Standard is Not Met.

The report will identify individual actions that have recommendations and/or comments.

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

In addition to achieving the actions required, measures of good quality and a higher level of achievement are evident. This would mean a culture of safety, evaluation and improvement is evident throughout the hospital in relation to the action or standard under review.

Action Recommendations

Recommendations are highlighted areas for improvement due to a need to improve performance under an action. Surveyors are required to make a recommendation where an action is rated as Not Met 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 survey team at the next on-site survey.

Risk ratings and risk comments will be included where applicable. Risk ratings are applied to recommendations where the action rating is Not Met to show the level of risk associated with the particular action. A risk comment will be given if the risk is rated greater than low.

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular action.

Recommendations are structured as follows:

The action numbering relates to the Standard, Item and Action.

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 survey team regarding progress in relation to those recommendations are also recorded.

The action numbering relates to the month and year of survey and the action number. For example, recommendation number NSQHSS0613. 1.1.1 is a recommendation from a NSQHS Standards Survey conducted in June 2013 with an action number of 1.1.1.

5 Standards Rating Summary Report

This section summarises the ratings for each Standard allocated by the survey team.

Organisation: ACT Health
Orgcode: 810004

Survey Report

Survey Overview

Australian Capital Territory Health (ACT Health) is the major provider of health services in the Australian Capital Territory. This is under a unique model within Australia. This service oversees all aspects of health planning, legislation, policy development and service delivery within the jurisdiction of the Australian Capital Territory. There are eight divisions of which 6 are led by Deputy Director General's reporting to the Director General. These divisions include: Health Services Programs, Territory wide Services Redesign; Corporate Services; Performance, Reporting and Data; Policy & Government Structures; Canberra Hospital and Health Service (CHHS); and Population Health Protection and Prevention. The later six have varying levels of operational accountability for services provided in regard to CHHS.

The current model does create a significant degree of confusion and fails to provide clear accountability across the organisation which leads to negativity in organisational culture. This is recognised in the organisations risk register with both accountability and culture rating in the top group on the risk register. The ACT's Minister for Health and Wellbeing has announced a restructure of the organisation to come into line with other jurisdictions which will separate the policy and operational components of the health service creating two new agencies.

The CHHS is a Division of the ACT Health. Services under this umbrella include acute tertiary inpatient beds (623 beds), Rehabilitation services, Mental Health, Drug & Alcohol and Justice Health services and community health services. CHHS is the tertiary provider of health services to people in Canberra as well as some parts of southern NSW.

At this survey, the organisation was assessed against the ten National Safety and Quality Health Service (NSQHS) Standards. All inpatient facilities and community services were visited and the surveyors met with managers, staff and patients and family/carers. A self-assessment against the standards was provided pre- survey and further evidence was provided on-site. There was not an in depth Mental Health Services assessment undertaken but rather was included within the broader assessment of the organisation. A report from an external review was provided to the surveyors.

The surveyors met with staff and patients when they visited, Canberra Hospital, Village Creek, Alexander Maconochie Centre, Adult Mental Health Unit, Belconnen Health Centre, Bimberi Youth Justice Centre, Brian Hennessy House, Canberra Regional Cancer Centre, Centenary Hospital for Women and Children, Dhulwa Secure Mental Health, Gungahlin Health Centre, Phillip Health Centre, Rehabilitation Services, Sterilising Services at Mitchell and Tuggeranong Health Centre.

The ACT Health has for some time been going through a significant churn at executive level with many in their roles less than 15 months. There has been what the staff would consider a revolving door at senior levels and this has created a great deal of instability, turmoil and fragmentation of leadership. In addition to this a significant body of 'corporate knowledge' has been lost and systems around good governance have been impacted. This turmoil at a senior level has resulted in the staff providing clinical services somewhat detached and rudderless so they have developed sub systems to try and achieve various goals. The last workplace culture survey was undertaken in 2015 and since then there has been a lack of follow through with an assessing organisational culture. There has been a recent review of the committee structure but it is important that this is done in conjunction with developing a robust clinical governance framework.

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Overall the organisation was found to be struggling with the current governance structure and there was a lack of clear accountability lines and follow through within the organisation. There are a number of recommendations and suggestions to address the deficits in the organisation.

Advanced Completion (AC) Review – 3-5 July 2018

Over the past few months the organisation has changed dramatically implementing sustainable systems and processes that provide direction and strong governance from both a corporate and clinical governance perspective. The surveyors would like to acknowledge the extensive work done by the staff across ACT Health plus the leadership to achieve this result. They demonstrate commitment and focus to drive sustainable positive change in the culture of the organisation. They have moved from a fragmented divided organisation to one of cohesion, teamwork, focused on what is best for the patient and the organisation to achieve great outcomes for all Canberrans. The engagement and ownership of the problems and solutions to the recommendations by staff at all levels was clearly demonstrated to the surveyors. This has been no mean feat and everyone needs to recognise this achievement in a positive productive light. This work will need to be sustained but the surveying team felt the systems and processes put in place over the last few months, will assist staff and the leader's confidence to drive towards excellence and safety in all patient care services.

All recommendations have been closed.

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STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

The ACT Health has over the past couple of years come under significant stress and the organisation has not been helped by the many leadership changes and therefore instability in direction. This survey focused on the CHHS but the blurring between ACT Health and CHHS is not only confusing for the staff but the Executive members of the service, also. The current structure makes it very difficult for individuals to be held accountable and to appropriately manage the services to provide safe patient care. The single point of accountability for ACT Health is the Director General of Health. The current day-to-day clinical accountability for CHHS sits with the Deputy Director General (DDG) of CHHS who works closely with the DDG of Quality, Governance and Risk (DDG QG&R)-the later position accountable for Quality, Safety and Risk. One manages the operational clinical services whilst the other manages all aspects of quality and safety in CHHS. Both of these roles also have strategic responsibilities for ACT Health. Other DDG's manage corporate services and information services. The inability of the DDG CHHS to manage or provide governance over a number of other areas including Information Management, Corporate Services lead to significant fragmentation and confusion around accountability. Some recommendations have been made to assist in moving forward.

Despite the challenges of direction and policy at the peak body level CHHS has established robust mechanisms to ensure that clinical and operational policies and associated procedures are current. The clinical operational Policy and Procedure system in place is now robust and provides a good framework for developing other Policy and Procedures in the organisation. There is allocated custodians for each procedure and there is clear documentation of who can amend or endorse each process. This unfortunately, doesn't appear to extend to organisational committees, strategic policy and direction. There has been a significant body of work done over the past few months to try and review clinical and operational policy documents that were overdue. There was a significant number overdue but with a dedicated team driving and overseeing the process these operational policies and procedures are nearly all current.

There is a major chasm between the operational functioning of the corporate and clinical services. This can be seen in linen services, maintenance (e.g. rectifying Ligature points), and information technology services with the risk of implementing clinical systems that are not integrated. It is difficult to drive change in the organisation if there is no accountability for staff or if safety and quality are not part of the KPIs for all strategic roles.

There was limited evidence that the Strategic Plan (the Health Directorate Corporate Plan dated 2012-2017) is current nor what was happening to progress its review but it is understood that there was a recent Strategic workshop held for the senior group but no outcomes were available. Individual services, due to the focus around the impeding accreditation survey developed their own business and quality plans with varying degrees of quality. There was limited evidence that the ACT Health's governing body peak committee, receives reports on quality and safety indicators or how they are responsible for patient safety and quality of care. To achieve this, it requires that Quality performance data be monitored by the executive level of governance, and action taken to improve the safety and quality of patient care. The current Executive Directors Council Safety and Quality (EDCS&Q) does receive reports on quality and safety but this is not the peak committee of the organisation nor formally reports to the highest level of governance.

The current Clinical Governance Framework (2015 – 2018) does not reflect the direction of the organisation and needs to be reviewed as a matter of priority.

There has recently been a paper titled “Quality Governance – Strengthening Governance in ACT Health” submitted by the DDG QG&R to the DG with in principle agreement. There were four recommendations with the first being to develop a Strategic Governance Framework for ACT Health then others include the need for clear organisational structure that cascades responsibility for delivering quality performance from “Board to Ward”. It is extremely important that a clear governance structure be implemented as soon as practicable and a recommendation has been made in relation to this issue.

The ACT Health key strategic and business plans are out of date. There is a need to review and update the Corporate Governance Statement and the Corporate Plan and ensure that the Divisional Business Plans are aligned. There was little evidence available in past projects that link Health Service Planning and to include details of patient clinical risk and safety objectives in any planning documents. A couple of examples of this include the major delays in rectifying the Ligature points in Mental Health, the poor state of the kitchen, and the legionella risks at Canberra Hospital. There was also no recent evidence of the assessed risk associated with ACT Health Technology Assessment Committee (HTAC), who previously performed this function but they haven’t met since 2016.

The Clinical Risk Management processes lack consistency and are not embedded across the organisation. The system is fragmented and although the individual risks are able to be found on the system there is limited ability to actively see relevant components of the overall risk summary. The system is not actively used by senior groups nor is it currently in enough detail to be of value to them. The Risk Register needs to be reviewed to facilitate its use and management of the organisations risks.

There is a strong focus on understanding the consumer and their family with a Patient Story being told at the beginning of most meetings and this sets the scene to drive a patient centred approach in the organisation. There is also strong engagement from consumers in the various meetings and groups across the Health Service.

The overarching education and training programs are well developed and most are competency based. There is an excellent orientation program in place for all external contractors. Locum and agency staff are provided with sound orientation and given a comprehensive but succinct reference guide to assist in their integration into the workforce. It is strongly suggested that all groups who provide education to staff come together under one committee to develop the strategic direction for education and training across the organisation.

Advanced Completion (AC) Review – 3-5 July 2018

The organisation demonstrated they had reviewed the systems around their governance and found that significant parts were out of date and no longer supported the organisation and have therefore been revised. This has resulted in the development and implementation of new Corporate and Clinical Governance structures. To support this the Committee structure has also been reviewed and a three-tier structure has been implemented. This has resulted in a number of changes including revised Terms of Reference (TOR) that more accurately reflect the intent of the group; agendas have been revised to include standard agenda items which report up through the organisation; and clear accountabilities, reporting lines and escalation processes.

The new Corporate and Clinical Governance Frameworks 2018-2023 which have been rolled out have provided clear guidance on role definition and accountabilities.

Feedback from staff clearly demonstrated that staff are aware of the new governance structure, their roles and responsibilities associated with these frameworks.

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The revised ACT Health Corporate Plan 2018-2023 provides direction, strategic objectives and operational goals that aligns with the organisation goals of access, sustainability and accountability. A template has been developed for the Divisions Annual Business Plans which is aligned to this Corporate Plan. These Business Plans are currently being populated. There was extensive evidence of the change in practice around business decision making in the organisation.

Over the past few months the finance team have worked closely with the relevant Divisions to determine the requirements of the Division to enable them to build sustainable, achievable and accountable budgets that facilitate patient safety and quality of care (for example addressing waiting lists). This will be the first year that all budgets and activity have been agreed, signed off and loaded by the 24th July for the 2018-19 financial year.

The new frameworks implemented have provided much greater clarity of who is responsible for what and how to escalate if a potential barrier is encountered. CHHS clinical services now report into the Directorate Leadership Committee (DLC) which previously was not the case. This is a Tier 1 committee or the peak committee for the organisation, chaired by the Director General (DG). Feedback from staff clearly demonstrated a major shift in the organisation to ensure decisions are timely and responsive to meet the needs of safe care.

The Corporate and Clinical Governance Frameworks and supporting documents have provided staff at all levels and designations, clear direction and accountabilities around their role in safety and quality. The ACT Health leadership team are clear of the direction, their own roles and responsibilities and the expectations of the organisation. People are being held accountable but they are also recognised at all levels by the Director General with a personalized phone call to acknowledge and thank them for their work. This has been very powerful in assisting with cultural change.

There is also a New Workforce Strategy under development which will include details of the workforce accountabilities and responsibilities in Safety, Quality and Risk. There has been targeted education to ensure staff are aware of their roles in this new environment.

The Director General has established weekly meetings which includes senior clinicians to achieve the requirements set out under the National Safety and Quality Health Service (NSQHS) Standards. In addition, he has established weekly communiques sent out to all staff as well as having staff forums to set the direction and answer any questions. A ‘Quality Capability Plan’ with supporting documents has also been developed and focuses on the ongoing capacity building of all staff.

The Risk Management Policy, Framework and Guidelines have been updated and recently endorsed by the DLC and have been communicated to staff and placed on the Intranet. The framework describes four levels of risk and the appropriate level in the organisation where they reside. The documents also provide triggers and processes for escalation or de-escalation. It was also evident to the surveyors that staff are aware of the different levels of the risk register and what is in their own domain.

The organisation now has a single Risk Register which has been reviewed and updated to reflect current risks and accountabilities with ongoing monitoring. Risk Management is also now a standard agenda item on all management meetings across the organisation. The organisation’s Tier 1 risks have now been tabled at the DLC and reviewed. This has resulted in some risks deescalated to appropriate levels, some removed, others added and additional actions taken to mitigate the risks.

The new Quality Strategy and the Implementation Plan is aligned with the Risk Management Framework and provides a consistent organisational wide approach to quality and safety improvements with clear pathways for escalation. All Risks now have an associated improvement plan and pathway. The budget process and its impact is also linked to each risk and the subsequent consequences for patient care.

High Risks are to be reviewed on a quarterly basis and extreme risk on a monthly basis or more frequently if required by the DLC.

The 'Quality Strategy 2018-2028' has now been supported by an 'Implementation Plan & Measurement Framework 2018-2020'. This includes the organisations strategic priorities and enablers and also a strategy for 'Building Capacity and Capability in Patient Safety and Quality Improvement 2018-2020'. The later strategy is being developed through a collaborative approach with staff, consumer's, managers and union representatives. The framework supporting the Strategy provides a three-level education and training infrastructure with an associated competence level at Foundation level (Bronze), Practitioner level (Silver) and Improvement Advisor Level (Gold).

Clinical practice

A wide range of clinical guidelines, pathways and care models are utilised across the service but not in all areas such as managing surgical waitlists and Outpatients. The challenge the organisation has is that there is not an agreed way of monitoring what pathways/guidelines are in place and their effectiveness. There is a need to establish a process for monitoring and approval of various pathways to ensure consistency across the organisation.

Although there are systems in place to enable benchmarking against like organisations through systems such as Health Roundtable, and Women's & Children's' Australasian Group there was little evidence that this was driving the overall benchmarking practices across the organisation. A number of clinical areas report to registries, for example Stroke and Intensive Care.

There are a range of screening tools that are utilised to identify 'at-risk' patients, including risk of falls, pressure injury, malnutrition and cognitive impairment. Compliance with screening tools is audited through clinical documentation audits and results are discussed at Unit meetings as well as presented to the various subcommittees of the National Standards Governance Committee.

In saying this, there is a concern by the surveyors that over the past three years there has been a number of suicides in the organisations' inpatient areas. Following these events there has been a lack of robust investigations with recommendations and appropriate action plan which is monitored by the highest level of the organisation. There has been a review of the ligature points by an external architectural consultant in Mental Health, Alcohol & Drugs, and Justice Health back in January 2017, which was finalized in August 2017. This was following the fourth deaths but the action plan for this report is only now being implemented over 12 months later. These delays and lack of robust actions following transparent investigations and associated action plans create an extreme risk for the organisation. These issues were discussed during the survey with the service management team and the executive around the need to urgently progress the rectification of the ligature points.

Patient clinical records are generally available at the point of care, although it is strongly suggested that there is work undertaken to define Point of Care for the organisation with most clinical records being kept at the staff station and only the nursing care plan, medication and observation charts available at the actual bedside. Medical records are all scanned on discharge and available electronically to the clinical staff and hard copies are destroyed after three month's post discharge.

A paper record is in operation across the organisation that provides clinical staff with day-to-day clinical notes.

This is supported by a number of independent electronic information systems in operation in various departments e.g. Charm (Oncology), Birthing Outcome System (BOS), EDIS (Emergency Department), MHAGIC / MAJICer (Mental Health).

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The Clinical Record Information System (CRIS) acts as the final repository for clinical records with scanned copies of the paper record, printed documentation from BOS, Charm and EDIS saved in CRIS to provide a centralised record for access by clinical staff. There is a performance target of three days associated with scanning into the system however this target is not always achieved.

The Pathology Laboratory software, Kestrel, is one of a number of other standalone pieces of software within the Canberra hospital systems that may not be possible to be integrated into an electronic record. At present Kestrel is used by the laboratory to audit for Wrong Blood in Tube and in doing so detects a number of labelling errors that happen within the hospital for blood and any other pathology specimen. This audit process has a highlighted the need for a number of safety and quality improvements in the departments that collect and send specimens to the laboratory. It is suggested that the organisation commence planning to integrate the electronic systems across the various services to improve staff access to a consolidated clinical record that will promote timely patient management.

There were some very good examples observed of clinical services across the organisation:

• Use of tele-health by renal services such that at any site the patient vital signs, fluid dialysed etc. can be viewed in real time.

• Use of IT viber to observe patients taking their TB medicines real time (rather than a nurse visiting the home)

• The trial roll out of the electronic medical record system for administration of medications, Vital signs recording and initiation (and review of results) of tests (pathology and radiology) - ward 7SU (stroke)

• Tele-health to review ECGs at remote locations to aid in consultation and treatment of patients

• Research projects at ICU and Allied health

• Enthusiasm on the wards; engagement in learning activities and quality boards and at the Community Centres

•The commitment to the management of ‘at-risk’ client’s safety, rights and respectful patient-centred care at the Mental Health, Justice Health and Alcohol and Drug services at Alexander Maconochie Centre, Bimberi, Dhulwa and Brian Hennessey Rehabilitation Centre. The commitment of these teams to ensure effective integration of Primary Heath Care Services and Mental Health Services was palpable and their proactive collaborative partnership approach with ACT Corrective Services to achieve the best health outcomes for clients demonstrated the true intent of the NSQHS Standards.

Advanced Completion (AC) Review – 3-5 July 2018

A new centralised governance process has been introduced for the management of clinical pathways to ensure organisational wide consistency.

The definitions have also been strengthened with a new process for approval that ensures sustainability of these pathways. As a result of reviewing all the current Clinical Pathways a number of pathways have been removed, often due to not being actively utilised.

A process has been implemented to guide clinicians to meet the new requirements and a support structure is being considered to assist in achieving this standardisation. This new process will be reviewed in six months.

An Independent External Review of the MHJHADS was undertaken on the 22-23 May 2018 and the final report was tabled on 1 June 2018. The report found the services to “be safe and very competently managed by a skilled and experienced senior management team”. They identified some opportunities for improvement and provided 11 recommendations.

These recommendations have been accepted and the team is utilising the newly developed Mental Health Advisory Body to oversee the implementation of the recommendations from this review.

Following survey, a Mental Health Ligature Minimisation Workers User Group was established to oversee the project scope and impact on clinical services. There is a 3 Stage remediation plan which was commenced on 23 April in conjunction with the Health Infrastructure Services team. Stage 1 resulted in removal of forty ensuites doors, barricade flaps and six off door closers that represented the highest ligature risk. Stage 2 will be completed by late August and Stage 3 by later this year. Ongoing progress of this will be monitored by the DLC.

The ongoing active management of ligature points by the team whilst still ensuring a recovery focused environment has been exceptional. The work to remove potential hazards and some of the solutions have found unintentional consequences. This has resulted in some potential solutions not being progressed but the MHJHADS with the Infrastructure team have continued to come up with other options. This includes a prototype room where options have been trialed. The surveyors acknowledge the leadership of the MHJHADS team and the large body of work undertaken to achieve closure of these recommendations in relation to Item 1.8.

Performance and skills management

CHHS has policies and systems in place for credentialling and defining the scope of practice for medical staff, nursing staff and allied health staff, all overseen by the relevant Committees. It is suggested that as these currently are fundamentally discipline based that they are combined to provide an overarching multidisciplinary process for credentialling and defining Scope of Practice.

For nursing and allied health staff, the current committee’s role is to credential and define the scope of practice of Nurse Practitioners and nursing and allied health practitioners with extended scope of practice. Registrars have their scope of practice determined by the Heads of Units but there is not a more sophisticated transparent process in place that records down to a procedural level for each individual registrar. Early work is currently underway to establish a framework for this and assist in defining more specifically the individual’s scope of practice. Once this system is further advanced it is worth considering further formalising so that specific procedures are documented for each registrar. E-Mercury is the system utilised to document and monitor credentials and scope of practice and this can be accessed by relevant staff, including theatre staff to ensure that a surgeon is operating within his/her scope of practice. The system at this point is only for Medical staff but it is planned to be used for both Nursing, Midwifery and Allied Health.

The old committee that reviewed applications for new interventions and technologies and associated scope of practice has not been meeting and a new group is in the process of being established.

This will be the “New Clinical Procedures, Services and Other Interventions Committee" with Terms of Reference developed in January but has yet to meet. The organisation is encouraged to progress this group as soon as possible.

Regular audits are undertaken of credentials and scope of practice, including compliance with AHPRA registration and criminal checks, annual checks of the database to ensure documentation is up-to-date and review of theatre lists (for senior and junior medical staff in procedural areas). Compliance reports are reviewed at the relevant committees. Junior staff are well supervised and supported by senior staff.

A system is in place to review and record performance and development needs of staff. The Performance Development framework was developed for the generic Public Service and not for clinical staff. This has led to concerns by staff as to its relevance to their practice and feel it is a compliance issue rather than a developmental and clinical feedback process. It is a recommended that a review of this system be undertaken to establish if it can be adapted to be relevant for the clinical workforce.

A range of quality and safety education and training activities are available to staff. These are available online and also in other modalities with strong links and relationships to the various Universities.

A staff survey was last undertaken in 2015 to ascertain staff understanding of quality and safety systems. It is strongly suggested that a repeat survey be undertaken to assist the organisation understand any gaps and issues and be able to move forward.

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The Health Technology Advisory Committee (HTAC) has been re-instigated with new TOR and membership is via invitation. The group has met and the process of assessing and proving new health technology or procedures is linked back to the credentialling process for the individual clinician.

Work had begun in August 2017 to implement a new tool for performance review but had not been fully rolled out nor were all staff aware of the new template. As a result of the recommendation the performance plan template was updated in May 2018 following further consultation with clinical leads. The template now incorporates specific performance review criteria for staff to articulate key safety and quality responsibilities, key tasks, responsibilities and performance indicators.

There is also the capacity to adjust the process and utilise other tools (for example College requirements) to load into the system and be recognised as part of the process. A review process will be undertaken over the next few months and an evaluation will be provided in October.

A number of process have been implemented to gain feedback from staff on their understanding and use of safety and quality systems. These include: weekly DG bulletins linking back to accreditation results; DG forums; CNMO Senior Nurses and Midwifery forums; Registrar training; CNMO and DON rounding; empowering Wardpersons in regard to patient identification; Quality Officers now aligned to Divisions with a focus on regular auditing of clinical practice (Hand hygiene, Clinical handover, patient identification) and providing staff with real time feedback allowing clinicians to change practice. These results are also displayed on Quality Boards which are being actively updated on a regular basis and this is then discussed at various meetings and forums.

Incident and complaints management

The staff were able to demonstrate knowledge of the RiskMan system. Incidents and complaints are reported, investigated and outcomes monitored. It was noted however that actions and any recommendations on the register are not always being addressed in a timely manner.

The system for monitoring serious events including coroner's cases etc. needs further work as does the completion rate of the incident and complaints entries.

There is a short 30-minute mandatory training program available for all clinical staff on Open Disclosure and it is planned in the coming months to run a full day program for senior staff and clinician as this has not been done for a few years. Open disclosure processes are in place but there is a missing link between the finalisation of an investigation, implementation of the recommendations and then the feedback closure loop to the patient or their family. This does happen at times but there is no consistent process.

Information on incidents and complaints is reported through the organisation to the Executive Directors Council Safety and Quality (EDC S&Q).

The survey team noted that offenders continue to smoke at Alexander Maconochie Centre (AMC). ACT Health staff and other offenders are exposed to the known harmful effects of passive smoking. The Surveyors suggest ACT Health actively work with ACT Corrective Services from a health and wellbeing perspective to identify and address the health impacts of smoking on offenders under the health care responsibility of Justice Health.

Advanced Completion (AC) Review – 3-5 July 2018

The Incident Management system has been reviewed and it is now clear about the four Tier approach to Incident Management. The system is clear who is responsible and accountable for working towards mitigating risks or resolving incidents in a timely manner. Incident data is more comprehensive and feedback loops have established to ensure issues have been resolved and have been approached on a systems basis to ensure sustainability. This includes reports on a regular basis now being tabled at the peak committee (Directorate Leadership Committee - DLC).

Clear guidelines have also been put in place for expected completion times for investigations at a local level and for Significant Incident Investigations which are now being monitored. Changes to RiskMan will assist in monitoring these timeframes. In addition, definitions have been strengthened and the process is all linked back to the Clinical Governance Framework.

Patient rights and engagement

The Australian Charter of Healthcare Rights posters were displayed across the organisation with 20 translated versions of the brochures accompanying these posters in some areas. The Canberra Hospital Inpatient Guide for consumers also contains patient rights information. This guide is currently under review to reduce its length and improve health literacy. The surveyors encourage the organisation to ensure continued consultation with the HCCA and Carers ACT before finalisation of this revised guide and consider translation of this guide into the major languages of patients who use the health service. The organisation was able to demonstrate that 143 staff completed the Australian Charter of Healthcare Rights eLearning program and 77 staff completed the working with interpreter's eLearning (patient experience in-service) in 2016/17. The surveyors suggest that an increase in completion rates would be warranted considering the number of clinical staff across the organisation. In 2016, the Measuring Patient Care Program inpatient survey found that 85% of patients had received information on and were aware of their healthcare rights. This inpatient survey has now been changed to one that is administered post discharge from which poorer results have been found thus far with 38% in the three months to March 2018. The organisation identified that this may be an issue of recall post discharge.

The surveyors suggest that the method of surveying should be reviewed along with implementing targeted strategies to improve these results.

The CHHS Consent and Treatment Policy (February 2016) outlines how the organisation ensures clinicians meet their ethical, professional, and legal obligations in seeking and obtaining consent.

The Quality and Risk Unit Audit Schedule shows that monthly audits on surgical consent are conducted. A report for Surgical and Oral Health Consent (January 2018) from a 15-month period found issues in use of interpreters and blood products with recommendations. However, it was not clear how this would be implemented or monitored. The surgical consent audit report (February 2018) demonstrated that interpreters were used in only 43% of applicable situations. The surveyors suggest that the Surgery and Oral Health Division compile and implement an action plan to improve these results. Whilst good results were found in RACC consent audits (July 2017), variable results for consent were found in the Division of Women, Youth and Children Clinical Record Documentation audit (2017). Particularly with only 67% of consent for every procedure in paediatrics, 67% have consent signed by a clinician and 50% where consent is signed by the patient/ guardian or representative. Recommendations were made but the surveyors were unable to note any evidence of an action plan or follow up to improve. Due to the varying results and disparate monitoring of consent processes, the surveyors have rated action 1.18.2 as Not Met and have made a recommendation to strengthen senior clinical governance of the consent program to improve consent compliance across the organisation.

The organisation currently capture data on interpreter bookings and report on a quarterly basis, however more specific information regarding numbers of individuals serviced does not occur. Currently the highest interpreter service accessed is for Arabic followed by Vietnamese. The organisation plans to audit interpreter data against ACT Patient Administration System (ACTPAS) data and clinical records to evaluate compliance with the Language Services – Interpreters, Multilingual Staff and Translated Materials policy. The surveyors suggest this will be an important strategy to assess whether the organisation meets CALD information needs.

The Advance Care Planning (ACP) Clinical Guideline (December 2016) and Advance Agreements, Advance Consent Directions, Nominated Persons (February 2016) for Mental Health consumers outline how patients and carers are supported in documenting their advance care needs. ACT Health has a service level agreement with HCCA to promote ACP in the community. HCCA completed an Advanced Care Planning Annual Report (2017) that documented the work completed to promote ACP amongst the community, CALD, and ATSI populations. Alerts have been developed on the electronic ACTPAS and a green sleeve has been placed in files to identify patients with an ACP. Weekly spot audits are conducted to ensure ACP opportunities are optimised.

ACT Health currently have a hybrid of paper based and electronic patient clinical records across the organisation. The organisation was able to demonstrate a system of security measures to restrict access to information from the electronic ICT network, applications and clinical systems. There was also evidence of auditing to monitor access as per numerous policy requirements.

There were numerous Consumer Carer Feedback Forms with self-addressed and stamped return panels observed throughout the organisation to encourage patient feedback. These are recorded through the RiskMan system and themed.

The organisation has changed their patient feedback survey system to a post inpatient discharge survey. Surveyors noted a report compiled for the National Standards Governance Committee (March 2018) that included results of the Discharged Inpatient Surveys. Twelve-month results (to December 2017) showed that the organisation has maintained above 80% satisfaction with overall care received.

Key themes were highlighted identifying areas of improvement including the hospital environment, physical comfort, information, communication and coordination of care. The report also monitored the number of complaints and compliments received.

This report period was for two years and demonstrated that there were 69% compliments versus 31% complaints.

The main themes for the complaints were about information and communication issues, access, and conduct. The organisation identified strategies to improve access to services through implementing evidence-based clinical criteria for waiting lists. Women, Youth and Children produced a divisional report on the paediatric survey for parents where tablets (Fabio) were used to collect feedback on their children's care during their hospital episode. Surveyors noted that this will be a timelier and appropriate method of collecting feedback information to identify improvement opportunities for this particular patient cohort.

Advanced Completion (AC) Review – 3-5 July 2018

The Partnering with Consumers Committee has been identified as the responsible committee for receiving, reviewing and escalating issues in relation to the consent process with an Executive member as the sponsor. The pathway has been mapped and the policy will be for review in 2019. Since May all consent forms have been risk rated and will be reviewed in line with their associated due dates. A quarterly comprehensive data report has been tabled at both the Safety and Quality Committee and the Partnering with Consumers Committee. Results have been disseminated to the relevant Clinical Divisions for action.

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.1.1	SM	SM
1.1.2	SM	SM
1.2.1	SM	SM
1.2.2	SM	SM
1.3.1	SM	SM
1.3.2	SM	SM
1.3.3	SM	SM
1.4.1	SM	SM
1.4.2	SM	SM
1.4.3	SM	SM
1.4.4	SM	SM
1.5.1	SM	SM
1.5.2	SM	SM
1.6.1	SM	SM
1.6.2	SM	SM

Action 1.1.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

There was little evidence to demonstrate how the governing body provide direction and overview for the development, regular review and maintenance of a comprehensive suite of organisational policies. The current system is fragmented, lacks consistency and clear direction across the organisation for the staff and service delivery.

The high level clinical governance policy (dated 2015 - 2018) has not been reviewed to match a changed committee structure and does not reflect the current organisations direction.

There is a major policy gap and interface between corporate and clinical governance within the governing body. There is confusion between what functions sit with ACT Health and what with the Canberra Hospital and Health Service due to lack of policy clarity and direction.

At an operational clinical level there is now good systems and processes in place to effectively manage the procedure and protocols for clinical services but the relationship with the governing body is unclear.

Advanced Completion (AC) Review – 3-5 July 2018

1. The organisation demonstrated they had reviewed the systems around their governance and found that significant parts were out of date and no longer supported the organisation and have therefore been revised. This has resulted in the development and implementation of new Corporate and Clinical Governance structures.

To support this, the Committee structure has also been reviewed and a three-tier structure has been implemented. This has resulted in a number of changes including revised Terms of Reference (TOR) that more accurately reflect the intent of the group; agendas have been revised to include standard agenda items which report up through the organisation; and clear accountabilities, reporting lines and escalation processes.

Recommendation is closed.

2. The new Corporate and Clinical Governance Frameworks 2018-2023 which have been rolled out have provided clear guidance on role definition and accountabilities. Feedback from staff clearly demonstrated that staff are aware of the new governance structure, their roles and responsibilities associated with these frameworks.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Action 1.1.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

There is no current strategic plan for the service either at the governing body or CHHS level (the Health Directorate Corporate plan is dated 2012 - 2017) and until recently there were few Divisional Business Plans with a consideration of patient safety and quality. There was no evidence available to the surveyors that this has been reviewed or evaluated. It was not commonly known to staff nor used as the basis for building business plans in CHHS or Divisional Level.

There was evidence that some business decision making priorities were not aligned to ensure patient safety. This was specifically in areas that have no reporting or accountability to CHHS clinical services.

Examples of this include the major delays in rectifying the ligature points in Mental Health after several suicides in the area. Other examples include the kitchen, ongoing high counts of Legionella rates in the Canberra Hospital and the Intravenous Cannula project. These examples highlight the fragmentation within ACT Health and that there are no appropriate processes in place to prioritise business decision making to ensure patient safety.

Advanced Completion (AC) Review – 3-5 July 2018

1. The Strategic Corporate plan has been reviewed and Business Plans have been aligned.

Recommendation is closed.

2. Systems have been implemented to ensure business decisions consider the impact on patient safety.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Action 1.2.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The current governance system requires approval from a number or areas prior to being approved and the timelines are often extensive with little or no feedback to the area who have raised the issue. Decision making is often lengthy and convoluted when a significant patient safety and quality issue is identified.

The organisation is not agile and responsive to significant patient incidents. An example of this is the failure to address the major risk of ligature points with well over a year since the last event and three years since the first suicide in the unit.

Advanced Completion (AC) Review – 3-5 July 2018

1. Actions have been implemented to ensure timely response to safety and quality of care.

Recommendation is closed.

2. Clear accountability lines have been established at senior levels.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Action 1.3.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

There is significant confusion amongst staff as to the current direction of the ACT Health which has led to staff instigating what they think is appropriate under their delegation. The current structure places all of quality and safety under one directorate and the CHHS directorate having no accountabilities for safety, quality and risk. This detracts from the stated direction of everyone being accountable for safety, quality and risk.

Advanced Completion (AC) Review – 3-5 July 2018

1. The new systems and process have given assurance that staff are aware of their delegated safety and qualities roles and responsibilities.

Recommendation is closed.

2. Systems are in place to inform staff of their accountabilities and responsibilities.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Action 1.5.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The risk management system is fragmented and although the individual risks are able to be found on the system in RiskMan, there is limited ability to actively see the relevant component on the actual risk summary or on the risk register. The system is not actively used by senior groups as it fails to provide enough detail to actively understand the risks.

Advanced Completion (AC) Review – 3-5 July 2018

1. The Risk Management Policy, Framework and Guidelines have been updated and recently endorsed by the DLC.

Recommendation is closed.

2. The organisation now has a single Risk Register which has been reviewed and updated to reflect current risks and accountabilities with ongoing monitoring.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Action 1.5.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Currently there is varying degrees of engagement in ensuring a robust risk management system is in place. There is limited trended data on incidents and varying compliance in completing risk assessments. The most recent climate survey to assess the organisations culture was conducted three years ago and came up with an organisational culture of one about blame.

Advanced Completion (AC) Review – 3-5 July 2018

The new Quality Strategy and the Implementation Plan is aligned with the Risk Management Framework and provides a consistent organisational wide approach to quality and safety improvements with clear pathways for escalation.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Action 1.6.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

There has, over the last few years, been a significant degree of churn in senior executive which has resulted in instability and lack of consistence of what is the organisation's agreed quality management system. This has been recognised by the DDG of Quality, Safety and Risk who has undertaken a significant body of work to engage with staff and consumers to develop a new quality framework which was launched in the week prior to survey. The next steps will be to develop the supporting tools to roll this new framework out across the organisation.

Advanced Completion (AC) Review – 3-5 July 2018

1. The new Quality Framework had been implemented supported by an 'Implementation Plan & Measurement Framework 2018-2020'.

Recommendation is closed.

2. The organisation-wide quality management system is being embedded through a number of strategies.

Recommendation is closed.

Organisation: ACT Health
Orgcode: 810004

Surveyor's Recommendation:

No recommendation

Action 1.6.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

There was a new quality strategy launched the week before survey but there is not yet a quality plan to support this framework.

Without a clear plan, accountabilities and feedback loop processes the quality process is fragmented and fails to embed across the organisation a culture of ongoing quality improvement and high standards.

Advanced Completion (AC) Review – 3-5 July 2018

A number of strategies have been implemented to ensure action has been taken to maximise patient quality of care.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Clinical practice

Ratings

Action	Organisation	Surveyor
1.7.1	SM	SM
1.7.2	SM	SM
1.8.1	SM	SM
1.8.2	SM	SM
1.8.3	SM	SM
1.9.1	SM	SM
1.9.2	SM	SM

Action 1.7.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Currently although there is a number of Clinical pathways in use across the organisation there is no process for standardising them across services, or monitoring their use and implementation.

Advanced Completion (AC) Review – 3-5 July 2018

A new centralised governance process has been introduced for the management of clinical pathways to ensure organisational wide consistency.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Action 1.8.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

There are parts of the organisation where there is good evidence of mechanisms in place to identify patients at increased risk of harm, for example, those at risk of falls, pressure injury, blood transfusion, and deteriorating patients.

Significant concern is expressed by the survey team around a number of issues in Mental Health and the number of suicides in the health service over the past three years which have not had a robust review nor strategies implemented to mitigate the risks.

Advanced Completion (AC) Review – 3-5 July 2018

An Independent External Review of the MHJHADS was undertaken on the 22-23 May 2018 and the final report was tabled on 1 June 2018.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Action 1.8.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Despite all the recent work in addressing the National safety and Quality Health Service Standards (NSQHSS) in general that the organisation has undertaken, there is significant concerns by the surveyors around five suicides over the past three years within the inpatient units of the health service. Four deaths in Mental Health and one death in a general medical ward. There was no immediate commissioning of any external review of all four deaths, nor was there a robust RCA undertaken in three of the cases. There was some form of general feedback with some suggestions but this failed to make any significant impact. There was a report undertaken by an external architect on ligature points in January 2017 and a GANNT chart has only been developed to commence in February-March 2018, over 12 months post the review. There appears to have been no regular ligature points audit undertaken nor was there any action plan done to implement strategies to prevent further cases.

Advanced Completion (AC) Review – 3-5 July 2018

1. A three stage plan was developed and as part of Stage 1 forty ensuites doors were removed that represented the highest ligature risk. Stage 2 is now being implemented.

Recommendation is closed.

2. A Mental Health Review Advisory body has been established.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM
1.10.3	SM	SM
1.10.4	SM	SM
1.10.5	SM	SM
1.11.1	SM	SM
1.11.2	SM	SM
1.12.1	SM	SM
1.13.1	SM	SM
1.13.2	SM	SM

Action 1.10.4 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The development of a robust system for the introduction of a new clinical service, procedure or other technology and the relationship to an individual's scope of practice is in its infancy. There is still work to be done on the process for approval and governance of new services, or technology with a new committee structure being introduced. The Terms of Reference have been developed in January 2018 but the group has not yet had the ability to meet. This Committee needs to have a strong relationship with the scope of practice approval process to ensure that all staff involved have the appropriate skills and knowledge to assist and the overall service has the capability to undertake these new services.

Advanced Completion (AC) Review – 3-5 July 2018

The Health Technology Advisory Committee (HTAC) has re-instigated and aligns scope of practice for new services or technologies.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Action 1.11.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Currently the organisation has been directed to utilise the generic Public Servant tool for performance review which fails to meet the need of the clinical workforce. This has resulted in difficulties in credibility of the tool and therefore its use. There has been a concerted effort to ensure a large number of staff have undertaken this process but the credibility of the system is seriously questioned by staff and provides little value to the individual clinician.

There is a need for a review of the generic tool to be undertaken to establish how it can be made into a valid and reliable tool that is appropriate for the clinical workforce.

Advanced Completion (AC) Review – 3-5 July 2018

The performance tool has been reviewed and feedback from clinicians has assisted in this process.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Action 1.13.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Currently there is no formal process in place to gain feedback from the workforce on their understanding and use of safety and quality systems. The most recent climate survey was undertaken in 2015. The recent consultation with staff around the development of the Quality Strategy is a good start to ensuring engagement of staff but work is still required to assess staff's understanding of the Safety and Quality system.

Advanced Completion (AC) Review – 3-5 July 2018

A number of process have been implemented to gain feedback from staff on their understanding and use of safety and quality systems.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Incident and complaints management

Ratings

Action	Organisation	Surveyor
1.14.1	SM	SM
1.14.2	SM	SM
1.14.3	SM	SM
1.14.4	SM	SM
1.14.5	SM	SM
1.15.1	SM	SM
1.15.2	SM	SM
1.15.3	SM	SM
1.15.4	SM	SM
1.16.1	SM	NM
1.16.2	SM	SM

Action 1.14.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

There are some systems in place to analyse and report on incidents but compliance with reporting is fragmented and the system is not embedded into the organisation. Compliance with reporting is unknown and a number of incidents reported in the system are only partially completed. There is also a need to ensure that all significant incidents are reported to the highest level of governance.

Advanced Completion (AC) Review – 3-5 July 2018

The Incident Management system has been reviewed, Incident data is more comprehensive and feedback loops have established to ensure issues have been resolved and have been approached on a systems basis to ensure sustainability.

Recommendation is closed

Surveyor's Recommendation:

No recommendation

Action 1.14.4 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

There is an ad hoc approach in some areas to reducing risks identified through the incident management. The lack of completeness of a number of incidents and closure makes it difficult to assess the thoroughness of the incident management system.

Advanced Completion (AC) Review – 3-5 July 2018

Clear guidelines have also been put in place for expected completion times for investigations at a local level and for Significant Incident Investigations which are now being monitored.

Recommendation is closed

Surveyor's Recommendation:

No recommendation

Action 1.16.1 Developmental

Organisation's Self Rating: SM **Surveyor Rating:** NM

Surveyor Comment:

There is an open disclosure program in place but there is a gap following the initial open disclosure and the finalisation of an investigation in closing the loop with the patient/family. There is currently no ability to establish if there is feedback to the patient/family following the completion and implementation of the recommendations from the RCA/investigation.

Surveyor's Recommendation:

Implement a system to identify and track the closure process of an open disclosure following an investigation.

Risk Level: Low

Patient rights and engagement

Ratings

Action	Organisation	Surveyor
1.17.1	SM	SM
1.17.2	SM	SM
1.17.3	SM	SM
1.18.1	SM	SM
1.18.2	SM	SM
1.18.3	SM	SM
1.18.4	SM	SM
1.19.1	SM	SM
1.19.2	SM	SM
1.20.1	SM	SM

Action 1.18.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The organisation has a policy on consent that includes various accountabilities at ward and clinical level. However, it did not have an overarching senior position that would oversee the consent processes across the organisation. As a consequence, the surveyors noted inconsistent monitoring across the organisation and little evidence of action plans and follow up to ensure improvements in areas of poor adherence to the policy.

Advanced Completion (AC) Review – 3-5 July 2018

A review of the consent governance process has been undertaken and pathways have been mapped and regular reports to accountable bodies.

Recommendation is closed.

Surveyor's Recommendation:

No recommendation

Organisation: ACT Health
Orgcode: 810004

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

ACT Health has an overarching Consumer and Carer Participation in ACT Health Policy that outlines how consumers and carers are involved in the governance of the service. There was strong evidence of active involvement of consumers and carers in many facets of clinical governance pertaining to quality and safety across the organisation. ACT Health demonstrated close working relationships with Health Care Consumers Association (HCCA), Carers ACT, and the ACT Mental Health Consumers Network. The organisation was able to evidence that representatives from these various groups reflected a good diversity of backgrounds including representatives from Culturally and Linguistically Diverse (CALD) and Aboriginal and Torres Strait Islander (ATSI) backgrounds. Whilst there was strong consumer and carer involvement at the clinical governance level of the organisation, there was now (over the past few years) no involvement at the organisational level of governance across the organisation. For this reason, the surveyors have agreed to rate action 2.1.1 as Not Met with a recommendation to expand consumer and carer participation in the organisational governance of the organisation.

The organisation was able to demonstrate strong consumer and carer involvement in the recently developed ACT Health Quality Strategy through 22 key informant interviews, four focus groups, 452 responses to online survey and HCCA Facebook page, and a review of ACT Health feedback data.

However, there was limited evidence that consumers and carers have been involved in any broader strategic planning and operational planning for the organisation. Thus, the surveyors have agreed to rate action 2.2.1 as Not Met with a recommendation to establish mechanisms to engage consumers and carers in the broader strategic and operational planning aspects of the organisation.

There were many examples across the organisation of consumers and carers being actively involved in decision making about safety and quality such as representation on service specific quality and safety committees. The above mentioned external consumer organisations provide their own orientation and training for their consumer and carer representatives. HCCA have recently revised their training program following review of other training programs throughout Australia. A toolkit continues to be provided for Chairs and Secretariats of committees that have consumers and carers represented. Consumers and carers interviewed over this survey week found this a valuable process and reported that they were well supported by the organisation.

The organisation has developed a Consumer Handout policy, an eLearning package on Writing Consumer Publications, and a toolkit to support staff in developing publications. There was evidence of a concerted effort to reduce the number of patient brochures and improve the quality of these through a dedicated Consumer Handout Committee with consumer representation. Many of the new publications advise of interpreter access with the standardised interpreter symbol. The surveyors suggest that a standardised symbol may also be useful to easily identify that a brochure has had consumer and carer input such as a consumer tick or readily identified stamp.

Consumer partnership in designing care

Consumer representatives were involved in many new builds and redesigns across ACT Health including the establishment of the Dhulwa Mental Health Unit, the Renal Outpatient Clinics and Renal Outpatient Haemodialysis Units in Belconnen and Tuggeranong Health Centres, establishment of Renal Supportive Care Service, and the establishment of renal telemedicine service for Bega Community.

The organisation was able to demonstrate that in the 2016/17 financial year, 2800 staff had received patient-centred care in-servicing covering topics such as patient experience (233 staff), cultural competence (120 staff), orientation that includes a patient experience session (1371 staff). Minutes of meetings also demonstrated that patient stories were used to train and focus members at the start of quality and safety committees.

In 2016/17, consumers were involved in 32 education programs with 11 in eLearning modules whilst 22 were involved in face-to-face training programs including patient stories workshops. Surveyors noted divisional examples where patient journeys have been used to train the workforce such as postoperative surgical and stoma complications, allied health graduate program on patient and family centred care, Inter professional Graduate program, Chronic Disease Symposium, Dying to Know Day, and ATSI Dying Death and Grieving Our Way sessions. Hence there was evidence of strong commitment to consumer partnerships in designing care across ACT Health.

Consumer partnership in service measurement and evaluation

Community and consumers are provided with safety and quality performance information through various means including online publication of reports such as the ACT Chief Health Officer Annual Report (2016), ACT Children's and Young People Death Review Committee Report (December 2016), ACT Health Protection Service reports, website notifications on public health matters (for example, measles November 2017), ACT Population Health Bulletin online, ACT Health and Wellbeing of Older Persons reports. Quality and Safety Boards were evident throughout many units and wards across the organisation. Whilst some displays were good in providing meaningful information, others were noted to include technical jargon. The surveyors suggest that the organisation would benefit in standardising these boards to ensure information is clear and meaningful for their consumers and carers.

There were numerous examples of where consumers and carers have participated in analysing safety and quality improvements. Examples include the MHJAOD Mortality and Morbidity Committee, Advance Care Planning Project, EDC Safety and Quality Committee, and Cardiac Rehabilitation and Central Outpatients First Impressions Report Project. The Kink Clinic was a project that was initiated by a consumer who then assisted in implementing an after-hours walk in clinic designed for polyamory consumers to increase access to sexual health care. This project won the person centred category of the 2017 Quality in Healthcare ACT Awards for 2017. These Awards had HCCA involvement in the judging panel with a specific category for consumer participation.

Some divisions have developed creative ways to engage consumers and carers in evaluating patient feedback data. The Women's Health Service invite recent patients on a quarterly basis to engage in planning improvements for the division, and have formed a ‘Friends of Prem Babies’ initiative to evaluate service improvement initiatives. A HCCA member will be chairing the Care Closer to Home initiative that will refocus clinicians to improve access to services. This will have wide implications and be a significant step in improving patient feedback pertaining to access. ACT Health were able to demonstrate many examples of consumer and carer participation in the implementation of projects relating to patient feedback including the HCCA Courtesy Bus review, first impressions project, circle of parenting strategy, family escalation care of patient safety project (CARE – call and respond early initiative).

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

The organisation is encouraged to continue their strong partnerships with consumers and carers in service measurement and evaluation to improve patient care.

Consumer partnership in service planning

Ratings

Action	Organisation	Surveyor
2.1.1	SM	NM
2.1.2	SM	SM
2.2.1	SM	NM
2.2.2	SM	SM
2.3.1	SM	SM
2.4.1	SM	SM
2.4.2	SM	SM

Action 2.1.1 Developmental

Organisation's Self Rating: SM **Surveyor Rating:** NM

Surveyor Comment:

The organisation was able to demonstrate many examples of where consumers and/or carers participate in the clinical governance of the organisation. Consumers and/carers actively participated in the development of the new Quality Strategy and are representatives on quality and safety committees. There was also evidence of consumer and/or carer participation in various quality and safety projects.

However, there was no evidence of consumers and/or carers participating in the governance of the organisation.

Surveyor's Recommendation:

Identify and implement a mechanism for involving consumers and or carers in the organisational governance of the health service.

Risk Level: Low

Action 2.2.1 Developmental

Organisation's Self Rating: SM **Surveyor Rating:** NM

Surveyor Comment:

The organisation was able to demonstrate the consumers and/or carers were actively involved in developing the recently launched Quality Strategy.

However, there was no evidence of involvement in broader strategic planning for the organisation beyond quality and safety. Further, there was no evidence of involvement in the operational planning for the organisation.

Organisation: ACT Health
Orgcode: 810004

Surveyor's Recommendation:

Establish mechanisms for engaging consumers and/or carers in both strategic and operational planning for the organisation.

Risk Level: Low

Consumer partnership in designing care

Ratings

Action	Organisation	Surveyor
2.5.1	SM	SM
2.6.1	SM	SM
2.6.2	SM	SM

Consumer partnership in service measurement and evaluation

Ratings

Action	Organisation	Surveyor
2.7.1	SM	SM
2.8.1	SM	SM
2.8.2	SM	SM
2.9.1	SM	SM
2.9.2	SM	SM

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

CHHS has a well-managed infection control and management service that is driven by a small multidisciplinary team. There is a CHHS National Standard Committee for Preventing and Controlling Healthcare Associated Infections (HAI) that has key stakeholder membership, inclusive of pathology, pharmacy, environmental and clinical representatives. This committee reports through to the National Standard Governance Committee.

The current structure for governance of effective infection prevention and control is fragmented and reports through three streams. For example, the Infection and Prevention Service, hospital assistants (responsible for clinical equipment) and Central equipment service report to Clinical Support Services; domestic and environmental services (ISS) report to Business Support Services; and building maintenance report through to Health Infrastructure. Prior to the restructure in 2016, Business Support Services and Health Infrastructure had one report line and a quarterly report covering key maintenance and infection control concerns was tabled at the HAI committee. Since the split, reporting is fragmented and it is unclear what risks are being escalated to the highest level of governance.

It is suggested that CHHS review how the HAI committee interacts and aligns with the highest level of the operational / executive committees'. For strategic planning in 2018, it is also suggested that CHHS review the model and resource allocation to the Infection Prevention and Surveillance Service (IP&S) to maximise quality improvement work rather than just focus on compliance requirements. It would be also beneficial to have a standardised approach to allocated time for management of audits and education requirements at the ward level.

At survey the most recent hepa filter maintenance report was reviewed and it was noted that in comparison to a 2016 report, not all The Canberra Hospital (TCH) hepa filters in the theatre complex were listed as tested. The anomaly was reported to the health service and despite a 48 hour search no record or explanation could be given for the missing hepa filters on the recent test record. The peri-operative manager also noted and confirmed the discrepancy.

Another significant concern is related to risk register number 54, the potential problem with Building One levels 4 and 5 maintaining hot water and creating correct environment for legionella outbreak. This risk was opened in December 2016 following positive legionella samples. The risk control action plan notes the inherent risk rating as high with major consequence and possible likelihood. The strategy to mitigate the risk is documented but there has been inadequate progression of the plan; of particular concern is a water quality management plan that is not due for completion until end of 2nd quarter 2018. A microbiology report dated 9th January 2018 notes a total legionella (CFU/ml) of 210 in level 6A of Building One. Building One currently has a number of vulnerable patient cohorts including: level 4, Oncology, Renal, Level 5 orthopaedics, plastics, and level 6 Vascular, Cardio-thoracic, (currently renovating where positive sample returned 6A). It was observed that signs are still displayed on level 5 warning patients not to drink the tap water and to run showers for five minutes prior to immersing. At the time of survey, it was unclear what cleaning and disinfection regimen had been undertaken to address the microbiology report dated January 9th. It is also noted that the risk rating has not altered on the risk register. Considering the vulnerable patients cohort in building one and lack of evidence around action of disinfection and progress against risk mitigation the ACHS risk rating is high and a recommendation has been made.

It was noted that risks associated with Infection control were on the risk register and the organisation had mitigation strategies in place. The progress to address these risks and implement action needs to be carefully monitored to ensure ongoing vigilance.

It is suggested that CHHS provide a time lined Gantt chart to address concerns outlined on the risk register.

It is also suggested that more frequent oversight from the highest form of governance is required to ensure timely progression on actions associated with the above.

A comprehensive range of policies and procedures are available for staff via the Intranet from both a territory and organisation level. These are relatively easy to access, and it was witnessed that staff had a comprehensive understanding on how to efficiently operate the system.

There was sufficient evidence during the survey to show that a proactive and comprehensive approach to surveillance and monitoring of healthcare associated infections is occurring and a surveillance plan has been adopted. Surveillance data feeds through into the CHHS Executive via the health service scorecard and the team are to be congratulated on the comprehensive annual Infection Prevention and Control Report.

An Infection Control audit schedule is in place which assists the organisation to regularly assess healthcare associated infection control risks. There are a number of compliance checks conducted through audits, data, indicators and incident review, however actions to address concerns were variable. In addition to the risks mentioned earlier in the report, there were other key infection control indicators that have had ongoing inadequate performance or slow progress against action plans. It was very evident at survey that local action plans to address concerns were developed and executed at the local clinical service level. Despite progress against actions at the local level being very well documented, there was little evidence at survey of governance support at a higher level with problems of non-compliance or actions that required executive decision making. Examples of inadequate performance include medical staff hand hygiene at 62-64 % for all quarters of 2017, inadequate compliance with AMS recommendations by some craft group specialties and inadequate progression of actions against the Food Safety Audit dated August 2017 that required higher delegation to close open recommendations.

It was noted that prior to survey medical hand hygiene rates had risen to 72% after a stubborn 12-month period and CHHS are encouraged to continue with actions to improve compliance. A recommendation has been made to support more visibility at an executive level to ensure risks are mitigated with clear accountability and timely action.

Quality improvement activities relating to Infection Control are noted and have included multiple presentations on VRE management, a clinical trial of CATH-TAG and use of alternate products to reduce surgical site infections in Caesarean sections, the introduction of Bundles of care to NICU, trialling of chlorhexidine showering to reduce MRO incidence, and many other small clinical projects. Considering the size of the team (5.7 EFT) the demonstrated level of commitment to managing quality in addition to significant compliance workload is to be commended.

Advanced Completion (AC) Review – 3-5 July 2018

There has been considerable work done over the past three months at ACT Health, Canberra Hospital to clarify and review the risks related to reporting and the HEPA Filter issues identified by the survey team in March 2018. Documentation and reporting has been improved. There was evidence of quarterly environmental, business support and facilities management reporting to the Standard 3 Committee.

HEPA filter and legionella water testing reports were undertaken previously however now they are routinely reported monthly to the Standard 3 Committee and in a clear format. The Standard 3 Committee demonstrated variance reporting to the highest level of governance. Reporting to the NSQHS Standards Committee, with escalation to the Clinical Services Executive which, reports to the Director General ACT Health. Comprehensive plans are in place and well documented to install HEPA Filters into the sterile stock room in Operating Suite in 2018.

A detailed and well documented water quality plan has been developed in May 2018 and controls implemented. Robust and sustainable monthly reporting to the Standard 3 Committee is occurring and has been improved over the past three months. The Standard 3 Committee chair and member's, Health infrastructure Services (HIS) Director and team have demonstrated excellent collaboration and leadership in addressing the issues in a timely and sustainable manner.

A comprehensive action plan has been developed and implemented with an achievement of an overall hand hygiene compliance rate of 80%. Targeted work has been implemented with visible medical leadership from the Chief Medical Officer, Clinical Directors and the Infection Control Team to improve the doctors hand hygiene with a compliance rate of 65% which is below the national benchmark. The organisation will need to maintain robust sustainable monitoring and review of the hand hygiene compliance rates across the health service to maintain compliance with the intent of Standard 3.

Infection prevention and control strategies

CHHS has overall compliance with the national hand hygiene initiative with the results at survey demonstrating 85.7% compliance. It could be inferred that this is contributing to the reduction in hospital acquired infections and CHHS is to be congratulated for continuing to push for better results with action plans rather than just accepting benchmark figures. The allied health and medical hand hygiene rates still need concentrated attention and it is suggested that the action plans in place continue to be monitored.

Workforce immunisation rates are managed by the Occupational Medicine Unit (OMU) and there is a robust system in place for assessment, screening and vaccination for both employees and contract workers. It is acknowledged that unless a policy dictates that new employees cannot commence without evidence of immunisation, it can be challenging to follow up and enforce compliance. A vaccination compliance certificate is now required by CHHS and the OMU are retrospectively improving compliance of existing staff. It was identified in December that 4270 staff were not complaint and since this time 1386 have been verified. This is a significant improvement for the timeframe and CHHS are encouraged to continue work on verification for the remaining 2844 staff.

It is suggested that CHHS review the strategic approach to vaccination compliance to ensure that the improved verification rates can be maintained going forward.

The rate of flu vaccination for the previous season at CHHS was 55% and the rate for contracted staff such as ISS was only 30 %. In 2017, 3078 patients were identified with the flu and 407 patients were admitted in comparison with 213 in 2016. It is likely that the 2018 influenza season will have significant impact on the community and it is suggested that CHHS develop innovative strategies to improve immunisation uptake across the entire organisation. It would also be worthwhile to review the process and resources for employees and contracted staff to access to influenza immunisation.

Staff has ready access to Personal Protective Equipment (PPE) and education is provided on its use.

There are regular audits on the use of PPE scheduled and results show good compliance. While it is noted that there was a decrease in allergy assessments done at CHHS, consideration should be given to a robust staff register of occupational allergies and a skin sensitisation program.

Management of occupational exposure is governed by the OMU with support from an After Hours Clinical Nurse Consultant. There is a clear and comprehensive policy for staff to refer to at the clinical level.

CHHS has a clearly identified risk management approach with invasive devices inclusive of indwelling catheters (IDCs), central venous catheter (CVCs) and peripheral intravenous cannulation (PIVCs) and there are developed audit tools to assess compliance. Audit results of compliance with policy and procedural management of invasive devices, particularly IDC (indwelling catheters) and PIVC (peripheral intravenous catheters) had variable results across the clinical service areas. At the time of survey, observation audits of PIVC's supported the findings of variation in compliance. It was noted that the hospital undertook a small clinical trial of CATH TAG that evidenced promising results and it is suggested that if the variation with compliance to best practice cannot be reduced by other intervention a larger clinical trial could be considered. It is also suggested that a more targeted approach be taken with the areas of non-compliance including an increased audit schedule governance scrutiny until practice improves and is embedded. A recommendation has been made to increase compliance for the use of invasive devices.

Aseptic non-touch technique (ANTT) training is well developed at CHHS and the organisation eLearning training rate at time of survey was over 90 % for all appropriate clinicians. It is noted that CHHS have fully met all transitional requirements for action 3.10.1.

Advanced Completion (AC) Review – 3-5 July 2018

The organisation has implemented significant actions to improve the documentation and monitoring of Invasive devices across the health service.

Over the past three months there has been an active staff education campaign to ensure improved documentation, dating and dwell time of peripheral intravascular catheters (PIVC) and comprehensive and regular observational audits. Because of monitoring compliance through the audit program, a comprehensive PIVC Bacteremia action plan has been developed and implemented aimed at preventing patient infections from PIVC.

There is an active genitourinary working group established to review policies and procedures, oversee the recent May 14th – 15th 2018 Indwelling catheter (IDC) point prevalence survey, monitor compliance against policy, incidents and trends of catheter associated urinary tract infections. The working party is under the governance of the Standard 3 Committee. The survey demonstrated a significant improvement of 97.5 % compliance with the securing, IDC as per the organisations policy compared to 90% in 2017.

The survey team noted evidence of improved compliance also with IDC reviews with 85% compliance in May 2018.

Managing patients with infections or colonisations

Standard precautions and transmission-based precautions are well understood by staff, and during survey it was demonstrated they were used effectively. Standard precaution audits have shown strong compliance and it is reasonable to assume that these results contribute to the relatively low infection rates demonstrated on surveillance reports.

There is comprehensive staff education provided on the use of standard and transmission based precautions and a number of quick reference charts for staff to refer to. Appropriate signage is in place where required. There is a CHHS approved sticker that is used by IPC staff to document infectious precautions and the ACTPAS and Clinical Portal provide an alert system for the re-admission of patients.

There are systems in place to communicate a patient's infectious status to environmental and food services.

CHHS is to be commended on the innovative approach with an Infection Cleaning Team specifically trained to undertake the required infectious cleaning regimen.

Inter-hospital transfer/discharge forms identify if any infection alerts are present. The CHHS initiative of GP liaison working with the IPC staff to develop a process to ensure infection status and surveillance is followed up post discharge is an excellent project and consideration should be given to support sustainability.

Antimicrobial stewardship

Since the last survey, the CHHS antimicrobial stewardship (AMS) team has continued to develop in its leadership and governance role, promoting and guiding best practice and adherence to guidelines. The team has further embedded well documented governance and reporting processes and prepares an annual report to the HAI committee on activities and achievements (2017 report noted in draft at time of survey). Although the Antimicrobial Stewardship Working Group (AMSWG) are a relatively new committee they have continued to be effective in promoting best practice at CHHS.

The AMS key performance indicator (KPI) report schedule includes monitoring and report of all audit variables to meet this criterion's clinical care standards requirements. There have been a number of significant AMS achievements since the last survey including an improvement of appropriateness of prescribing by absolute 17% (relative 32%) since the program was fully funded 18/12 ago and a decrease of 35% of carbapenum prescribing in ICU following a quality improvement project.

In addition to monitoring and surveillance actions the AMS team has undertaken a number of promotional and educational activities including the co-ordination of promotional events for Antibiotic Awareness Week and regular participation in grand rounds, orientation, pharmacy and nursing education sessions.

It is noted that AMS is integrated into an on-call arrangement for after-hours support.

A well mapped antimicrobial notification and approval process is in place. High-risk antimicrobial usage and the monitoring of antimicrobial resistance is well managed. Recent Point prevalence surveys demonstrate that there is still some work to be done, particularly with non-compliance with guidelines for community acquired pneumonia and surgical prophylaxis. It is suggested that targeted action plans be developed and monitored by the highest level of governance to ensure compliance improves. CHHS should also continue to benchmark practice not only within CHHS but externally with the National Antimicrobial Prescribing Survey (NAPS).

Evidence confirms that the requirements for ensuring surgical prophylaxis are included and addressed as part of the antimicrobial stewardship program. There is appropriate documentation for reason for prescribing, application of surgical prophylaxis guidelines and timely administration of prophylaxis, with some work to be done on reducing variation between craft groups.

Cleaning, disinfection and sterilisation

Comprehensive policies, procedures and manuals are available for staff within all the Central Sterilisation Services Departments (CSSDs) at CHHS. Ongoing audits on disinfection and sterilisation of reusable instruments show a high level of compliance that was observable during survey.

An established environmental cleaning schedule is in place and services are delivered in accordance with the cleaning standards for Victorian health facilities and NSQHS Standards. ISS conducted 740 environmental cleaning audits between February- November 2017 (average scores between 88-98%) in addition there are patient survey audits from ISS and ACT Health. Furthermore, there is a fortnightly/ monthly Infection Prevention and Control cleaning round that has executive support and presence that CHHS are to be commended on. It was noted however that there were major discrepancies between ISS audits and IPC cleaning round observations and reports. It is suggested that ISS auditors would benefit from attending IPC cleaning rounds to fully comprehend clinical significance and to better understand compliance deficiencies.

At survey, it was evidenced that transparency and current visibility of risks is currently hampered by the reporting structure and streams.

It is recommended that a comprehensive quarterly report on environmental cleaning, including air sampling, hepa filter maintenance and water testing be presented at the HAI committee on at least a quarterly basis and variances reported to the highest level of governance to ensure appropriate risk management. It is also suggested that timely decisions be made about the permanent location of the Central Clinical store as if it is to stay in the temporary location at Canberra Hospital the organisation of clean and dirty work flow needs review.

The linen audit provided showed excellent compliance with contract requirements. However, the management of storage and workflow of linen at Canberra Hospital needs review. It was noted that multiple trolleys of stored linen were uncovered in the dispatch area. The "clean" linen lifts were being used to return used food trolleys to the kitchen and being taken through the clean linen storage. Food scraps were noted on the floor of clean linen storage and dust and grime were present in corners and floors. The cleaning schedule and WHS standards of the linen dock need attention. Following surveyors concern and escalation of the collection schedule of dirty linen from the ward areas, a more frequent schedule for pick up has been adopted and executive are to be commended for their timely action. It is recommended that a full review is undertaken against the storage and workflow of linen management at Canberra Hospital with a focus on the maintenance of infection control and WHS standards.

The local actions to progress recommendations from the Food Safety Audit in August 2017 have been timely and documented [recommendations from this audit received in Nov. 2017]. However, a more detailed plan is required with clear deliverables and capital approval for the numerous items projected to be completed by 6th April 2018. Despite the Food Safety Audit noting in the August report that several areas required cleaning and sanitising the surveyors noted the same deficits during the visit. These included dusty ceiling vents, bugs/vermin in light fittings, dirty flooring, pooling water on the floor and broken tiles and inadequate cleaning of bench areas. The workflow of the wash and rinse area has already been identified as a risk by CHHS and a project in place to replace the washers. It is noted that this project work has been identified for three years and timely progression is required. Recommendations have been made to assist in improving compliance with the standards associated with hotel services.

While visiting some inpatient areas it was observed that storage space is limited, leading to overcrowding of equipment and stock. This is leading to potential inadequate cleaning practices (inability to surface clean appropriately) and breaches to sterile stock storage (440 mm from ceiling and 250 mm off floor). It is suggested that consideration is given to re-design projects across the organisation to allow for appropriate cleaning and infection control practice.

Local policies and registers are in place to address maintenance of building facilities and it is suggested that the new software system for repair and maintenance (MAINPAC) is implemented as planned to reduce clinical risk.

CHHS are also encouraged to consider having a governance model that supports collective, central decision making for building and replacement programs as it currently appears fragmented.

Reprocessing of reusable devices is undertaken by Mitchell Sterilising Services with pre-rinse services within Canberra and Calvary operating theatres. There are also smaller reprocessing units for Dental and endoscopy. It is suggested that a height adjustable bench in the washing area at Mitchell Sterilising Services be considered for WHS and work flow. Regular audits are undertaken to ensure that decontamination and sterilisation practices comply with standards. Staff are suitably qualified and there was evidence provided at each CSSD that demonstrated ongoing education and professional development.

As per the new Gastroenterological Nurses College of Australia (GENCA) position statement released in 2017 continuous monitored air-drying cabinets are required for scopes as part of AS4187:2014. CHHS had already identified this gap and are aware compliance is required by 2021.

Sterilising Services Update of Gap analysis with the revised AS/NZS 4187:20 went to HAI committee on the 9th March 2018. It was noted in the paper presented that a comprehensive gap analysis had been completed. There is little evidence that the gap analysis is sufficient against Advisory 16/03 as it did not show comprehensive compliance against the AS/NZS 4187:2014, nor did it have a detailed GANNT chart and clear deliverables for the recognised gaps.

It was noted that the project work required for the Canberra Hospital Pre-Rinse and Sterilizing Unit had an approved UMAHA business case. This included funding to address the risk that steam and sterilising equipment is not of the quality required for sterilising purposes and it was evidenced that there is progress with the cart washer to be ordered in 2018 at completion of procurement activity. It was noted that a nine-month delivery time will push completion into 2019. There are two ACT Health Sterilising Services projects currently under way. One at the Mitchell site and the other at Canberra Hospital PRSU;

The Cart washer is for Sterilising Services Mitchell site project.

The estimated equipment delivery time for Canberra Hospital PRSU project is June 2019. This project is a major capital project considering all complexities of retrofitting within the existing theatres.

CHHS use T-DOC for instrument tracking in CSSD. It is noted that currently there is no way to track single packed items or sets utilised in ward areas to the patient. This is a gap with AS/NZS 4187:2014 and CHHS are to be commended on the local development of sound project action plan to address non-compliance. It is suggested that the project plan now be endorsed and considered at executive level to ensure progression by 2021.

It is recommended that CHHS ensure full compliance with Advisory 16/03 which requires a comprehensive gap analysis and completed GANNT that demonstrates progress. It is noted that CHHS have not met the transitional requirements for action 3.16.1.

Advanced Completion (AC) Review – 3-5 July 2018

There has been considerable work done over the past three months to clarify and review the risk related to the HEPA filter issues and plans are now in place to install HEPA filters into the sterile stock room in Operating site at Canberra Hospital.

A comprehensive water quality plan has now been developed and controls in place with robust monthly reporting to the Standard 3 committee.

There was strong evidence of collaboration with, infection control team members, the chair and members of the Standard 3 Committee and Facilities Management leaders and team members. The survey team consider the risks identified during the March 2018 Accreditation survey have been mitigated.

There is evidence of quarterly environmental cleaning, air sampling, business support and facilities management reporting to the Standard 3 Committee. HEPA filter and legionella water testing reports were undertaken previously however now they are routinely reported monthly to the Standard 3 Committee and in a new and clearer format as of May 2018. The Standard 3 Committee demonstrated variance reporting to the highest level of governance. Reporting to the NSQHS Standards Committee has improved governance in relation to risks associated with infection control standards, with escalation to the Clinical Services Executive which, reports to the Director General ACT Health. The Standard 3 Committee chair, committee members and facility management leadership team have demonstrated great commitment and leadership in the implementation of actions to ensure improvements in this area.

Over the past three months ACT Health, Canberra Hospital has undertaken an extensive and comprehensive review of linen storage and linen workflow management. As a result, significant improvements in the management of this service has occurred, in relation to infection control and occupational health and Safety (OH&S) management. Significant change and improvements in physical infrastructure and flows of clean and soiled goods has been implemented. The surveyors noted there is strong commitment by staff to ensure compliance with the new clean and soiled lift system recently implemented.

ACT Health have achieved considerable improvements in the areas of general cleaning and work flows in the kitchen at Canberra Hospital. Clearing schedules have been reviewed and the implemented of an approved weekly cleaning schedule. Comprehensive and sustainable auditing of cleaning standards has been implemented and actively managed.

The work has significantly progressed in relation to prioritisation of corrective actions required from the food safety audit of August 2017. A comprehensive workflow redesign and replacement schedule is now in place for the replacement and installation of new dishwashers with a time frame for completion of November 2019.

Overall staff and the leadership team in the, food services and environmental services team, linen contractor team leaders/ manager and staff were very positive about the improvements and demonstrated a very positive “Can Do Approach" to ensure all improvements are sustained in the future. The leaders of the environmental services, food services, cleaning staff, infrastructure and team members, sterilising services management team, infection control team, chair and members of the Standard 3 Committee and Executive members are commended for their significant leadership, commitment to improve standards and support of staff. Their commitment and hard work has resulted in a significant shift and improvement in work place culture. With staff now openly taking pride in their work place environment and committed to delivering high quality cleaning standards. It will be crucial that this leadership and level of commitment is maintained to ensure all improvements are sustained and further developed across the health service.

ACT Health have updated and enhanced the AS4187 gap analysis tool, incorporating a comprehensive GANNT chart for not -met items, which ensure compliance with the Advisory 16/03. Met items are now included and supported with detailed evidence. The AS/NZS4187: 2014 self-assessment tool has been completed in June 2018 which identifies 97 % of items are met with detailed implementation plans ls for the 3% of not -met items. The organisation does require through the Standard 3 Committee to ensure work is progressed in addressing the outstanding issues of stand-alone desk top sterilising in the Dental Services to ensure compliance with the AS 4187 Standard by 2021. The dental teams demonstrated commitment to resolving this matter in partnership with the Standard 3 committee and the organisation as soon as possible.

Communicating with patients and carers

There is information available to patients and carers on common multi-resistant organisms and hand hygiene. The printouts evidenced at survey all were of an appropriate literacy level for consumers. Discharge Information is provided to for patients on MROs and GPs are informed by letter.

Hand hygiene stations, with appropriate signage are widely available throughout CHHS and hand hygiene audit outcomes are displayed on clinical area quality improvement boards, on the MyHospital website.

Transmission-based precautions signage is prominent and in plain language, with individual education provided to affected patients and carers by the IPC team. Patients and carers at survey commented that they appreciated the face-to-face consultation with the IPC team and this is an excellent personalised method by a minimally resourced team. It is suggested that CHHS consider how this work could be supported by other approaches such as “infection control champions” in each ward and clinical areas.

It is noted that handouts are evaluated and approved by the Consumer Handout Committee and that CHHS has undertaken a number of surveys in an attempt to gain more patient feedback on the effectiveness of information provided. Return rates to the surveys have been poor and it is suggested that CHHS consider other options for feedback including the access to consumers in Outpatient waiting areas and targeting specific community groups.

Governance and systems for infection prevention, control and surveillance

Ratings

Action	Organisation	Surveyor
3.1.1	SM	SM
3.1.2	SM	SM
3.1.3	SM	SM
3.1.4	SM	SM
3.2.1	SM	SM
3.2.2	SM	SM
3.3.1	SM	SM
3.3.2	SM	SM
3.4.1	SM	SM
3.4.2	SM	SM
3.4.3	SM	SM

Action 3.1.3 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

At the time of survey, the most recent hepa filter maintenance report was reviewed and it was noted that in comparison to a 2016 report, not all CH hepa filters in the theatre complex were listed as tested. The anomaly was reported to the health service and despite a 48 hour search no record or explanation could be given for the missing hepa filters on the recent test record. Another significant concern is related to the risk register number 54, the potential problem with Building One levels 4 and 5 maintaining hot water and creating correct environment for legionella outbreak. This risk was opened in December 2016 following positive legionella samples. The risk control action plan notes the inherent risk rating as high with major consequence and possible likelihood. The strategy to mitigate the risk is documented but there has been poor progression of the plan; of particular concern is a water quality management plan that is not due for completion until end of 2nd quarter 2018.

Advanced Completion (AC) Review – 3-5 July 2018

Non-compliance with policy and procedures in relation to Standard 3 have been robustly reviewed, risk rated and reported at the highest level of governance and risks mitigated.

This recommendation is now closed.

Surveyor's Recommendation:

No recommendation

Action 3.1.4 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

In addition to those risk discussed in 3.1.3, there were other key infection control indicators that have had ongoing poor performance or slow progress against action plans. It was very evident that local action plans to address concerns were developed and executed at the local clinical service level. Progress against actions at the local level were very well documented, however there was little evidence at survey of governance support at a higher level with problems of non-compliance or actions that required executive decision making.

Examples of poor performance include medical staff hand hygiene at 62-64 % for all quarters of 2017, poor compliance with AMS recommendations by the gastroenterology and orthopaedic specialties, and poor progression of actions against the Food Safety Audit dated August 2017 [with recommendations from this report received Nov. 2017] that required higher delegation.

Advanced Completion (AC) Review – 3-5 July 2018

A comprehensive action plan has been developed and implemented with an achievement of an overall hand hygiene compliance rate of 80%. There have been significant timely actions undertaken to improve the effectiveness of infection control and prevention systems across the organisation with improved accountability.

This recommendation is now closed.

Surveyor's Recommendation:

No recommendation

Infection prevention and control strategies

Ratings

Action	Organisation	Surveyor
3.5.1	SM	SM
3.5.2	SM	SM
3.5.3	SM	SM
3.6.1	SM	SM
3.7.1	SM	SM
3.8.1	SM	SM
3.9.1	SM	SM
3.10.1	SM	SM
3.10.2	SM	SM
3.10.3	SM	SM

Action 3.8.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Audit results of compliance with policy and procedural management of invasive devices, particularly IDC (indwelling catheters) and PIVC (peripheral intravenous catheters) had variable results across the clinical service areas. At the time of survey, observation audits of PIVC's supported the findings of variation in compliance.

Advanced Completion (AC) Review – 3-5 July 2018

There has been an overall improved focus on the monitoring of compliance against policy and on the system for the management of Peripheral Intravenous Catheters (PIVCs) and Indwelling Catheters. With timely improvement actions and effective reporting at the highest level of governance.

This recommendation is now closed.

Surveyor's Recommendation:

No recommendation

Action 3.10.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

CHHS has fully met transitional requirements with training rates documented over 90%.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

Action	Organisation	Surveyor
3.11.1	SM	SM
3.11.2	SM	SM
3.11.3	SM	SM
3.11.4	SM	SM
3.11.5	SM	SM
3.12.1	SM	SM
3.13.1	SM	SM

3.13.2	SM	SM

Antimicrobial stewardship

Ratings

Action	Organisation	Surveyor
3.14.1	SM	SM
3.14.2	SM	SM
3.14.3	SM	SM
3.14.4	SM	SM

Cleaning, disinfection and sterilisation

Ratings

Action	Organisation	Surveyor
3.15.1	SM	SM
3.15.2	SM	SM
3.15.3	SM	SM
3.16.1	SM	SM
3.17.1	SM	SM
3.18.1	SM	SM

Action 3.15.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Transparency and current visibility of risks is currently hampered by the reporting structure and streams.

Advanced Completion (AC) Review – 3-5 July 2018

There is evidence of quarterly environmental cleaning, air sampling, business support and facilities management reporting to the Standard 3 Committee. HEPA filter and legionella water testing reports were undertaken previously however now they are routinely reported monthly to the Standard 3 Committee and in a clear format. The Standard 3 Committee demonstrated variance reporting to the highest level of governance. Reporting to the National Standards Committee, with escalation to the Clinical Services Executive which, reports to the Director General ACT Health.

This recommendation is now closed.

Surveyor's Recommendation:

No recommendation

Action 3.15.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The linen audit provided showed excellent compliance with contract requirements.

However, the management storage and workflow of linen at Canberra Hospital needs review. It was noted that multiple trolleys of stored linen were uncovered in the dispatch area. The "clean" linen lifts were being used to return used food trolleys to the kitchen and being taken through the clean linen storage. Food scraps were noted on the floor of clean linen storage and dust and grime were present in corners and floors. The cleaning schedule and WHS standards of the linen dock need attention. Following surveyors concern and escalation of the collection schedule of dirty linen from the ward areas, a more frequent schedule for pick up has been adopted and executive are to be commended for their timely action.

Advanced Completion (AC) Review – 3-5 July 2018

Over the past three months ACT Health, Canberra Hospital has undertaken an extensive and comprehensive review of line storage and linen workflow management. As a result, significant improvements in the management of this service in relation to infection control and occupational health and safety (OH&S) management.

This recommendation is now closed.

Surveyor's Recommendation:

No recommendation

Action 3.15.3 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The local actions to progress recommendations from the Food Safety Audit in August 2017 have been timely and documented [recommendations received Nov. 2017]. However, a more detailed plan is required with clear deliverables and capital approval for the numerous items projected to be completed by 6th April 2018. Despite the Food Safety Audit noting in the August report that several areas required cleaning and sanitising the surveyors noted the same deficits during the visit. These included dusty ceiling vents, bugs/vermin in light fittings, dirty flooring, pooling water on the floor and broken tiles and poor cleaning of bench areas. The workflow of the wash and rinse area has already been identified as a risk by CHHS and a project in place to replace the washers. It is noted that this project work has been identified for three years and timely progression is required.

Advanced Completion (AC) Review – 3-5 July 2018

ACT Health have achieved significant improvements in the areas of general cleaning and work flows in the kitchen at Canberra hospital. The work has been significantly progressed in relation to prioritisation of corrective actions required from the food safety audit of August 2017. A comprehensive workflow redesign and replacement schedule is now in place for the replacement and installation of new dishwashers with a time frame for completion of November 2019.

All components of this recommendation are now closed.

Surveyor's Recommendation:

No recommendation

Action 3.16.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

There is little evidence that the gap analysis is sufficient against Advisory 16/03 as it did not show:

1. A comprehensive gap analysis with met items against revised AS/NZ 4187.

2. compliance by having a detailed GANNT and clear deliverables for the recognised gaps by the required timeframe.

Advanced Completion (AC) Review – 3-5 July 2018

ACT Health have updated and enhanced the AS4187 gap analysis tool, incorporating a comprehensive GANNT chart for not -met items, which ensures compliance with the Advisory 16/03.

All components of the recommendation are now closed.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

Organisation: ACT Health
Orgcode: 810004

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

CHHS has an appropriate system to provide governance of medication management. The Medication Management Committee is the peak committee and is supported by the Drug and Therapeutics (DTC) and the Adverse Drug Reaction Review (ADRRC) Committees. The MMC reports to the National Standards Committee. These committees are well attended and have representation from all divisions within CHHS. Since the last survey the many policies relating to medication management have been consolidated into one document. This is available to staff on the Intranet and has hyperlinks from the table of contents to the different sections making it easy to reference the section of the policy that is needed. This policy has been updated as needed as procedures change. The MMC has expressed concern and uncertainty about the overall governance of the EMM (Electronic Medication Management) implementation. This needs to be clarified to ensure appropriate management of the number of electronic systems that are in use in the organisation for the management of medication. In addition to the overall EMM product oncology use CHARM, an Oncology Medication Information System and the renal unit is using a software CV5 to manage their medical records and medication prescriptions.

The Women's, Youth and Children's division has recently completed the Medication Systems Self-Assessment (MSSA). This has not yet been considered by the MMC and an action plan needs to be formulated to respond to the issues identified. The surveyors viewed the endorsed plan to complete the MSSA for the rest of CHHS over the coming months to commence immediately after the completion of the survey. It is suggested that CHHS complete the MSSA or similar comprehensive review of the medication management system at least once every accreditation cycle. It should be repeated once the Electronic Medication Management implementation has been completed to identify remaining issues that require improvement.

CHHS regularly reviews the registration status of their staff against the AHPRA online register to monitor medication authorities. Nurse Practitioner formularies are governed by the Drug and Therapeutics committee and signed off by the Chief Nursing Officer. Prescription of chemotherapeutic medication is limited to advanced trainees and consultants. Pharmacists review prescriptions to ensure only those authorised to prescribe highly specialised medications are doing so. With the introduction of EMM the ability to prescribe is only provided once the individual has had training and their competence has been verified.

The MMC monitors incidents receiving regular reports of trended data to identify issues that are being reported. Action has been demonstrated to improve the system based on investigations of more serious reports. Significant improvement has been made to the Opioid Replacement Treatment program within Justice Health. This includes the introduction of iris scanning for identification and processes to prevent double dosing.

Documentation of patient information

The medication history is part of the admission history recorded where ever the patient enters the organisation. This is recorded currently in the paper record. With the introduction of EMM the electronic system will assist in the reconciliation of the medication and reduce the need for repeated transcriptions of the medication list.

Currently the medications are prescribed on the National Inpatient Medication Chart which is kept near the patient's bedside. When EMM is introduced the provision of computers on wheels will allow the clinical staff to have the medication records at the bedside.

The allergies are regularly recorded on the medication chart. This is regularly audited with good compliance. The ADRRC reviews all reported drug reactions to validate the event and when an allergic reaction is confirmed ensure that this is recorded in the alert system and the patient and the GP are notified. When appropriate the ADRRC reports the reactions to the Therapeutic Goods Administration.

Pharmacists are responsible for undertaking medication reconciliation. Formal reconciliation at admission is variably achieved with high risk areas such as aged care having higher completion that those where the risks are less. The results of the reconciliation are recorded on the Medication Management Plan with recommendations for the treating team. All discharge prescriptions are reconciled by the ward pharmacist before the medications are dispensed to the patient.

Medication management processes

Information and decision support tools are available to the workforce on the CHHS Intranet. There is an appropriate range of these resources available. The use of these resources is monitored by the number of "hits" recorded. This facilitates review of usage to guide decisions to change the resources. The availability of hard copy versions is discouraged.

Storage of medications is regularly reviewed. The results of executive walk arounds are reported to the MMC. While the security of most drug storage is appropriate, the surveyors noted the storage of medications in the operating room was in an open storage room. There is a recommendation relating to this. The staff have had opportunity to improve the design of medication storage rooms in the newly renovated wards. The introduction of the EMM has led to improvements in the storage and availability of medications to the nurses for medication administration. Following a review, the anaesthetic drug, propofol, is now more closely controlled with the supply in the operating room theatres stored in a locked cupboard with supplies being signed out to each theatre with excess returned to the storage cupboard at the end of the day. It is suggested CHHS reviews whether this additional step is necessary.

The temperature of drug fridges on the wards is monitored manually. Audit of this process has demonstrated variable compliance. In the report of the previous survey this was noted to be a concern and the implementation of central monitoring of the fridges was to be introduced. While this implementation is in process it is at an early stage. A recommendation has been made to ensure this is completed. Unused and out of date medications are returned to pharmacy where they are either reused or disposed in accordance with legislative requirements. The disposal of unused narcotic medications on the wards has been facilitated by the introduction of waste disposal pots that allow the inactivation of the drug on the ward. The surveyors suggest the organisation consider the implementation of one-way secure medication disposal unit especially in high-risk units such as Mental Health and Justice Health medication rooms to ensure the systems for disposal of unused, unwanted or expired medications is safely managed and monitored.

CHHS has reviewed the use of high risk medications such as insulin, narcotics and chemotherapeutic agents and improvements have been made. Insulin vials are now labelled for use by an individual and stored with their other medications once a vial is opened rather than in the fridge. Hydromorphone is now stored in distinctive packaging. The management of concentrated potassium solutions had not been reviewed for some time. A review which is yet to be considered by the MMC demonstrated significant issues with the availability of the concentrated potassium. While action has been taken to rectify the issues, a recommendation has been made to ensure a robust system is in place to prevent a recurrence of the issues identified.

Advanced Completion (AC) Review – 3-5 July 2018

ACT Health, Canberra Hospital has taken significant action to address the issue of medicines being stored in a general storage area within the operating suite, with unrestricted access.

The solution of installing pharmaceutical shelving with access controlled secure cabinets with electronic access for only authorised staff is impressive and innovative. This solution demonstrates the organisations and Standard 4 Committees, commitment to ensuring the safe and secure storage and distribution of medicines. The collaboration with the Operating Suite Nursing leadership team, Pharmacy Deputy Director and Medical staff, with support from the Chief Nursing and Midwifery Officer is to be applauded with this significant change to practice.

As an improvement activity the organisation has implemented a comprehensive 6-monthly audit in all areas, in partnership with Pharmacy and Nursing Services to ensure ongoing compliance with Standard 4. The organisation has also reviewed the storage and security of medications throughout the Operating Suite complex and purchased new and improved, secure medication trolleys for use throughout the complex.

Over the past three months the organisation has fully implemented in partnership with the information and technology team a comprehensive medication fridge temperature WIFI monitoring system. Manual monitoring continues in the few areas the Wi-Fi cannot be implemented such as Hume Health Centre and Brian Hennessy Rehabilitation Centre. The system is monitored 24/7 and when temperature is outside the agreed range of 2.5 -7 degrees Celsius, alerts are triggered to pharmacy and the After-Hours Hospital Manager. The system reports are reviewed and trends monitored by the Standard 4 Committee.

The organisation has implemented a robust process for the safe storage and distribution of concentrated potassium solutions. Concentrated potassium solutions are now only stored in 5 specialist areas (OR, ED, ICU Paediatrics High Care and NICU) and premixed solutions have been introduced to reduce risks associated with the administration of potassium solutions. Policy and procedures have been updated to reflect changes to practice. Staff have actively embraced the changes to practice to ensure safe provision of care and reduce potential harm to patients. A comprehensive auditing system has been implemented to ensure the change in practice is maintained.

Continuity of medication management

A current list of medications is provided to clinicians at handover through the medication chart and at discharge. The discharge summary provides a comprehensive list of medications along with details of changes to the medications while in hospital. Patients receive a copy of the discharge summary. In addition, when the pharmacists believe it is required a more detailed medication list is produced by the pharmacy software which is given to the patient along with their medications. At the time of the previous survey the compliance with the provision of discharge summaries to GPs within 24 hours was “almost total”. However, audits of the completion of discharge summaries provided to the survey team indicated that the compliance has decreased significantly. No evidence was provided to demonstrate that actions had been taken to improve this performance. A recommendation has been made.

Advanced Completion (AC) Review – 3-5 July 2018

The organisation has developed a comprehensive medication safety Medi-List improvement plan. Data collection systems have been implemented to enable trending and monitoring by pharmacy and the Standard 4 Committee to monitor performance in this area.

A documented guide for risk rating of patients has been developed to assist clinical staff and pharmacists to determined priority patients who require a Medi-List. Improvements in this area are also being linked to actions and improvements across the organisation in timeliness of patient discharge summaries to General Practitioners and patients.

Communicating with patients and carers

Medication information is provided to patients using the CMI documents that are available through MIMS.

This is available to all staff through the Intranet. Education on medications is a part of the community rehabilitation programs for those with chronic airways disease, heart failure and Parkinson's Disease.

Medication handouts that are intended for patients are reviewed by the Consumer Handout Committee before being approved. This ensures these handouts are meaningful for patients.

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

Governance and systems for medication safety

Ratings

Action	Organisation	Surveyor
4.1.1	SM	SM
4.1.2	SM	SM
4.2.1	SM	SM
4.2.2	SM	SM
4.3.1	SM	SM
4.3.2	SM	SM
4.3.3	SM	SM
4.4.1	SM	SM
4.4.2	SM	SM
4.5.1	SM	SM
4.5.2	SM	SM

Documentation of patient information

Ratings

Action	Organisation	Surveyor
4.6.1	SM	SM
4.6.2	SM	SM
4.7.1	SM	SM
4.7.2	SM	SM
4.7.3	SM	SM
4.8.1	SM	SM

Medication management processes

Ratings

Action	Organisation	Surveyor
4.9.1	SM	SM
4.9.2	SM	SM
4.9.3	SM	SM
4.10.1	SM	SM
4.10.2	SM	SM
4.10.3	SM	SM
4.10.4	SM	SM
4.10.5	SM	SM
4.10.6	SM	SM

4.11.1	SM	SM
4.11.2	SM	SM

Action 4.10.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The storage of medications throughout the organisation demonstrated appropriate control of access to the medication storage rooms with one exception. The access was limited by use of swipe card access using the personal identification cards. Medication trolleys are lockable and those observed during the survey were locked or in the medication rooms when not in use. The imprest drugs in the operating room were noted to be stored on open shelves in the general sterile stock storage room. The doors to this are open with staff moving through it continuously. The organisation has recently moved the storage of propofol from these shelves to a locked cupboard acknowledging the lack of security of the storage on the open shelving. It is the opinion of the team that the current arrangement does not meet the requirements of this action and a recommendation has been made.

Advanced Completion (AC) Review – 3-5 July 2018

The organisation has reviewed the storage of medications systems in the Operating Suite and installed pharmaceutical shelving with access controlled secure cabinets. There is electronic access for only authorised staff that is consistent with policy and legislative requirements.

This recommendation is closed.

Surveyor's Recommendation:

No recommendation

Action 4.10.3 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The drug fridges and cool room in the central pharmacy and the Oncology pharmacy are monitored electronically and warning alarms to the engineering services and on call pharmacist. The drug fridges in the rest of the hospital are currently dependent on manual checking of temperature using free standing monitors which record the current temperature as well as the maximum and minimum since last reset. The audits of this process demonstrated variable compliance with some wards having poor compliance with the daily checks. In the report of the last survey, the similar finding of inconsistent compliance was reported and that this was to be remedied by a central monitoring system.

While the survey team was shown an implementation plan for such a central monitoring system this was only in the early stages of implementation. A recommendation has been made to ensure this is completed.

Advanced Completion (AC) Review – 3-5 July 2018

The organisation has fully implemented in partnership with the information and technology team a comprehensive medication fridge temperature WIFI monitoring system.

This recommendation is now closed

Surveyor's Recommendation:

No recommendation

Action 4.11.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The storage, prescribing, dispensing and administration of high risk drugs are, in general, regularly reviewed with review made and actions taken in relation to insulin, narcotics (in particular the storage and use of hydromorphone) and chemotherapeutic agents. However, the storage and availability of highly concentrated forms of potassium had not been reviewed until shortly before the survey. A report dated the day of the survey commencement highlighted a number of problems the storage of ampules of concentrate potassium. By the time the team left the organisation action had been taken to rectify the issues identified but a recommendation has been made to ensure that there is ongoing monitoring and that the improvement is maintained.

Advanced Completion (AC) Review – 3-5 July 2018

The organisation has implemented a robust process for the safe storage and distribution of concentrated potassium solutions. Concentrated potassium solutions are now only stored in 5 specialist areas and premixed solutions have been introduced to reduce risks associated with the administration of potassium solutions.

This recommendation is now closed.

Surveyor's Recommendation:

No recommendation

Continuity of medication management

Ratings

Action	Organisation	Surveyor
4.12.1	SM	SM
4.12.2	SM	SM

4.12.3	SM	SM
4.12.4	SM	SM

Action 4.12.4 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

For the majority of patients managed by organisation the provision of a current and comprehensive list of medicines is dependent on the completion of discharge summary. Where it is considered advantageous the ward pharmacist arranges for a more detailed list to be provided using the pharmacy software. Audits of the timeliness of discharge summaries indicate that the performance of the organisation has not been maintained since the previous survey when it was noted “almost total compliance with completing the discharge summary within 48 hours of a patient discharge”. The organisation was unable to provide any evidence of actions to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines at clinical handover. A recommendation has been made.

Advanced Completion (AC) Review – 3-5 July 2018

The organisation has developed a comprehensive medication safety Medi-List improvement plan.

Data collection systems have been implemented to enable trending and monitoring by pharmacy and the Standard 4 Committee to monitor performance in this area.

This recommendation is closed.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
4.13.1	SM	SM
4.13.2	SM	SM
4.14.1	SM	SM
4.15.1	SM	SM
4.15.2	SM	SM

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

There is a comprehensive policy and corresponding procedures that clearly articulates the use of patient identification across all parts of the organisation describing using three identifiers on all critical occasions. There are also processes in place to manage unknown patients, particularly those from interstate.

The policy framework for patient identification and audit is comprehensive, with the use of white and red (later for allergy notification) wrist bands having a high compliance rate.

The correct site procedure guidelines are also evident across the organisation. Patient photographs (with consent) are placed on medication charts within Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS), to assist with identification. There is an ACT Health Standard 5 Committee which reports to the National Standards Governance Committee and minutes with corresponding actions were noted by the surveyors. Various clinical ward communication minutes were also seen highlighting discussions regarding patient identification.

Inconsistent use of 3 points of ID was observed across different clinical areas by various Clinician groups. Various written handover documents used by some clinicians only include two forms of ID. The use of Medicare cards in ED as part of the 3 points of ID was also observed and is contrary to CHHS policy. Audits are regularly occurring and being reported to various committees. Even with this level of knowledge and including some quality improvement activities, compliance is varied.

Errors in specimen labelling continues to occur across CHHS despite the efforts by various committees to implement effective change. The surveyors did observe a number of positive strategies that have been implemented to try and address the issues and include an initiative in ED of "bagging at the bedside" and a recent directive for Pathology to log all incidents in the organisation's report tool (Kestrel) should provide more reliable data for analysis.

Advanced Completion (AC) Review – 3-5 July 2018

ACT Health has implemented sustainable practices to embed the practice of using 3 points of ID across all clinical areas of Canberra Hospital & Health Service (CHHS). A focused effort has been implemented, by all areas and professional groups, to review current practices and ensure consistency of the patient identification system.

To ensure sustainable change, improvements in the patient identification system has been made in conjunction with the Clinical Handover, Blood and Blood Products and Medication Standard. Over the past three months handover templates have been reviewed and standardised to ensure a whole of organisation positive patient identification approach and ensure three unique identifiers are always utilised to correctly identify and match patients. A comprehensive and sustainable inter – professional education strategy has been developed and implemented.

The ACT Health, three professional leads, Chief Medical Officer, Chief Nursing and Midwifery Officer and Chief Allied Health Advisor have demonstrated palpable leadership in ensuring significant improvements with Standard 5 compliance over the past three months. Their supportive leadership and staff's commitment to address gaps in compliance lay the foundations for sustainable practice changes.

Because of the improvements made across all areas, ACT Health has seen an overall improvement of 18 % compliance with Standard 5 from 68% to 86% after one month of a proactive education campaign with all staff and active auditing. It will be important that the organisation ensures sustained effort in the important area of patient identification.

ACT Health has undertaken a comprehensive review of the organisations issues in relation to the error rates of specimen labelling. As a result, in June 2018 a very effective “Zero Tolerance” policy approach was implemented with a supportive staff education campaign aimed at reducing mismatching events. Even though this has only recently been implemented improvements are already being identified. However, it will be important that there is ongoing review and monitoring of compliance with the new introduced policy and staff management approach.

Processes to transfer care

Across all CHHS procedures are in place for patient handover, transfer and discharge with all incorporating the three patient identifiers. The recent introduction of the training and checklist for ward persons when transporting patients is an example of good practice. Staff have access to documented structured processes that ensure that continuity of patient care is maintained and that there is an effective handover process. CHHS continues to have Clinical Handover documentation and information available for all staff including eLearning tools.

Processes to match patients and their care

Throughout CHHS there are processes in place to support the matching of patients and their care. Patients with the same names are identified and within critical care areas appropriate action is taken including verbal acknowledgement at every care stage. CHHS continue to review their practice with any incidents being recorded on RiskMan and are discussed at the divisional meeting as well as being raised at the standards committee meeting. The Surgical Safety Checklist is not routinely completed and completion rates currently sits at 79.8%. Concerted effort has been applied to the various clinical groups with a significant rise in compliance noted in the last six months. There is an action plan signed off by various leaders including the Chief Medical Officer and the drive is to achieve 100% compliance.

Advanced Completion (AC) Review – 3-5 July 2018

The organisation, and relevant Division including the Clinical Directors and surgeons are applauded for the positive and direct action that has occurred over the past three months in improving compliance with the CHHS policy and procedure in relation to the use of the Surgical / Safety Checklist. A robust and sustainable policy including performance escalation pathways for ongoing individual non-compliance has been implemented. Effective communication and education processes have been implemented to support staff’s adherence to policy.

Robust weekly compliance reporting has been implemented and actively monitored by the Standard 5 and 6 committee. Positive feedback has also occurred for surgeons and surgical registrars who have maintained 100% compliance with the checklist policy. This is a very positive step to compliance sustainability. Because of this proactive leadership approach to quality improvement there has been a 19.27% improvement in compliance from 76% to 95.27% with use of the Surgical Safety Checklist. This has occurred from the time of the Organisation Wide Survey (OWS) in March 2018 till July 2018 which is a significant achievement. However, to achieve 100% compliance as required by the organisations policy, it will be important for organisation to continue to actively monitor performance of the process of matching patients and their care and use of the Surgical Safety Checklist.

Identification of individual patients

Ratings

Action	Organisation	Surveyor
5.1.1	SM	SM
5.1.2	SM	SM
5.2.1	SM	SM
5.2.2	SM	SM
5.3.1	SM	SM

Action 5.1.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Inconsistent use of 3 points of ID was observed across different clinical areas by various Clinician groups. Various written handover documents used by some clinicians only include two forms of ID. The use of Medicare cards in ED as part of the 3 points of ID was also observed and is contrary to CHHS policy.

Advanced Completion (AC) Review – 3-5 July 2018

ACT Health have implemented corrective sustainable actions to improve compliance with patient ID matching system and embed the practice of using 3 points of ID across all clinical areas of Canberra Hospital & Health Service (CHHS)

The practice of using Medicare cards as an identifier in the Emergency Department has ceased and the organisation now complies with policy.

A comprehensive review of all handover documentation has been undertaken and a robust and ongoing auditing and leadership observational rounding implemented to ensure a high level of compliance with this Standard 5.

This recommendation has now been closed.

Surveyor's Recommendation:

No recommendation

Action 5.2.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Errors in specimen labelling continue to regularly occur across CHHS despite effort by various committees to implement effective change.

Some of these positive changes include an initiative in ED of "bagging at the bedside" and a recent directive for Pathology to log all incidents in the organisation's report tool (Kestrel). Audits are also regularly occurring and being reported to various committees and the organisation is aware that it needs to take action. The recent directive of CHHS to Pathology to start recording all incidents into Kestrel should provide more reliable data for analysis. Even with this level of knowledge and including some quality improvement activities, this continues to be an issue.

Advanced Completion (AC) Review – 3-5 July 2018

ACT Health has undertaken a comprehensive review of the organisations issues in relation to the error rates of specimen labelling. As a result, in June 2018 a very effective "Zero Tolerance" policy approach was implemented with a supportive staff education campaign aimed at reducing mismatching events.

Even though his has only recently been implemented improvements are already being identified.

This recommendation is now closed.

Surveyor's Recommendation:

No recommendation

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

Action	Organisation	Surveyor
5.5.1	SM	SM
5.5.2	SM	SM
5.5.3	SM	SM

Action 5.5.3 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The Surgical Safety Checklist is not routinely completed and completion rates currently sits at 79.8%. Concerted effort has been applied to the various clinical groups with a significant rise in compliance noted in the last six months. There is an action plan signed off by various leaders including the Chief Medical Officer.

Advanced Completion (AC) Review – 3-5 July 2018

ACT Health has implemented positive and direct action over the past three months in improving compliance with the CHHS policy and procedure in relation to the use of the Surgical / Safety Checklist. Ensuring effectiveness of the process of matching patients to their intended procedure, treatment or investigation has led to a 19.27% improvement in compliance from 76% to 95.27% with use of the Surgical Safety Checklist. This has occurred from the time of the OWS in March 2018 till July 2018.

This recommendation is now closed

Surveyor's Recommendation:

No recommendation

Organisation: ACT Health
Orgcode: 810004

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

There is an ACT Health Standard 6 Committee which reports to the National Standards Governance Committee with a good documentation of policies and guidelines to facilitate a structured process for clinical handover using the ISBAR format. There was also evidence that risks and other quality activities associated with clinical handover are endorsed by the Standards committee with the minutes and actions of the relevant divisional and ward meetings reflecting this approach.

Inconsistent use of ISBAR was observed across different clinical areas by various Clinician groups and this is contrary to CHHS policy. There is a highly recommended online training tool that has just been updated by the organisation and various audits are conducted across departments to monitor compliance. Minutes of ward communication meetings were seen that highlighted the need to use ISBAR. Audits are reported to various committees and the organisations is aware that it needs to take action.

Even with this level of knowledge, compliance is varied. The prompt sheet used for handover at Dhulwa is an example of good innovation and could possibly be used across other areas of CHHS.

Inpatient discharge summaries completion rates are below CHHS target of completion with 48 hours (77%) and 86% within 7 days of discharge and the organisation is encouraged to continue with recent CHHS executive directives. CHHS will also need to urgently work through the issue of outstanding (over 30 days) discharge summaries in some clinical areas. Some issues that have impacted on completion rates have been problems with different computer system integration, staff turnover and workloads.

A recent CHHS directive that all discharge summaries be completed in one computer system, CRIS, should help alleviate any computer system interface problems. To maximise potential for patients to follow post discharge treatment and medication management advice it is suggested that the CHHS consider working towards ensuring that all patients receive written discharge instructions at time of discharge.

Advanced Completion (AC) Review – 3-5 July 2018

Over the past three months ACT Health have reviewed the organisations handover procedures to ensure they are contemporary and aligned to the intent of Standard 6. There has been a proactive review of all clinical areas compliance in relation to the use of ISBAR in handovers and transfer of patient care. A comprehensive and interactive train the trainer inter–professional training program has been implemented to improve staffs level of competence in the use of ISBAR. The surveyors observed effective use of ISBAR in the areas visited and were encouraged by staff comprehensive awareness and understanding of the ISBAR principles. However, it was clearly evident that this practice has only recently been introduced as standard practice in the organisation. Therefore, to embed the use of ISBAR across all clinical areas the surveyors suggest a very regular documented observation rounding / audit by senior leaders at all handovers is implemented to ensue sustainability of this practice and effective evaluation occurs.

The organisation has actively reviewed the process required to complete discharge summaries, this has identified many system barriers to timely completion of inpatient discharge summaries. The organisation should be commended for adopting a collaborative problem-solving approach to this challenging issue.

Involving non- clinical / medical records managers/coding staff, information technology staff, clinical, allied health and medical staff at all levels to find implementable solutions has proven to be very worthwhile and effective. The surveyors noted that through this collaborative approach and the significant medical leadership there was major improvements in this area.

One example was Neonatology developing a new process and achieving 100% compliance of all discharge summaries being completed in one week. Significant Improvements have occurred over the past three months. However, at this stage development of a sustainable system is still evolving which will ensure the organisations requirement to facilitate patients smooth transition of care to their General Practitioners (GPs) or other health services occurs within 48 hours of discharge from ACT Health.

Escalation and monitoring of discharge summary completion rates has been enhanced and regular reporting is now being provided to medical staff and senior leaders to monitor compliance in this area. This is also monitored at the Standard 5 & 6 Committee.

The Mental Health Division have demonstrated outstanding improvements in this area and are applauded for adopting, innovative approaches to creating a sustainable system of the production of timely patient discharge summaries. Working with information technology services to utilise the CHHS Clinical Portal rather than the Mental Health Portal which was delaying the completion of discharges summaries for mental health patients. The project undertaken by a senior General Practitioner (GP) staff member with extensive forensic mental health qualifications and clinical experience to review and complete the outstanding complex mental health discharge summaries from 2017, has demonstrated the organisation commitment to ensuring the delivery of quality patient care. This Medical role has provided valuable medico- legal education to junior medical staff on the quality and requirements for an effective and useful discharge summary for GPs to be able to utilise. The additional work done because of the identified learning's from the review of back logged outstanding discharge summaries has been very positive which in turn maximises the effectiveness of the organisations clinical handover policies and procedures. The organisation will require ongoing and robust monitoring of the management of discharge summaries to ensure the intent of Standard 6 is achieved on a sustainable basis.

Clinical handover processes

The guidelines for handover are easily accessible for all staff and education on handover is part of the new graduate nurses program. Individual patient boards are used next to the patient's bed and outlines patient information, which nurse is providing care for the shift and any critical tasks. Patient handover was seen in various clinical settings with the final step being a bedside handover. In Mental health inpatient setting, the shift handover uses a printed handover sheet that presents the patient with information in a structured manner and this is assisted by the use of the patient journey board in the handover room. The process of handover continues to be evaluated through formal audits and clinical incidents. Evidence was provided which demonstrated gap analysis had been conducted and presented to the Standard Six Committee and an action plan developed. The "Flash" handover project being an example of good practice resulting from this analysis as is the JMOs handover procedure (resulting in lowered MET calls) and the recent 'Friday night' medical staff handover. It was confirmed that time out procedures, consistent with the WHO surgical safety checklist, are mostly being conducted in the operating theatres and procedure rooms. The check in, check out document used by theatre, is a good example of quality improvement and collaboration being undertaken at a departmental level.

Patient and carer involvement in clinical handover

The surveyors attended several nursing clinical handover meetings and observed active engagement with patients with verification of identity, assessment of condition and any discussion of current issues.

Patients and carers (when present) were given the opportunity to provide feedback on care received and asked if there was anything they needed. The surveyors noted a high level of patient involvement in handover including the ‘Partnering with Parents’ program, the ongoing commitment to CARE and the involvement by patients in their care with renal dialysis. Within MHJHADS, the surveyors noted involvement of the consumer in developing care plans, setting daily goals and posting expected discharge date.

Governance and leadership for effective clinical handover

Ratings

Action	Organisation	Surveyor
6.1.1	SM	SM
6.1.2	SM	SM
6.1.3	SM	SM

Action 6.1.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Inconsistent use of ISBAR was observed across different clinical areas by various Clinician groups and this is contrary to CHHS policy. There is a highly recommended online training tool that has just been updated by the organisation and various audits are conducted across departments to monitor compliance.

Minutes of ward communication meetings were seen that highlighted the need to use ISBAR.

This activity is being done by some clinical groups, audits are also regularly occurring and being reported to various committees and the organisations is aware that it needs to take action. Even with this level of knowledge, compliance is varied.

Advanced Completion (AC) Review – 3-5 July 2018

ACT Health have reviewed the organisations handover procedures to ensure they are contemporary and aligned to the intent of Standard 6. There has been a proactive review of all clinical areas compliance in relation to the use of ISBAR in handovers and transfer of patient care. A comprehensive and interactive train the trainer inter–professional training program has been implemented to improve staffs level of competence in the use of ISBAR.

This recommendation is now closed.

Surveyor's Recommendation:

No recommendation

Action 6.1.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Inpatient discharge summaries completion rates are below CHHS target of completion within 48 hours of discharge. In one area, Mental Health, there are 235 uncompleted discharge summaries from 2017 and over 200 that are more than 90 days overdue since discharge.

Some issues that have impacted on completion rates have been problems with different computer system integration, staff turnover and workloads. A recent CHHS directive that all discharge summaries be completed in one computer system, CRIS, should help alleviate any computer system interface problems.

Advanced Completion (AC) Review – 3-5 July 2018

The organisation has actively reviewed the process required to complete discharge summaries and implemented significant system level changes to improve the timeliness and compliance rate of discharge summaries completed within 48 hours of post inpatient discharge.

Over the past three months a senior General Practitioner (GP) staff member with extensive forensic mental health qualifications and clinical experience completed a project to review and complete the outstanding complex mental health discharge summaries from 2017.

This recommendation is now closed.

Surveyor's Recommendation:

No recommendation

Clinical handover processes

Ratings

Action	Organisation	Surveyor
6.2.1	SM	SM
6.3.1	SM	SM
6.3.2	SM	SM
6.3.3	SM	SM
6.3.4	SM	SM
6.4.1	SM	SM
6.4.2	SM	SM

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

Governance and systems for blood and blood product prescribing and clinical use

The Canberra Hospital (TCH) receives its blood stocks from Sydney (approximately 2½ hours from Canberra) and supplies blood to the ACT, Southern New South Wales Local Health District and parts of Murrumbidgee Local Health District.

TCH and some of its associated community clinics use a large suite of evidence-based policy and procedures. Some of these are locally developed based on international and national evidence from organisations such as the National Blood Authority, National Health and Medical Research Council (NH&MRC). The policies, procedures and protocols are consistent with the requirements of the Australian Red Cross Blood Service and Blood Safe Australia and also satisfy ACT Health regulation. Some specific policies and procedures exist to guide transfusion, cross matching and collection of blood specimens such as “Daily stack order number audit” and “Transfusion laboratory investigation of suspected transfusion reaction”.

The organisation complies with Australian and New Zealand Standards for medical refrigeration and safe storage of blood and blood products within the hospital campus and also during transfer of blood and blood products to other campuses outside TCH.

Policies procedures and protocols are readily accessible to the staff through a number of systems but the Health HUB, the ACT health Intranet, is most easily accessible to staff.

The Standard 7 Committee is the principal group that monitors all activities associated with blood and blood products, transfusion, cross matching and specimen collection. The group receive reports of incidents reported in RiskMan, audit results from across TCH and quality improvement activities.

There appears to be a good cultural reporting of blood and blood product incidents into RiskMan. These data are used to inform the organisation of its risks and areas for improvement of patient safety and quality.

Documenting patient information

The clinical record is regularly audited and the outcome of the audits is fed back to the Standard 7 Committee and to the staff in the departments concerned. Examples of these audits are the Division of Women Youth and Children documentation audit December 2017, Neonatology Discharge Summaries Audit October 2017 and the Clinical Record Information System User Audit Report September 2016.

The CHHS Standard 7 Committee reports directly to the National Standards Governance Committee and from there to the EDC Safety and Quality.

Senior staff in the clinical departments also monitor compliance with policies and procedures and take steps to improve compliance and safety. This has resulted in a number of quality improvement projects being undertaken and some are still in progress throughout the organisation.

These projects were developed specifically to improve patient safety and staff compliance with policy in particular for patient identification and documentation.

The Emergency Department (ED) and Obstetrics are currently running projects to improve staff performance correctly identifying the patient using three identifiers and then transferring this identification accurately on to the documentation for blood specimens including on the tube. The project used the concept of “bag at the bedside” to ensure that documentation was completed with the assistance of the patient, where that was possible.

Managing blood and blood product safety

The Canberra Hospital (TCH) has a memorandum of understanding with the Blood Matters Program (Victoria) that provides benchmarking across a group of 80 hospitals within Victoria, Tasmania, the Northern Territory. TCH has been ranked very poorly in its peer group as a result of the high level of labelling errors on specimen tubes being reported) This group then benchmarks against the National Blood Authority data for all of Australia against eight different criteria.

There is a high rate of labelling errors across the organisation and a “zero tolerance for transfusion specimen errors”. Quality improvement programs are in place to address this issue in a number of departments including the Emergency Department (ED) and Obstetrics. Whilst these activities are having some impact the overarching reduction in errors remains problematic.

The project in the ED has a number of PDSA cycles in an effort to change the culture and develop processes that contribute to active and accurate patient identification. At triage patients attending ED are identified, using three approved identifiers, and a wristband is assigned to the patient. It is expected that this will simplify the process identification within ED. The next cycles are developed to support a good blood history, consent for the specimens and participation of the patient (where possible) and to complete the documentation at the patient’s bedside rather than some remote location where there is the possibility to mix up the samples. This has not had a full implementation as there have been some staff shortages.

The results of this project and several other similar projects are regularly reported to the Standard 7 Committee and feedback is provided to local department staff. This has led to a decrease in the more significant errors and some reduction in the documentation errors. “Wrong blood in Tube” has been reduced as a result of these projects however labeling errors have not been fully resolved and the organisation, via the Standards 7 Committee, are encouraged to continue to focus on reducing this error rate and full ensure full compliance.

The Pathology Laboratory is the principal source of error reporting. “Kestrel” is the laboratory information system and it contains the complete transfusion history of all blood and blood products issued by ACT Pathology. This provides pathology staff with the ability to check and crosscheck all blood sent to the laboratory and check patient’s identity. They are able to critically review the labeling, check the patient’s identification with older specimens and will then apply the “zero tolerance” for errors in cross matching for transfusion requests requiring new specimens.

This has led to some further improvement in safety and does provide significant protection for patients already in the system. However, there is scope for more significant improvements across the organisation. This may be assisted by a more aggressive stance on the errors being reported. Perhaps TCH could consider other improvements to clinical performance perhaps by developing staff accountability to assist the cultural change required across its workforce.

The organisation benchmarks usage and wastage data with national data. This has driven a slow decrease in wastage (provider discards) in the case of red blood cells this is approximately 2.6%.

There has also been a decrease in the usage of red blood cells following a quality improvement project.

The Standard 7 Committee reviewed blood usage at elective surgery. Using this data, the committee recommended that iron levels of patients be reviewed before elective surgery and if they are sufficiently low to recommend that patients are transfused with iron prior to their surgery. This has led to a decrease in use of red blood cells. A particular project “Improving blood management in obstetrics: a practice improvement partnership” led the way working with iron deficient women to develop a timeline for the patient to either build their own haemoglobin levels or have an iron transfusion prior to the delivery.

Communicating with patients and carers

All patients who provide specimens or are transfused in this procedure are advised of the risks associated with the procedures including painful joints and skin staining and following their consent patient may be transfused with iron.

A clinical discharge letter is expected to accompany a patient on discharge. This is not always the case however most general practitioners will receive a discharge letter within one to three weeks.

The consent process complies with the “blood and blood product prescription and checklist”. The checklist mandates the discussion of the risks and benefits of the blood and/or blood products and provides the patient a right to refuse should they wish it.

There are several pamphlets available for patients to learn about their treatment including the Patient Blood Management Guidelines for massive transfusion, perioperative, medical, critical care, obstetrics and maternity and neonatal and paediatrics. There is also a pamphlet blood transfusion: information for patients released by TCH and Calvary that contains the contact number for the ACT Transfusion Clinical Nurse Consultant.

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

Governance and systems for blood and blood product prescribing and clinical use

Ratings

Action	Organisation	Surveyor
7.1.1	SM	SM
7.1.2	SM	SM
7.1.3	SM	SM
7.2.1	SM	SM
7.2.2	SM	SM
7.3.1	SM	SM
7.3.2	SM	SM
7.3.3	SM	SM
7.4.1	SM	SM

Documenting patient information

Ratings

Action	Organisation	Surveyor
7.5.1	SM	SM
7.5.2	SM	SM
7.5.3	SM	SM
7.6.1	SM	SM
7.6.2	SM	SM
7.6.3	SM	SM

Managing blood and blood product safety

Ratings

Action	Organisation	Surveyor
7.7.1	SM	SM
7.7.2	SM	SM
7.8.1	SM	SM
7.8.2	SM	SM

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
7.9.1	SM	SM
7.9.2	SM	SM
7.10.1	SM	SM
7.11.1	SM	SM

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

A range of relevant policies and procedures are in place across ACT Health including the CHHS clinical procedure, which provides guidance on pressure injury assessment, screening, management and prevention across the adult, children and neonate patient groups. Procedures are evidence based and consistent with national guidelines, integrating the Pan Pacific Clinical Practice Guidelines to ensure a standardised and consistent approach.

The CHHS Standard 8 Preventing and Managing Pressure Injuries Committee (PMPIC) is a multidisciplinary team, comprising representatives from each division, Clinical Safety and Quality Unit lead, Quality Officer, Clinical lead and Executive Sponsor. The PMPIC have recently appointed an active consumer representative, after a nine-month absence of representation. The PMPIC meet monthly and review RiskMan data, Health Round Table data and clinical audit results for CHHS. Pressure injury prevention and management within ACT Health is governed through the PMPIC who reports to the National Standards Governance Committee, through to the EDC Safety and Quality Committee.

Incident management of pressure injuries is captured, recorded and reported via RiskMan, with the Wound Extension Module, documenting pressure injuries both present on admission, or hospital acquired pressure injuries also recognised in the database. All pressure injuries reported into RiskMan, are subsequently reviewed and investigated by the Tissue Viability Unit at Canberra Hospital and NP/CNC in the community, in addition to senior nursing staff of relevant clinical areas. The PMPIC review all pressure injury incidents on a monthly basis, including trended data and, where relevant clinical case reviews.

The Patient Care and Accountability Plan (PCAP) contains a section for Pressure Injury Risk Assessments to occur, with ‘at risk’ patients requiring additional care plans for intervention and management in order to diminish pressure injuries. Various equipment and device aids were evidenced, to assist with the prevention and management of pressure injuries.

Preventing pressure injuries

Risk assessment tools are in place throughout the organisation and evidenced in clinical areas, to screen for both adults and paediatrics / neonates for pressure injury. The Pressure Injury Prevention and Management Procedure: Adults, Children and Neonates include the Waterlow Risk Assessment Tool (WRAT), a modified Waterlow Risk Assessment for maternity patients, the Braden Q Risk Assessment Scale for under 15-year-old patients and the Braden Risk Assessment Scale utilised within the community setting. Issues identified in the neonatal unit encouraged collaborative work with researchers and the Skin Care Working Group, enabling the development of the neonatal Skin Risk Assessment and Management Tool (SRAMT) to systematise skin management and decrease potential skin damage. The introduction of softer nasal prong oxygen cannula should also decrease the number of soft skin tissue damage to the nose and ears, generally related to such devices.

The Central Equipment Services (CES) tracks the time taken for an appropriate air mattress to be available in the clinical areas from when the job was request, to delivery and is currently under an hour.

The CHHS Operational Procedure for the ACT Equipment Loan Service ensures that pressure relieving equipment is available for community and palliative care clients and outlines cleaning and maintenance requirements.

Numerous quality improvement projects have ensued, including the Hip Fracture Project between the Emergency Department and Orthopaedics involves patients being provided with ‘hip fracture packs’, including heel protectors, sacral pressure injury prevention devices and TED stockings to reduce the incidence of pressure injuries. The Renal nurse led foot assessment for pressure injury risk is conducted and recorded in the electronic medical record and has built in management plan triggers including podiatry assessment referrals and risk assessment reports.

The importance of nutrition and wound healing was identified in rehabilitation, aged and community care and acknowledged by staff when speaking to surveyors in clinical areas and community visits. The ISBAR handover approach and discharge summaries include provision for pressure injury and risks to also be documented.

Managing pressure injuries

Best practice, evidence-based wound management plans are apparent when visiting clinical areas and include the Wound Assessment and Management Plan with the Pressure Injury Prevention and Management Clinical Interventions Guideline. The Clinical Practice Guideline was evidenced by surveyors when visiting clinical areas. The staging of pressure injuries incorporates graphic charts available and visible in clinical areas, which follow the Wounds Australia (formerly Australian Wounds Management Association) guidelines.

The Tissue Viability Unit (TVU) integrates registered nurses / midwives into a six-month rotational mentorship program including significant education to ensure advanced skin and wound management expertise. On completion of the program nurses / midwives become resource leaders and champions in prevention; assessment and management in their respective clinical areas or community settings. The TVU has also developed and conducts master classes on skin and wound care for graduate nurses to improve their confidence in wound care, product and device usage, prevention, assessment and management of pressure injuries. There is a strong culture of ongoing education and training in pressure injury prevention and management via online eLearning programs, face-to-face education sessions and through the TVU champions as accessible and knowledgeable resources for clinical staff.

Measuring Patient Care Monthly Audit data is prominently displayed in clinical areas with staff reporting areas of improvement or decline. Several areas when visited by surveyors were enthusiastic about improvements facilitated with consumer input and common-sense approaches such as neonatal soft nasal tubing and maternity Touch Dry mats developed for birthing and postnatal care.

The organisation has systems in place to ensure that patients have timely access to appropriate equipment for the prevention and managing pressure injuries via the CES and Equipment Loan service.

Surveyors reported that staff, consumers, patients and their families described access to pressure relieving devices, including cushions and mattresses being readily accessible when required.

Communicating with patients and carers

Information on pressure injuries is reported at the ward level so that staff, consumers, family and carers can visually identify information easily.

The Measuring Patient Care Program Monthly Audit program displays information on pressure injuries in clinical areas in a manner that is meaningful for consumers, family and carers. Patient information is regularly reviewed by consumers to ensure it is easy to understand and meaningful.

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Recent reviews elicited no changes to current documents and consumers, family and carers when questioned by surveyors about the information provided responded that it was easy to understand and helpful in both the hospital setting and upon discharge.

Nursing handover routinely ensues at the patient bedside and involves the patient, family and/or carer regarding their care and, where relevant includes discussions of pressure injury risk and appropriate prevention strategies. Medical and allied health rounds provide further opportunities for patient and carer engagement. Staff and consumers are actively involved in the National Wound Awareness Week and International Stop Pressure Injury Day activities and education. Patient stories and shared learnings have augmented staff understanding and ramifications of pressure injury incidents.

Plans developed in partnership with consumers and Service Care Plans identify agreed goals and interventional strategies are completed in collaboration with consumers, family and carers. Ongoing collaboration with consumers and auditing of consumer, family and carer partnerships in developing pressure injury management plans will support and strengthen work already undertaken in this standard.

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

Governance and systems for the prevention and management of pressure injuries

Ratings

Action	Organisation	Surveyor
8.1.1	SM	SM
8.1.2	SM	SM
8.2.1	SM	SM
8.2.2	SM	SM
8.2.3	SM	SM
8.2.4	SM	SM
8.3.1	SM	SM
8.4.1	SM	SM

Preventing pressure injuries

Ratings

Action	Organisation	Surveyor
8.5.1	SM	SM
8.5.2	SM	SM
8.5.3	SM	SM
8.6.1	SM	SM
8.6.2	SM	SM
8.6.3	SM	SM
8.7.1	SM	SM
8.7.2	SM	SM
8.7.3	SM	SM
8.7.4	SM	SM

Managing pressure injuries

Ratings

Action	Organisation	Surveyor
8.8.1	SM	SM
8.8.2	SM	SM
8.8.3	SM	SM
8.8.4	SM	SM

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

STANDARD 9
RECOGNISING AND RESPONDING TO CLINICAL DETERIORATION IN ACUTE HEALTH CARE

Surveyor Summary

Establishing recognition and response systems

At ACT Health has a National Standards 9 Committee and is a member of a suite of National Standards Governance Committees. The committee has Divisional representatives including members of the Medical Emergency Team (MET), Staff Development Unit and consumers and the executive sponsor is the Executive Director of Critical Care. Terms of reference outlining responsibilities for the Committee, meetings and agendas and all policies, are current and on the SharePoint website. The subcommittees which report to this group are the Rapid Response Committee which has an overview and quality role for the Clinical Review of MET events and arrests and the Goal Setting End of Life Working Group.

Key responsibilities for the Governance Committee include vital sign and Modified Early Warning Scores (MEWS); Code Blue (cardiac arrest) and Medical Emergency Team (MET) responses; patient and family escalation processes; 'Goals of Care and Resuscitation' and advanced directives. The training numbers for Basic Life Support (BLS); the provision of adequate access to Advanced Life Support (ALS); assessment of BLS and ALS competencies; MET data collection and review of the MEWS escalation process are also monitored by the group.

The organisation has well established policies and has implemented processes to ensure appropriate recording of vital signs, escalation of abnormal vital signs and the triggers for urgent review of a patient who has abnormal vital signs and / or who reaches medical emergency response triggers or code blue (cardiac / respiratory arrest). There is regular audit and reflection regarding each patient in whom a response has been initiated; processes of feedback to staff and opportunities for refinement and improvement of systems and processes.

The organisation has several escalation processes for the deteriorating patient based on vital signs, altered conscious state or other physical concerns by staff for a patient and also a mechanism for patient of their families/friends to notify / call for help if concerned. Firstly, the MEWS response which is as according to a patient's vital signs and there are strata levels to whom the MEWS must be escalated (dependent on the degree of abnormality); next is the MET call and then Code Blue. Call and Respond Early (CARE) responses is the pathway for patient / family initiation.

The Rapid Response Committee reviews all Code Blue and MET calls and incidents related to recognising and responding to clinical deterioration considering potentially precipitating issues or unrecognised earlier 'warning' signals (delayed MEWS or MET calls). All MET calls are entered on Risk Man. The Rapid Response Committee meets weekly which enables pertinent feedback from the responders and activating staff to have timely discussion. Information is shared at Clinical Forums and staff meetings. Divisional reports are generated monthly regarding MET data and these in turn can also be used as an educational tool for morbidity and mortality reviews. Monthly MET/MEWS newsletters which include data, audit and case discussions are also circulated to staff. Identified cases with concerning issues (system or process) when reviewed by the Rapid Response Committee, are the referred to the Clinical Review Committee which may choose to focus on particular issues and generate recommendations in a de-identified and themed manner.

Recognising clinical deterioration and escalating care

Initial coloured coded charts with clear triggers points for escalation were implemented in 2007.

The chart is in use for all patients and has clear instructions on whom to call for and elevated MEWS (stepwise for levels of 4, 6 or 8), as well as re-enforcing the MET criteria. There are specific paediatric and neonatal versions and they are also supplemented by ward specific charts such as neurological charts.

The charts are routinely audited for compliance from each ward and distributed to the units to be tabled at Divisional quality and safety meeting and also published in the monthly newsletters. The numbers of patients who had delayed MET and MEWS versus MET activation has decreased significantly to around four and three percent (respectively) and this has been sustained over the last few years. Audits for completeness of the observation charts are also undertaken and information is displayed on quality boards for ward staff and discussions held at ward meetings.

While the MEWS, MET and Code blue processes are well established in the hospital some of the outpatient areas which are considered 'too distant' from the core Hospital (even though still on the main Canberra Hospital campus) and thus an ambulance is called to respond to MET or code blue. Consideration should be given to include buildings such as the seven (drug and alcohol services) and eight (pain services) in the Hospital MET / code blue response.

The next tier of escalation in concern for a patient is the MET/Code Blue response. Staff felt confident about the process and would have no hesitation in activating a response when needed.

Responding to clinical deterioration

There are clear policies, procedures and protocols available on the organisational website and staff have regular updates and refresher information supplied. Contingencies for multiple simultaneous responses throughout the hospital are in place which ensure adequate seniority and skill mix of those who attend the response so there are responders present who have ALS skills. Data is collected at the point of activation and analysis occurs by the Rapid Response Committee as described and reflection for improvements and refinement of processes is occurring.

The Basic Life Support (BLS) policy outlines the training requirements for staff and the yearly completion is monitored electronically and discussed at annual performance discussions for individual staff. Much effort has been undertaken to produce relevant education packages for BLS and ALS and regular sessions are available for all staff to attend training (initial and refresher) but there is inconsistent and varied uptake of the opportunity such that there is about one third 'wastage' of spaces in each course and in particular, the engagement of medical staff is challenging. Concerted effort in March resulted in clinical staff attaining satisfactory compliance levels of assessed BLS skills especially for the medical staff cohort.

While the organisation met the ALS and BLS mandatory competencies at survey engagement of the medical staff, in particular, must be an ongoing focus. The organisation has a well-established process for Advance Care Planning and also embedded processes for Goals of Care for patients and their families.

Communicating with patients and carers

Much effort has been directed on ensuring patients and their families are aware and know how to alert someone to concerns with a patient's welfare or potential deterioration. The program Call and Respond early (CARE) had its first roll out in 2012. This has been closely monitored and audited and in 2017 refined with the roll out of new poster "getting sicker" posters for both paediatric and adult patients being developed and rolled out to all the wards earlier this year. There was considerable consumer involvement in the creation of the charts and the result is a clear step one, two, three process.

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These posters are displayed at each bedside, in hallways and noticeboards and are a component of orientation of a patient and family to their bed environment.

A process titled "Respecting Patient Choices" began in 2006. this has evolved into the Advanced Care Planning Program with dedicated staff, guidelines and a framework of operation. This group focus on ensuring information is available to patients by means of a face-to-face meeting with a member of the Advance Care Planning Team (often initiated by ward staff), brochures and documentation and the opportunity to discuss options including Enduring Power of Attorney and Statement of Choices and Health Direction. Once completed this information is registered with medical records and at the ward level with staff at handover meetings and in the patient's history. Opportunities also exist for forms to be completed in the community after discharge from hospital and with the involvement of the family practitioner.

Goals of Care forms are also in use and these are completed at admission or during the patient stay by medical staff in consultation with the patient (and / or spokesperson) during the inpatient stay and express the limits of resuscitation (and potentially limits on intensive care admission or cardiopulmonary resuscitation or MET calls) which are to be undertaken while a patient is in hospital. This information is also highlighted at handover and in the patient's history. Completion of forms and their use is audited in terms of MET calls and the number of Advance Care Plans in place for patients who die, has steadily increased to around 25%.

Organisation: ACT Health
Orgcode: 810004

Establishing recognition and response systems

Ratings

Action	Organisation	Surveyor
9.1.1	SM	SM
9.1.2	SM	SM
9.2.1	SM	SM
9.2.2	SM	SM
9.2.3	SM	SM
9.2.4	SM	SM

Recognising clinical deterioration and escalating care

Ratings

Action	Organisation	Surveyor
9.3.1	SM	SM
9.3.2	SM	SM
9.3.3	SM	SM
9.4.1	SM	SM
9.4.2	SM	SM
9.4.3	SM	SM

Action 9.4.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

While the MEWS, MET and Code blue processes are well established in the Hospital some of the outpatient areas which are considered 'too distant' from the core Hospital (even though still on the main Canberra Hospital campus) and thus an ambulance is called to respond to MET or code blue. Consideration should be given to include buildings such as the seven (drug and alcohol services) and eight (pain services) in the Hospital MET / code blue response.

Surveyor's Recommendation:

No recommendation

Responding to clinical deterioration

Ratings

Action	Organisation	Surveyor
9.5.1	SM	SM
9.5.2	SM	SM
9.6.1	SM	SM
9.6.2	SM	SM

Action 9.6.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Concerted effort in March resulted in clinical staff attaining satisfactory compliance levels of assessed BLS skills especially for the medical staff cohort. This fully meets the intent of action.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
9.7.1	SM	SM
9.8.1	SM	SM
9.8.2	SM	SM
9.9.1	SM	SM
9.9.2	SM	SM
9.9.3	SM	SM
9.9.4	SM	SM

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

ACT Health has comprehensive and appropriate governance structures and systems in place to reduce falls and minimise harm from falls. There is supportive and committed executive support for this standard which is a shared responsibility by the Executive Sponsor, a Medical Clinical lead and Director of Nursing sponsor. The organisation has comprehensive and contemporary policies, and guidelines for prevention of falls and harm from falls for patients with a strong focus on preventing harm from falls in older persons.

This is well aligned to the patient demographic cohort of ACT Health including the Mental Health and Justice Health client groups. Policies and procedures to guide clinical fall management practices are accessible to staff through ‘Share Point' via the ACT Health Intranet. Staff were generally well informed and educated on the prevention of falls policies and procedures and during the survey were easily able to access all falls policy and procedures and falls documentation tools within the inpatient and community health settings including the Mental Health and Justice Heath Services.

Falls management guidelines have been regularly reviewed and updated and are consistent with best practice guidelines. Reporting of falls occurs through a well embedded staff self-reporting RiskMan clinical incident management system. The Standard 10 Multidisciplinary Falls Prevention Committee is very effective, well managed and proactive in governing the overall management of Standard 10 across ACT Health. The committee reviews on a monthly basis falls clinical incident data from the RiskMan incident management system which is utilised to monitor and trend the regularity and severity of falls across all inpatient, ambulatory, community, Mental Health and Justice Health areas of ACT Health.

The Committee provides a monthly comprehensive report to the ACT Health National Standards Governance Committee with improvement actions as required; ensuring information on falls is reported to the highest level of governance in the organisation. Health Round Table (HRT) data on falls is also actively monitored by the committee. The surveyors noted ACT Health remains higher than the HRT median in the risk adjusted rate of in-hospital falls. The Survey team suggests the HRT data is proactively distributed across all levels of the organisation and more actively monitored to ensure improved performance in this key patient safety indicator.

In addition to ensure overall effective governance, falls are reported monthly on the ACT Health internal scorecard reports to the Clinical Divisions and disseminated throughout the Divisional Quality and Safety meetings. As a result of the proactive work that has been undertaken at ACT Health in relation to preventing falls and harm from falls, the health service has seen an overall reduction in falls and harm from falls since late 2017. The survey team suggest ACT Health implement reporting of falls data per 1000 occupied beds days (OBD) to ensure there is evidence that a general continued trend down in falls events and harm from falls across the organisation is monitored effectively and is sustained.

Screening and assessing risks of falls and harm from falling

ACT Health has implemented a validated evidence-based multidisciplinary falls risk screening and assessment tool which is incorporated into the patient care and accountability plan. The falls risk assessment tool is based on the Northern Hospital - stratified tool.

There has been recently published data that indicates this tool is limited in its ability to capture all patient groups at risk of falls due to the tools focus on screening only low and high risk categories of falls.

The surveyors strongly suggest the Standard 10 Committee in partnership with ACT Health immediately review the effectiveness of the current falls risk assessment tool in use and implement a more comprehensive and best practice based screening tool to assist clinical staff to identify and monitor patients at risk of falls and harm from falls.

An established audit program is in place which has been used to establish the effectiveness of current assessment tools in use and to identify if patient management plans are in place.

Audit data demonstrated 90% compliance with inpatient falls risk screening on admission. The Surveyors reviewed patient clinical records during the survey week and sighted evidence including in the Mental Health in patient units of comprehensive and well documented falls risk assessments completed on presentations to the Emergency Departments across ACT Health, and on admission and during admission including mental health inpatients at risk of falling from medication related falls risks. This was also evident in the Justice Health system for the high-risk patient cohort of ageing offenders, increasing in population in the Justice Health environment. Pre-admission falls risk assessments are also undertaken in the outpatient environment.

The January 2018 falls risk assessment audits data monitored by the Standard 10 committee indicate only 61% of patients are reassessed for their falls risk in the previous 24 hrs of admission. Considering the ACT Health ageing patient population base and the high number of at risk Mental Health and Justice Health client's the surveyors suggest the committee implement a comprehensive action plan. This is to ensure effective action is taken to increase the proportion of 'at-risk' patients who undergo a timely and comprehensive falls risk reassessment 24 hrs after admission.

The psychiatric inpatient falls risk assessment quality improvement activity at the Dhulwa Mental Health Unit and the trial of the Wilson Sims psychiatric inpatient falls risk assessment tool is an excellent example of ACT health staff's commitment to implementing systems to ensure the intent of Standard 10.

Preventing falls and harm from falling

The organisation has recently re-established a clinical network of falls champions representing all areas within the health service, and all sites across the organisation including Community, Mental Health and Justice Health services. The "Falls Champions" demonstrated great committed to their falls portfolio management and are actively identified in clinical areas to enable all staff to have access to them for expert advice and support The "Falls Champions" model has driven improved adherence in the clinical setting by staff to the falls prevention policies and guidelines. Many units across the health service have actively developed multifactorial falls prevention plans and activities to address falls risks identified.

The implementation of the daily visual green dot falls monitoring system implemented in ward 11B sub-acute unit is a simple quality improvement activity which has been effective in reducing falls and increasing staff awareness of the importance of implementing Falls Prevention strategies routinely in clinical practice.

The Standard 10 Committee and organisation has been very proactive in implementing effective, contemporary and relevant staff falls education programs. The falls eLearning package has been revised in 2017 and evaluated to incorporate staffs feedback on the effectiveness of the program.

Equipment and contemporary devices are available to staff, patients and carers to effectively implement prevention strategies for clients at risk of falling. There is evidence of robust oversight of the management of falls prevention equipment and products by the Standard 10 committee.

The surveyors congratulate the organisation on the significant quality improvement activity of the establishment of the Central Equipment Store (CES) within Canberra Hospital which has demonstrated a significant improvement in the quality, maintenance and access to falls prevention equipment.

The implementation of the post –falls medical documentation form and review system is an innovative approach by ACT Health to improve quality of patients care and ensures there is a well-documented plan of care in place to prevent further falls and harm from falls. The Surveyors encourage the organisation to undertake a full evaluation of this new process in 6 months' time to assess its utilisation and impact on falls reduction and harm from falls.

Effective discharge systems and process are proactively implemented to ensure patients at risk of falling are referred to appropriate support services to ensure continuity of care when patients transition home or to community care. Staff actively refer 'at-risk' patients to the Community Falls and Falls Injury Prevention Clinic. Roles such as the Aged Care Nurse Practitioner and Discharge Allied Health Assistants actively assist patients in the discharge planning phase to prevent further falls post discharge in the community.

Communicating with patients and carers

The dedication and involvement of the Consumer Representative into all aspect of the Standard 10 Committee is impressive and making a real difference to ensuring systems implemented to prevent falls and harm from falls are patient, carer and consumer focused.

The patient/carer/family is included in the planning for discharge and use of tailored falls prevention devices should the need arise. Verbal and written information is provided to the patient /carer on falls prevention. Patient information resources are available throughout ACT Health that also provides information to patient/carers on how they themselves can prevent falls.

Patients/carers are involved in a partnership approach in the development of their falls prevention plan if a plan is required. Patient Satisfaction Surveys also provide the opportunity for patient/carers to make comment not only with respect to falls prevention and management but also other aspects of their care as a consumer of the health service. Falls information, incident data and audit results are proactively displayed on quality and falls information boards across the sites the survey team visited enabling access for staff, patients, carers and the general community who visit the health service.

The participation in the Dementia Care in Hospitals Program (DCHP) and involvement of consumers in the design of the recently refurbished aged care units demonstrates ACT Health's strong commitment to involvement of consumers in the prevention of falls and harm from falls across the health service.

NSQHSS Survey

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Governance and systems for the prevention of falls

Ratings

Action	Organisation	Surveyor
10.1.1	SM	SM
10.1.2	SM	SM
10.2.1	SM	SM
10.2.2	SM	SM
10.2.3	SM	SM
10.2.4	SM	SM
10.3.1	SM	SM
10.4.1	SM	SM

Screening and assessing risks of falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.5.1	SM	SM
10.5.2	SM	SM
10.5.3	SM	SM
10.6.1	SM	SM
10.6.2	SM	SM
10.6.3	SM	SM

Preventing falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.7.1	SM	SM
10.7.2	SM	SM
10.7.3	SM	SM
10.8.1	SM	SM

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Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

NSQHSS Survey

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Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

Action	Description	Organisation's self-rating	Surveyor Rating
1.1.1	An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols	SM	SM
1.1.2	The impact on patient safety and quality of care is considered in business decision making	SM	SM
1.2.1	Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance	SM	SM
1.2.2	Action is taken to improve the safety and quality of patient care	SM	SM
1.3.1	Workforce are aware of their delegated safety and quality roles and responsibilities	SM	SM
1.3.2	Individuals with delegated responsibilities are supported to understand and perform their roles and responsibilities, in particular to meet the requirements of these Standards	SM	SM
1.3.3	Agency or locum workforce are aware of their designated roles and responsibilities	SM	SM
1.4.1	Orientation and ongoing training programs provide the workforce with the skill and information needed to fulfil their safety and quality roles and responsibilities	SM	SM
1.4.2	Annual mandatory training programs to meet the requirements of these Standards	SM	SM
1.4.3	Locum and agency workforce have the necessary information, training and orientation to the workplace to fulfil their safety and quality roles and responsibilities	SM	SM
1.4.4	Competency-based training is provided to the clinical workforce to improve safety and quality	SM	SM
1.5.1	An organisation-wide risk register is used and regularly monitored	SM	SM
1.5.2	Actions are taken to minimise risks to patient safety and quality of care	SM	SM
1.6.1	An organisation-wide quality management system is used and regularly monitored	SM	SM
1.6.2	Actions are taken to maximise patient quality of care	SM	SM

Clinical practice

Action	Description	Organisation's self-rating	Surveyor Rating
1.7.1	Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce	SM	SM
1.7.2	The use of agreed clinical guidelines by the clinical workforce is monitored	SM	SM
1.8.1	Mechanisms are in place to identify patients at increased risk of harm	SM	SM
1.8.2	Early action is taken to reduce the risks for at-risk patients	SM	SM

1.8.3	Systems exist to escalate the level of care when there is an unexpected deterioration in health status	SM	SM
1.9.1	Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care	SM	SM
1.9.2	The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards	SM	SM

Performance and skills management

Action	Description	Organisation's self-rating	Surveyor Rating
1.10.1	A system is in place to define and regularly review the scope of practice for the clinical workforce	SM	SM
1.10.2	Mechanisms are in place to monitor that the clinical workforce are working within their agreed scope of practice	SM	SM
1.10.3	Organisational clinical service capability, planning and scope of practice is directly linked to the clinical service roles of the organisation	SM	SM
1.10.4	The system for defining the scope of practice is used whenever a new clinical service, procedure or other technology is introduced	SM	SM
1.10.5	Supervision of the clinical workforce is provided whenever it is necessary for individuals to fulfil their designated role	SM	SM
1.11.1	A valid and reliable performance review process is in place for the clinical workforce	SM	SM
1.11.2	The clinical workforce participates in regular performance reviews that support individual development and improvement	SM	SM
1.12.1	The clinical and relevant non-clinical workforce have access to ongoing safety and quality education and training for identified professional and personal development	SM	SM
1.13.1	Analyse feedback from the workforce on their understanding and use of safety and quality systems	SM	SM
1.13.2	Action is taken to increase workforce understanding and use of safety and quality systems	SM	SM

Incident and complaints management

Action	Description	Organisation's self-rating	Surveyor Rating
1.14.1	Processes are in place to support the workforce recognition and reporting of incidents and near misses	SM	SM
1.14.2	Systems are in place to analyse and report on incidents	SM	SM
1.14.3	Feedback on the analysis of reported incidents is provided to the workforce	SM	SM
1.14.4	Action is taken to reduce risks to patients identified through the incident management system	SM	SM
1.14.5	Incidents and analysis of incidents are reviewed at the highest level of governance in the organisation	SM	SM
1.15.1	Processes are in place to support the workforce to recognise and report complaints	SM	SM
1.15.2	Systems are in place to analyse and implement improvements in response to complaints	SM	SM

1.15.3	Feedback is provided to the workforce on the analysis of reported complaints	SM	SM
1.15.4	Patient feedback and complaints are reviewed at the highest level of governance in the organisation	SM	SM
1.16.1	An open disclosure program is in place and is consistent with the national open disclosure standard	SM	NM
1.16.2	The clinical workforce are trained in open disclosure processes	SM	SM

Patient rights and engagement

Action	Description	Organisation's self-rating	Surveyor Rating
1.17.1	The organisation has a charter of patient rights that is consistent with the current national charter of healthcare rights	SM	SM
1.17.2	Information on patient rights is provided and explained to patients and carers	SM	SM
1.17.3	Systems are in place to support patients who are at risk of not understanding their healthcare rights	SM	SM
1.18.1	Patients and carers are partners in the planning for their treatment	SM	SM
1.18.2	Mechanisms are in place to monitor and improve documentation of informed consent	SM	SM
1.18.3	Mechanisms are in place to align the information provided to patients with their capacity to understand	SM	SM
1.18.4	Patients and carers are supported to document clear advance care directives and/or treatment-limiting orders	SM	SM
1.19.1	Patient clinical records are available at the point of care	SM	SM
1.19.2	Systems are in place to restrict inappropriate access to and dissemination of patient clinical information	SM	SM
1.20.1	Data collected from patient feedback systems are used to measure and improve health services in the organisation	SM	SM

Partnering with Consumers

Consumer partnership in service planning

Action	Description	Organisation's self-rating	Surveyor Rating
2.1.1	Consumers and/or carers are involved in the governance of the health service organisation	SM	NM
2.1.2	Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback	SM	SM
2.2.1	The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation	SM	NM
2.2.2	Consumers and/or carers are actively involved in decision making about safety and quality	SM	SM
2.3.1	Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role	SM	SM

2.4.1	Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)	SM	SM
2.4.2	Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients	SM	SM

Consumer partnership in designing care

Action	Description	Organisation's self-rating	Surveyor Rating
2.5.1	Consumers and/or carers participate in the design and redesign of health services	SM	SM
2.6.1	Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care	SM	SM
2.6.2	Consumers and/or carers are involved in training the clinical workforce	SM	SM

Consumer partnership in service measurement and evaluation

Action	Description	Organisation's self-rating	Surveyor Rating
2.7.1	The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance	SM	SM
2.8.1	Consumers and/or carers participate in the analysis of organisational safety and quality performance	SM	SM
2.8.2	Consumers and/or carers participate in the planning and implementation of quality improvements	SM	SM
2.9.1	Consumers and/or carers participate in the evaluation of patient feedback data	SM	SM
2.9.2	Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data	SM	SM

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

Action	Description	Organisation's self-rating	Surveyor Rating
3.1.1	A risk management approach is taken when implementing policies, procedures and/or protocols for: • standard infection control precautions • transmission-based precautions • aseptic non-touch technique • safe handling and disposal of sharps • prevention and management of occupational exposure to blood and body substances • environmental cleaning and disinfection • antimicrobial prescribing • outbreaks or unusual clusters of communicable infection • processing of reusable medical devices • single-use devices	SM	SM

	• surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases • provision of risk assessment guidelines to workforce • exposure-prone procedures		
3.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
3.1.3	The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation	SM	SM
3.1.4	Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols	SM	SM
3.2.1	Surveillance systems for healthcare associated infections are in place	SM	SM
3.2.2	Healthcare associated infections surveillance data are regularly monitored by the delegated workforce and/or committees	SM	SM
3.3.1	Mechanisms to regularly assess the healthcare associated infection risks are in place	SM	SM
3.3.2	Action is taken to reduce the risks of healthcare associated infection	SM	SM
3.4.1	Quality improvement activities are implemented to reduce and prevent healthcare associated infections	SM	SM
3.4.2	Compliance with changes in practice are monitored	SM	SM
3.4.3	The effectiveness of changes to practice are evaluated	SM	SM

Infection prevention and control strategies

Action	Description	Organisation's self-rating	Surveyor Rating
3.5.1	Workforce compliance with current national hand hygiene guidelines is regularly audited	SM	SM
3.5.2	Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation	SM	SM
3.5.3	Action is taken to address non-compliance, or the inability to comply, with the requirements of the current national hand hygiene guidelines	SM	SM
3.6.1	A workforce immunisation program that complies with current national guidelines is in use	SM	SM
3.7.1	Infection prevention and control consultation related to occupational health and safety policies, procedures and/or protocols are implemented to address: • communicable disease status • occupational management and prophylaxis • work restrictions • personal protective equipment • assessment of risk to healthcare workers for occupational allergies • evaluation of new products and procedures	SM	SM
3.8.1	Compliance with the system for the use and management of invasive devices in monitored	SM	SM
3.9.1	Education and competency-based training in invasive devices protocols and use is provided for the workforce who perform procedures with invasive devices	SM	SM

3.10.1	The clinical workforce is trained in aseptic technique	SM	SM
3.10.2	Compliance with aseptic technique is regularly audited	SM	SM
3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	SM

Managing patients with infections or colonisations

Action	Description	Organisation's self-rating	Surveyor Rating
3.11.1	Standard precautions and transmission-based precautions consistent with the current national guidelines are in use	SM	SM
3.11.2	Compliance with standard precautions is monitored	SM	SM
3.11.3	Action is taken to improve compliance with standard precautions	SM	SM
3.11.4	Compliance with transmission-based precautions is monitored	SM	SM
3.11.5	Action is taken to improve compliance with transmission-based precautions	SM	SM
3.12.1	A risk analysis is undertaken to consider the need for transmission-based precautions including: • accommodation based on the mode of transmission • environmental controls through air flow • transportation within and outside the facility • cleaning procedures • equipment requirements	SM	SM
3.13.1	Mechanisms are in use for checking for pre-existing healthcare associated infections or communicable disease on presentation for care	SM	SM
3.13.2	A process for communicating a patient's infectious status is in place whenever responsibility for care is transferred between service providers or facilities	SM	SM

Antimicrobial stewardship

Action	Description	Organisation's self-rating	Surveyor Rating
3.14.1	An antimicrobial stewardship program is in place	SM	SM
3.14.2	The clinical workforce prescribing antimicrobials have access to current endorsed therapeutic guidelines on antibiotic usage	SM	SM
3.14.3	Monitoring of antimicrobial usage and resistance is undertaken	SM	SM
3.14.4	Action is taken to improve the effectiveness of antimicrobial stewardship	SM	SM

Cleaning, disinfection and sterilisation

Action	Description	Organisation's self-rating	Surveyor Rating
3.15.1	Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including: • maintenance of building facilities • cleaning resources and services • risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved	SM	SM

	• waste management within the clinical environment • laundry and linen transportation, cleaning and storage • appropriate use of personal protective equipment		
3.15.2	Policies, procedures and/or protocols for environmental cleaning are regularly reviewed	SM	SM
3.15.3	An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly	SM	SM
3.16.1	Compliance with relevant national or international standards and manufacturer's instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored	SM	SM
3.17.1	A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place	SM	SM
3.18.1	Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
3.19.1	Information on the organisation's corporate and clinical infection risks and initiatives implemented to minimise patient infection risks is provided to patients and/or carers	SM	SM
3.19.2	Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience	SM	SM

Medication Safety

Governance and systems for medication safety

Action	Description	Organisation's self-rating	Surveyor Rating
4.1.1	Governance arrangements are in place to support the development, implementation and maintenance of organisation-wide medication safety systems	SM	SM
4.1.2	Policies, procedures and/or protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines	SM	SM
4.2.1	The medication management system is regularly assessed	SM	SM
4.2.2	Action is taken to reduce the risks identified in the medication management system	SM	SM
4.3.1	A system is in place to verify that the clinical workforce have medication authorities appropriate to their scope of practice	SM	SM
4.3.2	The use of the medication authorisation system is regularly monitored	SM	SM
4.3.3	Action is taken to increase the effectiveness of the medication authority system	SM	SM
4.4.1	Medication incidents are regularly monitored, reported and investigated	SM	SM
4.4.2	Action is taken to reduce the risk of adverse medication incidents	SM	SM
4.5.1	The performance of the medication management system is regularly assessed	SM	SM

4.5.2	Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use	SM	SM

Documentation of patient information

Action	Description	Organisation's self-rating	Surveyor Rating
4.6.1	A best possible medication history is documented for each patient	SM	SM
4.6.2	The medication history and current clinical information is available at the point of care	SM	SM
4.7.1	Known medication allergies and adverse drug reactions are documented in the patient clinical record	SM	SM
4.7.2	Action is taken to reduce the risk of adverse reactions	SM	SM
4.7.3	Adverse drug reactions are reported within the organisation and to the Therapeutic Goods Administration	SM	SM
4.8.1	Current medicines are documented and reconciled at admission and transfer of care between healthcare settings	SM	SM

Medication management processes

Action	Description	Organisation's self-rating	Surveyor Rating
4.9.1	Information and decision support tools for medicines are available to the clinical workforce at the point of care	SM	SM
4.9.2	The use of information and decision support tools is regularly reviewed	SM	SM
4.9.3	Action is taken to improve the availability and effectiveness of information and decision support tools	SM	SM
4.10.1	Risks associated with secure storage and safe distribution of medicines are regularly reviewed	SM	SM
4.10.2	Action is taken to reduce the risks associated with storage and distribution of medicines	SM	SM
4.10.3	The storage of temperature-sensitive medicines is monitored	SM	SM
4.10.4	A system that is consistent with legislative and jurisdictional requirements for the disposal of unused, unwanted or expired medications is in place	SM	SM
4.10.5	The system for disposal of unused, unwanted or expired medications is regularly monitored	SM	SM
4.10.6	Action is taken to increase compliance with the system for storage, distribution and disposal of medications	SM	SM
4.11.1	The risks for storing, prescribing, dispensing and administration of high-risk medicines are regularly reviewed	SM	SM
4.11.2	Action is taken to reduce the risks of storing, prescribing, dispensing and administering high-risk medicines	SM	SM

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Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	SM	SM
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM
4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
4.13.1	The clinical workforce provides patients with patient specific medicine information, including medication treatment options, benefits and associated risks	SM	SM
4.13.2	Information that is designed for distribution to patients is readily available to the clinical workforce	SM	SM
4.14.1	An agreed medication management plan is documented and available in the patient's clinical record	SM	SM
4.15.1	Information on medicines is provided to patients and carers in a format that is understood and meaningful	SM	SM
4.15.2	Action is taken in response to patient feedback to improve medicines information distributed by the health service organisation to patients	SM	SM

Patient Identification and Procedure Matching

Identification of individual patients

Action	Description	Organisation's self-rating	Surveyor Rating
5.1.1	Use of an organisation-wide patient identification system is regularly monitored	SM	SM
5.1.2	Action is taken to improve compliance with the patient identification matching system	SM	SM
5.2.1	The system for reporting, investigating and analysis of patient care mismatching events is regularly monitored	SM	SM
5.2.2	Action is taken to reduce mismatching events	SM	SM
5.3.1	Inpatient bands are used that meet the national specifications for patient identification bands	SM	SM

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Processes to transfer care

Action	Description	Organisation's self-rating	Surveyor Rating
5.4.1	A patient identification and matching system is implemented and regularly reviewed as part of structured clinical handover, transfer and discharge processes	SM	SM

Processes to match patients and their care

Action	Description	Organisation's self-rating	Surveyor Rating
5.5.1	A documented process to match patients and their intended treatment is in use	SM	SM
5.5.2	The process to match patients to any intended procedure, treatment or investigation is regularly monitored	SM	SM
5.5.3	Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	SM	SM

Clinical Handover

Governance and leadership for effective clinical handover

Action	Description	Organisation's self-rating	Surveyor Rating
6.1.1	Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored	SM	SM
6.1.2	Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols	SM	SM
6.1.3	Tools and guides are periodically reviewed	SM	SM

Clinical handover processes

Action	Description	Organisation's self-rating	Surveyor Rating
6.2.1	The workforce has access to documented structured processes for clinical handover that include: • preparing for handover, including setting the location and time while maintaining continuity of patient care • organising relevant workforce members to participate • being aware of the clinical context and patient needs • participating in effective handover resulting in transfer of responsibility and accountability for care	SM	SM
6.3.1	Regular evaluation and monitoring processes for clinical handover are in place	SM	SM
6.3.2	Local processes for clinical handover are reviewed in collaboration with clinicians, patients and carers	SM	SM
6.3.3	Action is taken to increase the effectiveness of clinical handover	SM	SM
6.3.4	The actions taken and the outcomes of local clinical handover reviews are reported to the executive level of governance	SM	SM
6.4.1	Regular reporting, investigating and monitoring of clinical handover incidents is in place	SM	SM

6.4.2	Action is taken to reduce the risk of adverse clinical handover incidents	SM	SM

Patient and carer involvement in clinical handover

Action	Description	Organisation's self-rating	Surveyor Rating
6.5.1	Mechanisms to involve a patient and, where relevant, their carer in clinical handover are in use	SM	SM

Blood and Blood Products

Governance and systems for blood and blood product prescribing and clinical use

Action	Description	Organisation's self-rating	Surveyor Rating
7.1.1	Blood and blood product policies, procedures and/or protocols are consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products	SM	SM
7.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
7.1.3	Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products	SM	SM
7.2.1	The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed	SM	SM
7.2.2	Action is taken to reduce the risks associated with transfusion practices and the clinical use of blood and blood products	SM	SM
7.3.1	Reporting on blood and blood product incidents is included in regular incident reports	SM	SM
7.3.2	Adverse blood and blood product incidents are reported to and reviewed by the highest level of governance in the health service organisation	SM	SM
7.3.3	Health service organisations participate in relevant haemovigilance activities conducted by the organisation or at state or national level	SM	SM
7.4.1	Quality improvement activities are undertaken to reduce the risks of patient harm from transfusion practices and the clinical use of blood and blood products	SM	SM

Documenting patient information

Action	Description	Organisation's self-rating	Surveyor Rating
7.5.1	A best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record	SM	SM
7.5.2	The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed	SM	SM
7.5.3	Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record	SM	SM
7.6.1	Adverse reactions to blood or blood products are documented in the patient clinical record	SM	SM
7.6.2	Action is taken to reduce the risk of adverse events from administering blood or blood products	SM	SM

7.6.3	Adverse events are reported internally to the appropriate governance level and externally to the pathology service provider, blood service or product manufacturer whenever appropriate	SM	SM

Managing blood and blood product safety

Action	Description	Organisation's self-rating	Surveyor Rating
7.7.1	Regular review of the risks associated with receipt, storage, collection and transport of blood and blood products is undertaken	SM	SM
7.7.2	Action is taken to reduce the risk of incidents arising from the use of blood and blood product control systems	SM	SM
7.8.1	Blood and blood product wastage is regularly monitored	SM	SM
7.8.2	Action is taken to minimise wastage of blood and blood products	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
7.9.1	Patient information relating to blood and blood products, including risks, benefits and alternatives, is available for distribution by the clinical workforce	SM	SM
7.9.2	Plans for care that include the use of blood and blood products are developed in partnership with patients and carers	SM	SM
7.10.1	Information on blood and blood products is provided to patients and their carers in a format that is understood and meaningful	SM	SM
7.11.1	Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation	SM	SM

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines and incorporate screening and assessment tools	SM	SM
8.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
8.2.1	An organisation-wide system for reporting pressure injuries is in use	SM	SM
8.2.2	Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries	SM	SM
8.2.3	Information on pressure injuries is regularly reported to the highest level of governance in the health service organisation	SM	SM
8.2.4	Action is taken to reduce the frequency and severity of pressure injuries	SM	SM
8.3.1	Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries	SM	SM

8.4.1	Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries	SM	SM

Preventing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.5.1	An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury	SM	SM
8.5.2	The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation	SM	SM
8.5.3	Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation	SM	SM
8.6.1	Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries	SM	SM
8.6.2	Patient clinical records, transfer and discharge documentation are periodically audited to identify at-risk patients with documented skin assessments	SM	SM
8.6.3	Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries	SM	SM
8.7.1	Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record	SM	SM
8.7.2	The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed	SM	SM
8.7.3	Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan	SM	SM
8.7.4	Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan	SM	SM

Managing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.8.1	An evidence-based wound management system is in place within the health service organisation	SM	SM
8.8.2	Management plans for patients with pressure injuries are consistent with best practice and documented in the patient clinical record	SM	SM
8.8.3	Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans	SM	SM
8.8.4	Action is taken to increase compliance with evidence-based pressure injury management plans	SM	SM

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Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
8.9.1	Patient information on prevention and management of pressure injuries is provided to patients and carers in a format that is understood and is meaningful	SM	SM
8.10.1	Pressure injury management plans are developed in partnership with patients and carers	SM	SM

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

Action	Description	Organisation's self-rating	Surveyor Rating
9.1.1	Governance arrangements are in place to support the development, implementation, and maintenance of organisation-wide recognition and response systems	SM	SM
9.1.2	Policies, procedures and/or protocols for the organisation are implemented in areas such as: • measurement and documentation of observations • escalation of care • establishment of a rapid response system • communication about clinical deterioration	SM	SM
9.2.1	Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems	SM	SM
9.2.2	Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as not for resuscitation or do not resuscitate) are reviewed to identify the use of the recognition and response systems, and any failures in these systems	SM	SM
9.2.3	Data collected about recognition and response systems are provided to the clinical workforce as soon as practicable	SM	SM
9.2.4	Action is taken to improve the responsiveness and effectiveness of the recognition and response systems	SM	SM

Recognising clinical deterioration and escalating care

Action	Description	Organisation's self-rating	Surveyor Rating
9.3.1	When using a general observation chart, ensure that it: • is designed according to human factors principles • includes the capacity to record information about respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness graphically over time • includes thresholds for each physiological parameter or combination of parameters that indicate abnormality • specifies the physiological abnormalities and other factors that trigger the escalation of care • includes actions required when care is escalated	SM	SM
9.3.2	Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan	SM	SM

9.3.3	Action is taken to increase the proportion of patients with complete sets of recorded observations, as specified in the patient's monitoring plan	SM	SM
9.4.1	Mechanisms are in place to escalate care and call for emergency assistance	SM	SM
9.4.2	Use of escalation processes, including failure to act on triggers for seeking emergency assistance, are regularly audited	SM	SM
9.4.3	Action is taken to maximise the appropriate use of escalation processes	SM	SM

Responding to clinical deterioration

Action	Description	Organisation's self-rating	Surveyor Rating
9.5.1	Criteria for triggering a call for emergency assistance are included in the escalation policies, procedures and/or protocols	SM	SM
9.5.2	The circumstances and outcome of calls for emergency assistance are regularly reviewed	SM	SM
9.6.1	The clinical workforce is trained and proficient in basic life support	SM	SM
9.6.2	A system is in place for ensuring access at all times to at least one clinician, either on-site or in close proximity, who can practise advanced life support	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
9.7.1	Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include: • the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce • local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration	SM	SM
9.8.1	A system is in place for preparing and/or receiving advance care plans in partnership with patients, families and carers	SM	SM
9.8.2	Advance care plans and other treatment-limiting orders are documented in the patient clinical record	SM	SM
9.9.1	Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response	SM	SM
9.9.2	Information about the system for family escalation of care is provided to patients, families and carers	SM	SM
9.9.3	The performance and effectiveness of the system for family escalation of care is periodically reviewed	SM	SM
9.9.4	Action is taken to improve the system performance for family escalation of care	SM	SM

Preventing Falls and Harm from Falls

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

Governance and systems for the prevention of falls

Action	Description	Organisation's self-rating	Surveyor Rating
10.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools	SM	SM
10.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
10.2.1	Regular reporting, investigating and monitoring of falls incidents is in place	SM	SM
10.2.2	Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service organisation	SM	SM
10.2.3	Information on falls is reported to the highest level of governance in the health service organisation	SM	SM
10.2.4	Action is taken to reduce the frequency and severity of falls in the health service organisation	SM	SM
10.3.1	Quality improvement activities are undertaken to prevent falls and minimise patient harm	SM	SM
10.4.1	Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls	SM	SM

Screening and assessing risks of falls and harm from falling

Action	Description	Organisation's self-rating	Surveyor Rating
10.5.1	A best practice screening tool is used by the clinical workforce to identify the risk of falls	SM	SM
10.5.2	Use of the screening tool is monitored to identify the proportion of at-risk patients that were screened for falls	SM	SM
10.5.3	Action is taken to increase the proportion of at-risk patients who are screened for falls upon presentation and during admission	SM	SM
10.6.1	A best practice assessment tool is used by the clinical workforce to assess patients at risk of falling	SM	SM
10.6.2	The use of the assessment tool is monitored to identify the proportion of at-risk patients with a completed falls assessment	SM	SM
10.6.3	Action is taken to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment	SM	SM

Preventing falls and harm from falling

Action	Description	Organisation's self-rating	Surveyor Rating
10.7.1	Use of best practice multifactorial falls prevention and harm minimisation plans is documented in the patient clinical record	SM	SM
10.7.2	The effectiveness and appropriateness of the falls prevention and harm minimisation plan are regularly monitored	SM	SM
10.7.3	Action is taken to reduce falls and minimise harm for at-risk patients	SM	SM

10.8.1	Discharge planning includes referral to appropriate services, where available	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
10.9.1	Patient information on falls risks and prevention strategies is provided to patients and their carers in a format that is understood and meaningful	SM	SM
10.10.1	Falls prevention plans are developed in partnership with patients and carers	SM	SM

Organisation: ACT Health
Orgcode: 810004

Recommendations from Current Survey

Standard: Governance for Safety and Quality in Health Service Organisations
Item: 1.16
Action: 1.16.1 An open disclosure program is in place and is consistent with the national open disclosure standard

Surveyor's Recommendation:

Implement a system to identify and track the closure process of an open disclosure following an investigation.

Standard: Partnering with Consumers
Item: 2.1
Action: 2.1.1 Consumers and/or carers are involved in the governance of the health service organisation

Surveyor's Recommendation:

Identify and implement a mechanism for involving consumers and or carers in the organisational governance of the health service.

Standard: Partnering with Consumers
Item: 2.2
Action: 2.2.1 The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation

Surveyor's Recommendation:

Establish mechanisms for engaging consumers and/or carers in both strategic and operational planning for the organisation.

Organisation: ACT Health
Orgcode: 810004

Recommendations from Previous Survey

Standard: Preventing and Controlling Healthcare Associated Infections
Criterion: Communicating with patients and carers
Action: 3.19.2 Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience

Recommendation: NSQHSS Survey 0515.3.19.2

Recommendation:

Evaluate the patient infection prevention and control information provided to patients to determine the needs of the target audience.

Action:

To address this recommendation, the Canberra Hospital and Health Services Infection Prevention and Control (IPC) Team distributed the Multi Resistant Organism (MRO) information pamphlet survey to inpatients identified with an MRO in July 2015.

The pamphlet, which detailed information about the patient's specific MRO, was included in an MRO pack and given out by IPC staff. An envelope addressed to IPC was included in the pack.

A total of 100 surveys were distributed; only 18 were completed and returned. IP&C staff went to wards to collect results, but this did not significantly improve the number of responses. Results of the survey were very positive with only one unsatisfied consumer. Overall feedback indicated consumers were satisfied with the information provided.

Due to the difficulty in evaluating such a small response, the Consumer Representative for Healthcare Associated Infections Standard Group spoke with five consumers identified with an MRO. She asked about their experience with information provided and documented any concerns raised. The Standard Group then added these concerns to its Quality Plan, with actions to address any identified issues.

One of the concerns raised was that the brochure was not clear on whom interstate consumers should contact if they had any concerns after they had been discharged. The brochure was re-written to clarify contact information and work continues to ensure staff information to consumers aligns with written information.

Infection Prevention and Control continue to review consumer handouts that have been developed by the unit. Most recently IPC have reviewed the hand out for respiratory illness. The numbers reviewed were only small due to the time constraints of the flu season. However, information received from the consumer is extremely valuable and it is planned that changes will be made to the hand out prior to the winter flu season 2018. All IPC consumer handouts have been to the Consumer Handouts Committee.

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

Completion Due By: June 2017

Responsibility: IP&C Unit

Organisation Completed: Yes

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

Sufficient evidence was provided to satisfactorily meet this recommendation. CHHS are encouraged to look at innovative ways to capture patient feedback (i.e. waiting areas, involvement of community groups) to ensure the collection is easily obtained.

Standard: Medication Safety
Criterion: Communicating with patients and carers
Action: 4.15.2 Action is taken in response to patient feedback to improve medicines information distributed by the health service organisation to patients

Recommendation: NSQHSS Survey 0515.4.15.2

Recommendation:

Provide evidence that patient feedback has been used to improve the way medicines information is communicated to patients/carers.

Action:

The implementation of the Consumer Handout Committee (CHC) requires that all publications targeted to consumers are submitted to this committee prior to distribution. There is a requirement that consumers are included in the consultation process and their feedback incorporated into the document prior to submission to the CHC. The CHC also has several consumer members who review documents to ensure they are appropriate for their audience.

The CHC and Medication Management Committee (MMC) are working collaboratively in the approvals of all medication related handouts that come to the CHC, to ensure that the information provided is correct, appropriate health literacy levels and meets consumers' needs. The consumer handout coordinator sends submissions to the MMC for handouts related to medication prior to progressing to the handout committee. ACT Health predominately provides consumers Pharmaceutical Drug information brochures with few internal documents developed. Methadone Treatment and ECG Screening and Methacholine Challenge Test are examples of internally developed documents that have been endorsed by the Consumer Handout Committee.

Completion Due By: October 2017

Responsibility: MMC Working Party

Organisation Completed: Yes

Organisation: ACT Health
Orgcode: 810004

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

Action has been taken to satisfactorily close this recommendation.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Responding to clinical deterioration
Action: 9.6.1 The clinical workforce is trained and proficient in basic life support

Recommendation: NSQHSS Survey 0515.9.6.1

Recommendation:

All members of the clinical workforce be trained and be proficient in basic life support.

Action:

The Essential Education Policy Outlines that all clinicians who are required to provide the initial response to unexpected deterioration or who provide care and interventions that are likely to cause unexpected deterioration are trained in Basic Life Support (BLS).

The requirement to complete BLS is assigned to the position in their Capabiliti profile. Compliance is monitored through the Performance Information Portal (PIP) and can be monitored by both Divisional and Professional reports.

Completion Due By: October 2017

Responsibility: Narelle Boyd

Organisation Completed: Yes

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

The Essential Education Policy of ACT Health has the overarching Policy regarding the requirements for clinical staff to complete Basic Life Support (BLS) training. This is monitored by an Organisational electronic system. There are numerous initial and refresher courses available for all staff: medical, nursing and allied health. Medical staff engagement has improved and overall greater than 85% has been achieved for BLS and senior medical staff is above 80% and Organisation wide 87% at the time of survey.

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

Standards Rating Summary

Organisation - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	39	0	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	20	0	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**209**	**0**	**209**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	3	0	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**47**	**0**	**47**

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**209**	**0**	**209**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	11	0	11
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	3	0	3
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**47**	**0**	**47**

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	0	15	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	23	0	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**0**	**256**	**0**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	15	0	15	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**256**	**0**	**256**	**Met**

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

Surveyor - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	39	0	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	20	0	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**209**	**0**	**209**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	1	8	0	9
Standard 2	2	9	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	3	0	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**3**	**44**	**0**	**47**

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**209**	**0**	**209**

Standard	SM	MM	Total
Standard 1	8	0	8
Standard 2	9	0	9
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	3	0	3
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**44**	**0**	**44**

NSQHSS Survey

Organisation: ACT Health
Orgcode: 810004

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	1	52	0	53	Met
Standard 2	2	13	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	23	0	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**3**	**253**	**0**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	52	0	52	Met
Standard 2	13	0	13	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**253**	**0**	**253**	**Met**