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

ACT Health

Canberra, ACT

Organisation Code: 81 00 04

Survey Date: 11-15 May 2015

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:

1. a customer focus
2. strong leadership
3. a culture of improving
4. evidence of outcomes
5. 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:

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

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

1Survey Team Summary Report
2 Action Ratings Summary Report
3 Summary of Recommendations from the Current Survey
4 Recommendations from the Previous Survey
5 Standard Ratings Summary Report

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:

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

High Priority Recommendations (HPR) -

A High Priority Recommendation (HPR) is given to an organisation when:
1. consumer / patient care is compromised and / or
2. the safety of consumers / patients and / or staff is jeopardised.

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

2 Actions Ratings Summary Report

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

3 Summary of Recommendations from the Current Survey

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular 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 Ratings Summary Report

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

Survey Report

Survey Overview

The ACT Health has a strong executive management team whose members provide active guidance and support to ensure compliance with the National Safety and Quality Health Service Standards (NSQHSS). Leadership is shown by their membership on all the relevant committees. An impressive well-resourced HealthCare Improvement Division provides the infrastructure support to all clinical and support divisions of the service. During this survey it was clear there was a strong culture of accountability demonstrated by all staff and there was consistent evidence of ward and unit staff being aware of the elements of the various standards and being aware of how they were reflected in the day-to-day operations of their departments. An impressive feature of this organisation is the presence and strength of consumers, with active representation on every significant committee, including the appointment committees for the most senior executive members of staff. Data collection consistent with the requirements of the standards is comprehensive. During the next survey period, evaluation may reveal opportunities to refine current arrangements, by reducing the frequency of data collections for those items assessed as low risk and consistently high performers. ACT Health is a visibly consumer focused organisation. Public areas and ward corridors all contain consumer focused information, together with visual displays of outcome results associated with NSQHS Standards data collection.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

ACT Health has developed a tiered governance structure that is clearly defined. Policies, procedures and guidelines have recently undergone a major review that has resulted in over 600 policy documents being ceased and all other documents updated. A new policy, as well as new policy development guidelines, is now in use. All policy documents are very accessible via the intranet. Compliance with legislation, Australian Standards and organisational policies and procedures is closely monitored. Incidents and patient complaints are actively reported and managed via the RiskMan system that escalates the risk according to the priority given to the risk at the time of reporting.

A robust framework of committees is in place. The overarching committee for quality and safety is the high level Executive Directors' Safety and Quality Committee. The Measuring Patient Care Program is used to evaluate patient care outcomes through a very comprehensive auditing and report program. Outcomes of the audits are reviewed at each unit/service and provided to the Tier One Executive Director's Safety and Quality Committee (EDC) Feedback is provided to staff in a number of ways - one of particular note is the Improvement Library (IL) (via intranet), that staff can easily access and see the contents of the organisation's Improvement Register; the outcomes of patient care evaluations and audits; and comments from Morbidity and Mortality reviews. The IL also provides links to other safety and quality information. Staff commitment to quality and safety (Q&S) is fostered through; mandatory and developmental staff education; targeted education about Q&S and the expectations of ACT Health. Members of the Executive team participate in Q&S meetings at the different tiers and participate in clinical conversations and provide staff an overview of the role of governance systems and how they support the provision of quality safe care and safety for staff, consumers and the community. Staff were found to be actively participating in the quality and safety activities.

ACT Health has a Quality and Clinical Governance Framework 2015-2018 that guides all staff in relation to what is expected the quality improvement processes and patient safety. The Document is comprehensive and informative.

Patient safety is maintained via: Morbidity and Mortality monitoring; risk and incident management; quality improvement (QI) education and workforce management and development.

Very comprehensive monitoring of QI activities, legislation and PP compliance, outcome performance and workforce is undertaken. A strong culture of reporting the outcomes of monitoring and auditing is present. Feedback is also a provided to staff via the Measuring Patient Care Data Summary Reports. An IL is also able to be accessed by staff. This library provides links to safety and quality information as well as the quality improvement register and other quality and safety reports and activities.

A new comprehensive governance framework is currently being established for the management of healthcare technology. Currently biomedical engineering staff are in the process of implementing the new AS 3551 but they have been slowed down by the requirements of the new standard that are not able to be met by using the current IT system. At the time of survey, it was stated that the new governance framework is about 80% complete. The new Biomedical Engineering service is responsible for the operation and maintenance of technology. It is expected that the development of this new governance framework will be completed and the new standard (AS 3551) fully implemented.

Governance of point-of-care testing (POCT) has recently been comprehensively reviewed and has resulted in the development of a new POCT policy and set of standard operating procedures.

The ACT Health Corporate Governance Statement clearly sets out the principles, elements and mechanisms to drive and support governance. It clearly links the audit, compliance and control activities of the quality improvement processes with the risk management system. In relation to quality and safety, evidence was found of staff putting into practice the expectations and standards stated in the document. A Quality Plan is in place. The risk management system is continually being reviewed and has, as a consequence, continued to be adjusted to meet corporate, strategic and operational needs.

An extremely committed consumer group was found to play an important role at ACT Health in relation to the evaluation of patient care, complaints, risks and reported incidents. This group also participated in the development and implementation of improvement actions plans to address identified issues.

Clinical practice

The recent review of clinical guidelines pathways policies and SOPS has resulted in improved access to the documents by all categories of staff. Appropriate policies, guidelines, pathways and SOPS are in place that guide staff to deliver all aspects of clinical care, including the deteriorating patient and also in the management of the clinical record. The documents are available electronically at the point of care and are used by all clinical groups. Compliance and variation is monitored regularly with reports generated for CHHS divisional and unit/ward level. Due to the monitoring process staff across CHHS were noted to have an excellent knowledge of the standard of care they provide.

There are systems in place which identify patients at high risk of harm including: The patient Care and Accountability Plan which on admission assesses and identifies those at risk for infection prevention / control, mobility, falls, pressure injury, nutrition and venous thromboembolism. ACTPAS (patient administration system) contains an alert trigger to assist staff identify those patients with allergies, behavioural or environmental issues. The pre-anaesthetic assessment identifies past medical history, risk factors and current condition. To meet the needs of the varied CHHS case mix there are a range of track and trigger observation charts in place e.g. adult paediatric and maternity. The charts provide clinical staff with decision-making guidance and a pathway of care escalation. Families and others are encouraged to escalate care concerns about care through the Care and Respond Early (CARE) program. Extensive data are collected around the MET MEWS (Emergency Response system) and care of the dying as part of the standard 9 scorecard. The collection of data around these risks, escalation of care and actions taken is reflected in minutes of CHHS Divisional unit/ward and morbidity/mortality meetings. CHHS has been responsive to the number of bariatric patients and manages the associated risk with appropriate equipment including a number of ceiling tracked lifting devices.

The Clinical Record Information System (CRIS) is the electronic document storage and retrieval method used. There are a number of specialised clinical applications associated with the CRIS that support and facilitate access and auditing/data collection including: MetaVision (ICU) BOS (birthing) MHAGIC (mental health) and RIS-PACS for imaging. The Clinical Record Service monitors a range of indicators including coding of records timeliness of scanning of inpatient and outpatient records. Compliance rates are high and a system is in place which appropriately prioritises any backlog. The clinical records are easy to navigate through with tabs separating different sections of the record e.g. progress notes and pathology. The development of new forms and electronic templates is impressive with approval and barcoding undertaken by the Clinical Records Form Committee prior to staff notification and posting on the Clinical Forms Register.

Of the clinical records observed there was a high level of legibility noted and this should be encouraged whilst continuing to review the formal audit results periodically. Overall the clinical record provides contemporaneous tracking of the patient condition care interventions and responses to care. They are sufficiently detailed to provide auditing review and data collection of the contents against the requirements of each NSQHS Standard.

The ACT Dental Service has the same access to clinical policy, procedure and protocols using the ACT Health intranet. Patients access care through a centralised telephone access centre and are triaged to determine clinical risk and prioritise access to treatment. Patient identification is routine in the oral health service clinics with processes that commence at the reception desk and continue into the clinic immediately prior to commencing treatment.

The ACT Dental Service has an integrated digital record that utilises Titanium software from Spark Dental. This software manages the eRecord including digital imaging, and bar coded sterile instrument tracking. Patient records including radiographs are immediately available to staff at any clinic attended by the patient including the mobile oral health clinic that is predominately stationed at Residential Aged Care Facilities. There are plans to integrate further by incorporating the digital dental record to the ACT PAS to create a record accessible to all the ACT Health clinical staff.

Performance and skills management

The ACT Health Medical and Dental Appointments Advisory Committee provides the governance over the appointment of medical and dental appointments. Its role has been recently extended to include credentialing of eligible midwives. Effective systems are in place to ensure currency of Australian Health Practitioners Regulation Agency registration for relevant staff. Surveyors were impressed with the processes in place to support advanced practice roles amongst different clinicians - for example, the Advanced Practice Nurses who staff the ACT Health's Walk in Centres, the Nurse Practitioners and the changing scope of practice for some physiotherapists. Within the Division of Surgery, Oral Health and Medical Imaging, surgical trainee competency is rigorously assessed through a process of supervision/ competency assessment, direct observation and log book review on a case by case basis.

A noteworthy effort has been made by ACT Health to ensure that staff are aware of and understand their role and responsibilities safety and quality at all levels throughout the organisation. The themed "patient safety conversation" and the resulting feedback and action plan is developing robust lines of communication in the organisation. Staff refer to the fortnightly audit results reported and distributed on the "score card" to monitor progress on specific indicators for quality and patient safety.

The induction process works effectively across all staff categories including casual and contracted staff and contract workers. Duty statements, ongoing training and the performance review process reinforce the roles and responsibilities in safety and quality at all levels in the organisation

The ACT Public Service Performance Framework defines activity in this criterion. The "Let's talk performance" training has been completed by managers and learnings are used to guide performance management meetings.

All the medical leaders have participated in leadership training through the Royal Australasian College of Medical Administrators and use this training to guide their supervision and management of junior medical officers.

The Essential Education Policy prescribes the essential training requirements for all staff, volunteers and contractors including those on rotation from other hospitals, locums, students. This is supported by a robust system for additional learning through e learning packages operated using "Capabiliti". This system provides an easy to use interface for staff and their managers to track and report on training activities. "Capabiliti" also supports staff to maintain their own record of additional self-initiated professional development programs.

Incident and complaints management

The management of risks at ACT Health has continued to be evaluated and developed over the past few years. All reporting of risks and incidents, patient and non-patient, is done using the RiskMan system and staff are taught how to use the system at orientation.

The ACT Health Executive Director's Council Safety and Quality Committee is the governing body for the management of risk and patient safety. This committee consists of all members of the ACT Health executive team and provides regular feedback to staff.

ACT Health has an incident management and investigation system guided by current policies and guidelines. Corrective Action Plans are used to address the issues identified by an investigation. Accountable persons and dates for completion are used to guide the implementation of the plan by key staff. The actions and outcomes of the action plans are closely monitored to ensure risks and incidents are managed to an acceptable outcome. ACT Health Staff have developed a culture of reporting risks, incidents and near misses. A review of trended data on reported incidents over the past three years provided evidence that reporting has been increasing but critical incident and adverse events have remained very low.

ACT Health has developed an Improvement Library that staff can easily access to gain information about identified risks and risk management outcomes; and quality improvements. It also provides links to safety and quality information and the Divisional Improvement Libraries. Trended data is used in the feedback provided to staff and there was strong evidence that this data is used to inform decisions on the provision of safe patient care, as well as staff and community safety. Consumers play a key role in the management of risks and complaints at ACT Health.

The ACT Health Risk Management System is a key component of corporate and clinical governance. All staff are expected to report risks and carry out treatment strategies as per the ACT Health policies and protocols. Comprehensive education has been provided to staff to ensure they have the skill required to use RiskMan system competently. The Staff notification rate has continued to increase in recent years and this is seen as evidence that risk identification and management has become imbedded within the workplace culture. Responsibility for the management of risks has also been devolved down to the various workplace tiers and groups, branches, divisions and units. The outcomes of risk management plans are closely monitored by Tier 2 Managers.

Risk management is closely aligned to the quality and safety system.

ACT Health has an excellent Improvement Library that is a tool for providing a link for staff to quality, safety, risk and data related to evaluation of patient care outcomes.

Overall the risk management system was found to be well embedded across and throughout the organisation. All staff spoken to could describe the system and their responsibility in relation to the management of risks. Risk management and the use of the RiskMan system is provided to new staff at orientation.

Patient rights and engagement

The Australian Charter of Healthcare Rights is made available in multiple languages to all patients through poster signage, on the television screens in waiting areas, in pamphlets and within the welcome compendium as part of the patient admission package. This includes staff providing a verbal explanation to all patients at the point of care and ensuring that this is signed as attended in the admission notes. The Charter and the multiple dissemination modes throughout the organisation, has been developed in collaboration with consumers and the effectiveness of the Charter's implementation is done through the Measuring Patient Care Program.

There was demonstrated evidence that patients and their carers partner in the planning of their treatment. This is achieved mainly through the use of care and treatment plans and the discussions the patients and carers have with staff when completing these plans. All staff are made aware at orientation of their responsibilities in regard to this partnership.

A number of surveyors identified that written and informed consent is obtained at the point of care, including recording the use of an interpreter and that this is monitored through regular audits. Advance Care Planning is actively addressed and utilises the Respecting Patient Choices Program. The Health Care Consumers' Association (HCCA) has taken on the role of raising awareness and increasing the participation of advanced care plans, with specific information available on the internet and intranet.

The Clinical Record Information System (CRIS) within ACT Health provides clinicians with 24hr electronic access to the patient's clinical record at the point of care. The clinical records are scanned into the CRIS system and a number of security measures are in place to ensure that the clinical record remains private and secure. Records identified that staff undertake a 100-point identity check before being placed on the system and given access rights to the ICT network drive access.

ACT Health currently utilises six patient experience trackers, which are rotated through a number of departments, to obtain timely patient feedback on five questions (which can be changed) at the point of care. This information is reported back to the relevant divisions and then grouped into themes for inclusion in Divisional scorecard reports for discussion at monthly meetings. Improvements are then instigated in collaboration with the consumer representatives.

Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.1.1	SM	SM
1.1.2	SM	MM
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	MM
1.5.2	SM	SM
1.6.1	SM	MM
1.6.2	SM	SM

Action 1.1.2 Core

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

Surveyor Comment:

The ACT Health Corporate Governance Statement (2015) clearly outlines the clinical governance systems that ensure services are being continually improved; risks are identified and managed; and safety is provided to consumers, staff and the community. ACT Health Tier 2 Managers are accountable for setting the strategic direction for the service/s. Quality and safety goals and priorities are set out in the following plans: Corporate, Business, Clinical Services and Workforce. Scorecard and RiskMan reports are used to closely monitor: patient care outcomes, management of incidents and near-misses and identified risks. The goal of Tier 2 plans are to “provide a coordinated approach to improving … performance and accountability”.

At ACT Health, clinical governance includes a comprehensive quality and safety framework that provides staff in the different tiers of service delivery an opportunity to participate in quality and safety meetings, activities and receive feedback on the Organisation’s performance and care outcomes.

The comprehensive scorecard reporting system has been in place for some time now and informs all levels of ACT Health of the outcomes of audits, risk assessments and notifications of incidents. It was noted that the progress of the implementation plans is closely monitored and the end–date set out on the action plan is also closely observed.

Surveyor's Recommendation:

No recommendation

Action 1.5.1 Core

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

Surveyor Comment:

The ACT Health Risk Management System is key component of corporate and clinical governance. All staff are expected to report risks and carry out treatment strategies as per the ACT Health policies and protocols. Comprehensive education has been provided to staff to ensure they have the skill required to use RiskMan competently. The staff notification rate has continues to increase in recent years and this is seen as evidence that risk identification and management has become embedded within the workplace culture. Responsibility for the management of risks has also been devolved down to the various workplace tiers and groups, branches, divisions and units. The outcomes of risk management plans are closely monitored by the Tier 2 Managers.

Risk management is closely aligned to the quality and safety system.

ACT Health has an excellent improvement Library that is a tool for providing a link for staff to quality, safety, risk and data related to evaluation of patient care outcomes.

Overall, the risk management system was found to be well embedded across and throughout the organisation. All staff spoken to could describe the system and their responsibility in relation to the management of risks. Risk management and the use of the RiskMan system is provided to new staff at orientation.

Surveyor's Recommendation:

No recommendation

Action 1.6.1 Core

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

Surveyor Comment:

At ACT Health, the quality management system is managed through the Audit and Risk Management Committee. Accountabilities and objectives of the committee are set out in a charter and terms of reference. A policy and guidelines provide the direction for how the system operates across the organisation.

The Audit and Risk Management Committee provides reports to the Executive Director's Council (EDC) on a quarterly basis. A comprehensive auditing and monitoring schedule is being actioned across the organisation. Results are fed back to staff regularly.

The risk register was found to be linked to the quality and safety system and used to inform ongoing staff education, development and Improvement.

All activities set to manage or remove a risk are set out in an action plan. The progress of the plan is very closely monitored to ensure that risks are managed in a timely manner according to their risk rating. There was evidence of a culture of reporting risks and incidents across the organisation and this is enabled by the use of group level risk registers.

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

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

Incident and complaints management

Ratings

Action	Organisation	Surveyor
1.14.1	SM	SM
1.14.2	SM	MM
1.14.3	SM	MM
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	SM
1.16.2	SM	SM

Action 1.14.2 Core

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

Surveyor Comment:

At orientation and other ongoing education, staff at ACT Health are introduced to a range of processes that are in place to help staff recognise and report incidents. A RiskMan Helpdesk is also available to help staff to report incidents. Policies and procedures provide a framework for this information and practices.

Incident management also encompasses: the correct way to manage incidents and near misses; how to classify an incident; open disclosure following a mistake; learning from incidents; and providing feedback to staff and consumers. Staff interviewed during the survey could all explain the incident reporting and management system and processes. Trended data showed evidence of a culture of incident reporting. Minor incident numbers were noted to be increasing while major or more serious incident numbers have remained quite static over the past three years.

ACT Health has an Incident Management Team and incidents can be referred to this team for investigation. Staff receive education on how to investigate an incident and identify ways to improve patient care.

Data on the incidents reported is collated and provided in the feedback to staff. Reports are generated and provided to the Director-General on a quarterly basis. Critical incidents are reported promptly as per the policy requirements.

All the processes described above are soundly embedded within the organisation.

Surveyor's Recommendation:

No recommendation

Action 1.14.3 Core

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

Surveyor Comment:

A variety of approaches is used to ensure that the workforce receive feedback on the analysis of reported incidents. Audits are undertaken as established by the Internal Audit and Risk Management Unit. Qualitative and quantitative performance indicators have been established and are used to measure the performance of each defined area/unit/service.

Feedback is provided in the form of: scorecards; regular reports on compliance and/or audit outcomes; audit summaries; reports that provide trended data; and reports where the outcomes have been converted using a legend to represent the outcome.

The ACT Health Improvement Library provides a one-stop-shop for staff to access to an improvement register, patient care evaluation data and de-identified reports from morbidity and mortality reviews. This is an excellent feedback tool. Further expansion of this Library is planned.

Surveyor's Recommendation:

No recommendation

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

There is an impressive consumer engagement within ACT Health and the extensive partnership with consumer representatives through all levels of ACT Health and through representation on all NSQHS Standard groups. Consumers are actively involved in the selection process of new staff, including being on the interview panels for very senior appointments, including the ACT Director General.

ACT Health has three major consumer representative groups which include the Healthcare Consumers Association (HCCA), Carers ACT and the ACT Mental Health Consumers Network; with HCCA consumers represented on over 100 committees. The HCCA consumers undertake a two-day training program and there is also a toolkit provided for Chairs of committees to ensure that they are able to adequately orient individual consumers to their committees. Consumers come from very diverse groups that include Aboriginal and Torres Strait Islanders (ATSI), Culturally and Linguistically Diverse (CALD) populations, mental health, children and young consumers, to help ensure appropriate and effective health service is delivered to these groups.

The comprehensive engagement of consumers ensures that the patient and community perspective is always represented at all levels of the organisation. Consumers are represented on very senior committees including Ethics, Policy, Local Health Network Council, Executive Council, Health Infrastructure, Clinical Senate, National Standard Groups, the Divisional Safety and Quality Committee and the Executive Directors' Council Safety and Quality Committee. This Executive Director's Q&S committee has a standing agenda item where consumer representatives are able to discuss pertinent issues or bring new initiatives to the attention of the ACT Health Executive. HCCA also has a quarterly liaison meeting with the Director General, Deputy Director Generals and the Patient Experience Leader (PEL).

The PEL has implemented a number of innovations including televisions in waiting areas to provide consumers with information about their rights, services offered and how to escalate their concerns (complaints). The introduction of Patient Experience Trackers is another innovation which allows consumers to feedback anonymously on how well the service meets their needs and to provide feedback on newly proposed initiatives, which is then used to improve service delivery. There is also a consumer feedback portal on the ACT Health Website. A new Canberra Hospital Inpatient Guide was developed in collaboration with HCCA and is now available online and in hard copy for distribution to inpatients.

Consumers are actively involved in reviewing all information provided to patients, including pamphlets. The Handouts Policy ensures that all information which will be provided to consumers undergoes a rigorous process which includes seeking feedback from consumers as to the value of the information and whether the information is well displayed and easy to read. The newly established Consumer Handout Committee, with consumer and carer representatives, oversees the endorsement process for consumer handouts.

Consumer partnership in designing care

Consumers are actively engaged and encouraged to provide input into the design and function of health infrastructure projects and models of care through their participation on committees and working groups. The accreditation surveyors who visited the new Centenary Hospital for Women and Children saw first-hand how the design and function of this facility was influenced by the consumer representatives. A more specific example was the suggested consumer changes made to NICU with the introduction of discrete two-cot pods that incorporated a patient zone for families (lockable cupboard, sleeping bay and personal information board), as well as consumer involvement in the Award winning NICU CAM project.

The Mental Health, Drug and Alcohol and Justice Health services also actively encourage Mental Health consumers to provide input into the design and redesign of these health services. Consumers contributed to the design of the new community health centres and the new cancer service. Consumers were also involved in the implementation and evaluation of the new visiting hours that were standardised and implemented throughout the hospital.

There have been a number of initiatives and policies developed to ensure that all staff are provided with appropriate training on consumer-centred care and partnering with consumers. The patient experience is included as part of the staff's mandatory orientation. A Patient Experience Educator trains staff in how to write for consumers and how to involve consumers in quality improvement activities.

All the accreditation surveyors were very impressed with the two plays that were conducted and made available for both staff and patients. The plays told a story from the patient's perspective and it was very powerful in conveying the message of the patient's experience within the health system. Another powerful medium for conveying the patient's experience is the Patient Story initiative, which occurs at the beginning of each Safety and Quality Committee. A recent audit identified that consumer input into Education programs has risen from 9% to 47%. There is strong support for indigenous consumers with a small dedicated team with its own quality improvement plan which picks up many of the standard two elements. The dedicated Wamburrang lounge area is reserved for indigenous families.

Consumer partnership in service measurement and evaluation

Pertinent information on the organisations safety and quality performance is provided to the community, patients and carers through a number of portals including the MyHospitals Website, the ACT Health Annual Report and the quarterly performance reports. There are also many notice boards throughout the organisation which display `information dashboards' on hand washing compliance and Patient Experience Tracker results and what improvements had been implemented.

A recent innovation which provides pertinent information to the community is the introduction of ED Live and the upgrading of the ACT Health Surgeon's Waiting List. ED Live provides consumers with live data showing the wait times at both Canberra and Calvary Hospitals' Emergency Departments. This allows patients to make well informed decisions about where to seek care in the event of needing urgent treatment. The surgeon waiting times and theatre sessions are also available for patients wanting elective surgical procedures, so that they can make informed decisions on who they would prefer to see based on performance and waiting times.

The organisation has consumer representatives on Clinical Review Committees, Clinical Audit Committees, Safety and Quality Committees, Medical and Dental Appointments Advisory Committee (MDAAC) and also on all the National Standard Group committees.

The Standard 2 – "Partnering with Consumers" committee, which has consumer and carer representatives, routinely reviews and analyses patient feedback data. This includes online feedback from the Patient Experience Trackers, Website and social media platforms, as well as surveys.

In summary, ACT Health has an admirable and sophisticated approach to providing service within the requirements of National Standard 2. All actions have been met and five have been re-rated to Met with Merit.

Consumer partnership in service planning

Ratings

Action	Organisation	Surveyor
2.1.1	SM	MM
2.1.2	SM	MM
2.2.1	SM	MM
2.2.2	SM	MM
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:** MM

Surveyor Comment:

The survey team has increased this rating to MM because consumers and carers are represented at the highest level of ACT Health governance through participation in the most senior decision making committees such as the Local Health Network Council, Executive Council, the Clinical Senate, the Health Infrastructure Program Strategic Committee and the Executive Directors' Council Safety and Quality Committee. This high level of governance representation by consumers is so well embedded within the normal day-to-day governance of ACT Health, that serious quality and safety matters are discussed with consumers and their input is acted upon and regularly evaluated.

Surveyor's Recommendation:

No recommendation

Action 2.1.2 Developmental

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

Surveyor Comment:

ACT Health has excelled in establishing governance partnerships with consumers from a diverse range of backgrounds by partnering with three major consumer representative groups which include the HCCA, Carers ACT and the ACT Mental Health Consumers Network. These three consumer groups provide trained consumers and carers from very diverse groups that include ATSI, CALD populations, mental health, children and young consumers onto over 100 committees to help ensure appropriate and effective health service is delivered to these groups. A review of ACT demographic data is regularly reviewed to ensure that new and emerging patient groups are also recruited as consumer representatives to ensure that their overall consumer representation is sustainable and reflective of the population they serve.

Surveyor's Recommendation:

No recommendation

Action 2.2.1 Developmental

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

Surveyor Comment:

Consumer engagement within ACT Health is extensive, well-established and is demonstrated through comprehensive partnership with consumer representatives through all levels of ACT Health. This includes engagement through representation on all the National Standard groups as well as consumers being actively involved in the selection process of new staff, including being on the interview panels for very senior appointments, including the ACT Director-General.

Surveyor's Recommendation:

No recommendation

Action 2.2.2 Developmental

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

Surveyor Comment:

The survey team increased this rating to MM due to the well communicated engagement culture of consumer and carers being actively involved in the decision making process of safety and quality at the highest level of ACT Health. ACT Health has consumer representatives on Clinical Review Committees, Clinical Audit Committees, Safety and Quality Committees, Medical and Dental Appointments Advisory Committee (MADAAC) and also on all the national standard group committees. The high level of consumer representation and engagement is well embedded with the day-to-day operations of ACT Health.

A key initiative of ensuring that consumers are actively involved in quality improvement activities is the establishment of the Patient Experience Leader (PEL). This role definitely enhances the engagement of consumers in the strategic and operational planning of the organisation, which is demonstrated by the PEL role implementing initiatives such as televisions in the foyer and public areas of the hospital which provide consumers with information about services provided and initiatives that the organisation is undertaking. The introduction of Patient Experience Trackers (PET) and hand washing dashboards on notice boards, allow consumers to see regular monitoring of hand washing performance and to also provide feedback anonymously through the PET on how well the Service has met their needs. This information is used by Divisions to drive quality improvement activities to improve service delivery.

Surveyor's Recommendation:

No recommendation

Consumer partnership in designing care

Ratings

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

Action 2.5.1 Developmental

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

Surveyor Comment:

The survey team increased the rating to MM based on the clearly demonstrable positive contributions that the consumers and carers have made in the design and redesign of health services through many examples of health service refurbishments and new building works. The ACT Health Infrastructure and Planning Group ensure that their key groups have at least one consumer representative on them and prior to designing any facility, consumers are always invited into focus groups and other avenues to provide input into how the facility should look and feel.

The accreditation surveyors who visited the new Centenary Hospital for Women and Children saw first-hand how the design and function of this facility was influenced by the consumer representatives; with a more specific example being the suggested consumer changes made to NICU floor plans and also the introduction of discrete two-cot pods that incorporated a patient zone for families with a lockable cupboard, sleeping bay and personal information board. All of these improvements have been evaluated against the patients experience and have proven to be very effective. The consumer's involvement was also well evidenced within the design of the two new Community Health Services and Cancer Services buildings; as well as encouraging mental health consumers to provide input into the design and function of Mental Health, Drug and Alcohol and Justice Health services.

Surveyor's Recommendation:

No recommendation

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

The infection prevention and control system is managed well across ACT Health with overarching governance through a formal, multidisciplinary committee: the National Standards Group for Preventing and Controlling Healthcare Associated Infections (HAI), including executive sponsorship and consumer representation. A risk management approach is employed when addressing infection prevention and control matters and a comprehensive surveillance system is in place with regular reporting to executives and clinicians. A range of quality improvement initiatives has been implemented over the recent years, many aimed at addressing increasing challenges faced by the organisation including more patients with multi-resistant organisms (MROs).

Infection prevention and control strategies

The hand-hygiene program is standardised across the organisation with good rates of compliance. Hand-hygiene stations are distributed across all sites with good usage rates by staff and visitors.

Staff health includes immunisation screening at employment and periodic follow-ups, as well as seasonal influenza and every effort is made to increase uptake rates. Occupational exposure is well managed including incident trends analysis and optimal support for injured staff.

A comprehensive mapping of invasive devices was undertaken, and training and competency assessment is provided to relevant staff. There is notable improvement in the rates of compliance with the correct use and management of invasive devices, as well as aseptic technique. Action 3.10.1 has been assessed as fully met.

Managing patients with infections or colonisations

Proactive management of patients with infections and colonisation is in place, including screening policies and precautions. While many clinical areas have access to isolation rooms, there is a shortage in the Emergency Department. This is being addressed as part of the upcoming expansion works. Compliance with standard and transmission based precautions is routinely monitored by infection control staff. Audit reports indicate that there are still opportunities to demonstrate further compliance with standard precautions.

Antimicrobial stewardship

An antimicrobial stewardship (AMS) program is in place with commitment from a multidisciplinary AMS team, including microbiology and clinical pharmacy representation. Usage and resistance is monitored and a comprehensive action plan is being implemented. Additional resources announced during the survey and plans for a potential transition to an electronic system should facilitate further improvement, although additional strategies may also be required to maximise the necessary buy-in from all relevant clinicians.

Cleaning, disinfection and sterilisation

Environmental cleaning is undertaken by an external provider (ISS) and service delivery is aligned with infection control requirements and contractual arrangement, including risk rated cleaning regimes and regular compliance audits, including annually by a third party. The on-site Business and Infrastructure (BI) team undertakes regular planned and risk rated reactive property maintenance, with support from relevant external contractors.

There is good collaboration between the BI and infection control team, with regular consultation and reporting of infection control related results (e.g. Legionella, etc). Food is provided through an on-site cook/chill service and an efficient reheating and automated delivery system. Staff is trained in food safety and there are regular, internal and external food safety reviews. Facilities for handling and segregation of waste and linen are available, although many of the back of house areas appeared tight and dated. A review of the current protocols and practices for decanting, cleaning and restocking of patient linen trolleys is encouraged to minimise potential risk of cross-infection.

Cleaning and sterilisation of re-usable surgical devices is undertaken through an on-site pre-rinse sterilisation service (PRSS) located within the operating theatre at Canberra Hospital and an off-site facility (ACT Health sterilising service at Mitchell), which also provides services to other external clients (e.g. Calvary Hospital, etc). The ACT Health Sterilising service has been recently re-certified to ISO 9001 and most staff have or are working towards formal qualifications in sterilisation (e.g. Certificate III). An electronic instrument tracking system (T Doc) is in use. Flexible endoscopes and ultrasonic probes are reprocessed in the respective departments at the Canberra Hospital and dental facilities have cleaning and sterilising equipment at the relevant sites, including the mobile van. There is high prevalence for disposable, single use accessories.

Sterilisers are regularly maintained and validated annually across the organisation, although those located at Mitchell and one at Canberra Hospital PRSS were quite old. Both automatic (tunnel) washers at Mitchell were not operational during the survey; however, a business continuity plan including various workaround arrangements was in place. ACT Health confirmed (COR15/5535) that consistent with their risk assessment the interim workaround measures implemented while repairs or replacement to the tunnel washers were completed “did not compromise the integrity of the sterilising process”. A further risk assessment from an external party was also being sought by ACT Health to further validate their initial assessment.

Communicating with patients and carers

A range of brochures on infection prevention and control is available and provided to patients on admission and discharge. A video on how to perform hand hygiene also runs regularly on the television in the main waiting area. The infection control team visits all patients requiring transmission-based precautions and discusses the rationale and associated requirements. Hand hygiene dashboard diagrams are displayed in public corridors, as well as on the MyHospital website.

ACT Health is working towards full implementation of developmental action 3.19.2. A potential mail out is anticipated over the coming months and the Patient Experience Tracker (PET) may also help substantiate if the information provided to patients in relation to infection prevention and control has met their needs. Patient feedback on this as obtained during the survey was most complimentary.

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

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

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	NM

Action 3.19.2 Developmental

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

Surveyor Comment:

Consistent with the HAI action plan (April 2015) a questionnaire mail out to over 100 patients is planned for July 2015. It is understood that a range of other complementary strategies is being considered to further assist with the evaluation of the information provided to patients on infection prevention and control. Feedback from patients as ascertained during the survey was complimentary as regards the amount and type of information provided in regards to various infection control aspects related to them.

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

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

Risk Level: Low

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

The Medication Safety Standards Group (MSSG) and the Drug and Therapeutics Committee are the peak medication safety committees within ACT Health and there are numerous sub-committees each with a specific medication safety focus. It is apparent that there is a comprehensive approach to medication safety and audits are undertaken daily on each ward using the Audit Angel tool. These are analysed and the aggregated audit reports are reviewed at each MSSG meeting; remedial action is implemented if medication safety risks are identified. It is suggested that when the MSSG provides written information updates for staff about medication safety issues they document the date of publication and who prepared and authorised it so staff are aware that it has been endorsed and is current.

Documentation of patient information

A review of patients' medical records at ACT Health revealed that there is overall compliance with documenting a best possible medication history and a medication management plan for each patient. Medication reconciliation is undertaken on each patient's admission and discharge. Adverse drug reactions (ADRs) are documented in the patient's medical record and recorded in the patient administration system, ACTPAS, so that the ADR is readily identified by all staff. All ADRs are reported to the Drug and Therapeutics Committee (DTC) and reviewed by the Adverse Drug Reactions sub-committee. Where relevant, the DTC reports ADRs to the Therapeutic Goods Administration. The eLearning tool for medication incident reporting is only a recommended rather than a mandatory educational tool and it is suggested that as a quality improvement activity there be a greater promotion of this eLearning tool to encourage medication incident reporting.

Medication management processes

There is a comprehensive library of decision support tools available to clinicians within ACT Health and these are reviewed regularly and available on their mobile devices. Medication security is managed effectively with either swipe or key pad access to medication rooms. Ongoing concerns by the MSSG with compliance in monitoring temperatures in ward and departmental medication fridges are being addressed by implementing a central monitoring system. It is also planned to implement an electronic medication management system within the next few months.

Continuity of medication management

Clinicians receive information about each patient's medications during handover of care throughout their current episode of care and a list of current medications is documented in the discharge summary. There is also almost total compliance with completing the discharge summary within 48 hours of a patient's discharge and this is provided electronically to their General Practitioner. Patients are also provided with education about their discharge medications.

Communicating with patients and carers

ACT Health is working towards full implementation of these developmental actions in this criterion. There is evidence of participation by patients and carers in the development of their medication management plans in wards and departments, good examples of this are in the Cancer Centre, Neonatal and Paediatric wards.

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

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

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	NM

Action 4.15.2 Developmental

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

Surveyor Comment:

There needs to be further work towards seeking patients'/carers' feedback about the tools/publications, and any other resources used to provide medication information, to ensure that its format, language and style meet their needs. Any publications and patient/carer educational resources need to be approved by the Consumer Experience Team.

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

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

Risk Level: Low

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

The Standard 5 committee providing oversight of this standard includes strong consumer representation. Associated policy is consistent with the national standards. Only white and red wrist bands are used - the later specifically for medication allergies. Confirmation of patient identification is a component of the daily standards auditing program. White wrist bands are used in the mental health inpatient unit. Photo identification is used in the Brian Hennessy House mental health rehabilitation and the corrections services. Iris scanning is used within Drug and Alcohol service for patients receiving methadone or buprenorphine. During survey examples of changes and improvements in process were identified. The Division of Medicine medical record documentation audit results showed 100% compliance with requirements for patient identification.

Processes to transfer care

During survey several clinical hand overs were attended by different surveyors. It was clear the principles of effective clinical handover have been internalised across the workforce. There was a strong emphasis on multidisciplinary team meetings. The ECHO (Effective Communications in Clinical Handover) providing relevant education, daily practice monitoring in all clinical areas and the annual ACT Health GP Liaison Unit audit of discharge summaries are just three of many activities designed to enhance the quality of transfer for care processes. For the year 2013/2014 of the 50 records audited, discharge summaries were provided to GPs 96% of the time within 48 hours. Across the hospital there are several variations of bedside communication boards which provide the opportunity for patients/carers to document trigger notes or messages for staff. Detailed posters were noted providing information for parents of neonates who may be requiring transfer to another facility.

Processes to match patients and their care

Assertive action has been taken to improve compliance with the Surgical Safety Checklist briefings and the Time Out Procedures. The outcome has been enhanced compliance by most surgeons. There do however remain a small number who have yet to embrace the concept of Time Out and there are organisational strategies to address this. Processes in the Imaging Department to ensure correct patient identification were comprehensive and impressive. Women's and children's services have very specific processes and triggers to ensure safe management of milk.

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

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

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

There is a Standard 6 Committee providing oversight of this standard. The committee is well represented from the various divisions of the service together with a consumer member. ISBAR is the nominated handover tool for the inpatient areas. In community settings ISOAP (Introduction, Subjective information, Objective Information, Analysis/Action /Advice/Plan) is used. There is a clinical handover procedure and various specific documents outlining expectations of handover practice for specific areas and for engaging with parents and carers where appropriate. To date, through the ECHO program (Effective Communication in Clinical Handover) train the trainer programs have been provided for 130+ nursing and an allied health staff member. An eLearning package is available for junior medical staff and the concept of clinical handover is reinforced at the medical school level.

Clinical handover processes

The surveyors witnessed a variety of handover scenarios during the week. These included several nurse/nurse shift handovers, divisional medical staff day/evening hand overs and a morning night/day medical staff meeting. The nursing handovers included a component of interaction with patients and parents, and carers with the opportunity for parents/carers to provide input and ask questions. Many handover scenarios are multidisciplinary with some areas reporting some staff changing roster starting times to facilitate participation. The General Practice Liaison Unit conducts an annual review of discharge communication provided to GPs. Outcomes demonstrate sustained improvement and high rates of discharge letters being received within 48 hours.

The Surgical Safety Checklist is used in the operating theatres with work progressing on increasing surgeon active participation. In the context of evaluating current practice the organisation is planning on introducing an electronic format which will enhance the quality of the checklist procedure. Team time out and patient identification procedures observed during this review by one surveyor (with a strong theatre background) were described as "near perfect - the best I've ever seen". Imaging services staff were also able to describe strategies and improvements to ensure that clinical handover practices were sound and that safety checks were in place prior to procedure commencing.

The medical officers' electronic notice board is being progressively introduced throughout the organisation. This tool is designed to enhance communication across professional groups and enable more efficient use of staff time, tracking and timing of tasks and most importantly allowing prioritising and monitoring of tasks.

Patient and carer involvement in clinical handover

During this survey several surveyors attended clinical handovers during shift changes during which they observed patients and carers being actively involved in and contributing to the handovers. In the Imaging Department, patients are asked to reconfirm their consent for the procedure and provide their own explanation of what is going to happen. This is an excellent way of confirming the effectiveness of the information provided to the patient at the time original consent was received. It was noted that perhaps twice a month, after the Imaging Department handover checks, procedures are cancelled or postponed pending patient receiving further clinical advice. The CARE project empowers family members to escalate requests for care intervention. Video explanations of steps to initiate CARE were noted in public waiting areas of the hospital.

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

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

ACT Health has evidence-based policies and guidelines for the management of blood and blood transfusions. These cover the pre-transfusion management to minimise the need for transfusion, the collection of blood from the patient for testing, the prescription and administration of the blood products. These have been recently revised. The organisation collaborates with the National Blood Authority to lead improvement in blood management. This has been the introduction of a subcutaneous IgG infusion as an alternative to Intravenous delivery. The policy on the use of IgG has been revised to include this practice. The use of the policies is monitored through the audit program of ACT Health.

The risks associated with the use of blood and related products are monitored and added to the risk register as required. The risk of the incorrect blood in the test tube has been escalated to the organisational level risk register. Incidents and adverse events are reported into the incident reporting system and these reports are regularly reviewed by the organisation. Serious incidents are investigated with recommendations made to reduce the risk of recurrence. ACT Health participates in the haemovigilance activities of Blood Matters Victoria providing the organisation's data and benchmarking this against other hospitals in that state. The organisation has undertaken a number of quality improvement projects to improve the management and safety of the use of blood in the hospital. The collection of specimens for blood typing has been shown to be a significant risk with examples of the wrong patient's blood in the specimen tube being identified. A staff reflection tool and counselling process has been initiated with some evidence of improvement sighted by the survey team.

Documenting patient information

The best possible blood history is available in the medical record system. The pathology records of previous blood product usage and blood group information is available to clinicians on the Clinical Information System that is available on all computers in ACT Health. In addition the blood prescription form requires the medical officer to enter the history as part of the documentation required before the blood product is released. The completeness of the records is reviewed as part of the regular Managing Patient Care audit that provides feedback fortnightly. The blood product prescription form has been modified to assist the medical practitioners in the provision of the required information. This is a recent innovation and has yet to be evaluated for its effectiveness. The adverse events are recorded on the prescription form as well as being reported in the risk reporting system. Actions have been taken to reduce the risk of such adverse events. The adverse events are reported in the governance system internally and to Blood Matters Victoria.

Managing blood and blood product safety

The Blood and Blood Products Working Group of ACT Health demonstrated that there was regular monitoring of the risks associated with the management and wastage of blood and blood products. Actions have been taken to reduce the risks to patients and the wastage of blood and associated products. The documentation of the ordering of blood products has been audited to review the adequacy of the documentation. Improvements to this form have led to increased provision of information by the medical staff completing the form. Another significant action has been the removal of the blood storage refrigerator from the theatre suite. The use of temperature sensitive label attached to the blood products demonstrated that a significant number of units had been removed from the refrigerator and subsequently replaced into that storage. Following facilitation of timely transport of blood products, by improving the courier service, the surgeons and anaesthetists agreed to the removal of the refrigerator thus removing this as source of a break in the cold storage chain.

There has also been an improvement in the management of blood at the Calvary Hospital with units nearing expiry being returned to the Canberra Hospital that has greater usage of blood products. It is recognised that as ACT Health is a regional centre there will be a greater need to maintain significant stores of blood and blood products in case of urgent need which will lead to a greater wastage than might occur in a metropolitan setting.

Communicating with patients and carers

ACT Health has available a patient information brochure to inform patients and carers about blood transfusions. This document has been reviewed recently with input from consumers. Further improvement in the document is being considered. The consent documentation indicates demonstrates that the patient has been part of the preparation of the plan of care. Audit has shown the compliance with this documentation has improved over the period since the previous survey. A recent audit demonstrated over 90% compliance with the obtaining of consent for the transfusion of blood products. Where there is a clinical need for frequent blood transfusion the policy allows for consent to be valid for an agreed period of time to prevent the need for repeated consent documentation.

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

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

The survey team was impressed with ACT Health's interdisciplinary commitment to preventing and managing pressure injuries. There is a Preventing Pressure Injuries Framework based on the National Standards which is consistent with evidence-based practice and outlines the responsibilities for policies and procedures, wound management and pressure injury prevention and management with expected outcomes. The Pressure Injury Prevention Committee has representation from all divisions and disciplines across the organisation and reports to the National Standards Steering Committee and reports are also tabled at the Quality and Safety Committee. The policies, procedures and guideline documents have been recently reviewed and updated and are comprehensive and referenced to best practice.

A number of audits have been implemented to evaluate prevention and management practices and includes an annual Pressure Injury Prevalence (PIP) survey that has demonstrated not only a trend in reduction of the number of pressure injuries over the last five years but also a decrease in Stage 3 and above. Pressure injuries are reported as incidents on RiskMan, with stages specified. Incidents are trended and analysed at local, organisational and executive levels. Data on frequency and severity is collected from RiskMan and monitored by the Pressure Injury Prevention Committee. Staff across the organisation have a good understanding of the reporting process and quality boards in the ward areas display graphic incident data for staff and patients/carers to view.

Validated assessment tools are used across the organisation to assess individual risk and implement appropriate management plans. Supporting information on staging and choice of pressure relieving equipment is available to staff and the use of pressure relieving equipment was in evidence during the survey. The Tissue Viability Unit (TVU) and Nurse Practitioner (Community) have expertise in grading pressure injuries, review all pressure injuries and provides advice on care. The staff reported that pressure injury care is successful due to early intervention, education to staff, patients and families and especially that prevention is everyone's responsibility. The interdisciplinary approach is exemplary with a seamless transition from hospital to home and access to community resources.

Preventing pressure injuries

Prevention of pressure injury is the philosophy of care and this was evident in the wards visited by the survey team. The agreed tools used across the organisation are the Waterlow for adults with a modified version in Emergency Department, Braden Q for paediatrics and there is now a validated tool for the newborn. It was pleasing to note that risk screening occurs in the Emergency Department, ICU and paediatrics and neonates. Strategies to increase the number of patients risk assessed and improve prevention and management are ongoing and the survey team saw evidence of improvement in compliance with completed assessments and implementation of action plans. All patients with a pressure injury recorded on RiskMan are reviewed by the TVU or Nurse Practitioner for a wound assessment and advice on appropriate care.

Development of pressure injuries at Stage 3 and above is regarded as an organisational risk. Regular reports to the Executive team ensure that the risk is monitored and managed appropriately. The introduction of the Patient Care and Accountability Plan with the pressure injury risk assessment section has improved compliance with completion of the initial assessment. Collated data from the most recent audits identified a significant improvement with up to 90% of patients having had a risk assessment conducted within the required time. The Clinical Nurse Consultants on the wards check one patient record per day for completion. Reassessments are also undertaken according to policy. Audits undertaken regularly demonstrate that the prevalence of pressure injuries is reducing and that most recorded are stages 1 and 2.

A nutrition assessment using the Malnutrition Screening Tool (MST) supports the identification of patients at risk of pressure injuries with an accompanying nutrition action plan for ongoing care. Education has been extensively undertaken across the organisation and staff spoken to by the survey team were aware of their responsibilities to improve risk assessment and management.

Equipment and devices are readily available to assist prevention strategies for patients at risk and the Central Equipment Store is able to provide requested equipment within a short timeframe. There is a rapid response for equipment needs in the community and these are available for patients prior to discharge. The equipment supplied includes pressure relieving mattresses, heel troughs and other devices.

Managing pressure injuries

The TVU provides an impressive service to the hospital for consistent and best practice wound assessment, planning, treatment, monitoring and documentation. The newly developed 2014 International Prevention and Treatment of Pressure Injuries Clinical Practice Guidelines are used as the basis for wound management and the organisation has a clinical procedure based on these guidelines. The TVU and Nurse Practitioner provide a layer of knowledge and capability for the grading of pressure injuries and as they focus on wound management, there is consistent practice across ACT Health. This service is available across all areas of the organisation. Of note are the six monthly rotations for RNs to the TVU for professional development based on a conceptual framework that concentrates on wound management and includes education, a research project and presentation at a conference. On return to their usual area of practice they are available to their peers for discussion about wound care and prevention. Evidence based and cost effective wound and skin care products are used across the hospital and have been standardised within the community setting.

There is a wound assessment and management for patients with a documented pressure injury and this is reviewed by staff daily and evidence for compliance of this is very good. There are clinical reviews for documented prevention and management measures in place and some of the actions reviewed include (but are not limited to) daily assessment, pain score, use of pressure relieving devices and referrals to appropriate disciplines such as the TVU, Nurse Practitioner, occupational therapy and physiotherapy.

The survey team has elevated Action 8.8.4 from an SM to an MM based on the actions taken to increase compliance with action plans and resultant outcomes.

Communicating with patients and carers

The consumer representative on the pressure injuries committee reported that consumers are now expecting more information, asking more questions on their care and to be more involved in care. This may occur through the information brochure and patient booklet that are available for patients and carers. Consumers are involved in the introduction and review of these brochures and booklets. The Healthcare Consumer Meetings are a forum for distributing information “up and down” the organisation. Staff report that pressure injury management and prevention plans are discussed with patients/carers on admission and if there is a change in condition. Feedback is that the information provided is meaningful and understandable.

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	MM

Action 8.8.4 Core

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

Surveyor Comment:

The survey team has elevated Action 8.8.4 to an MM rating given the evidence sighted on management plans and improvement activities. The TVU reviews all documented pressure injuries and in conjunction with the multidisciplinary team plans the ongoing care of wounds. The introduction of an education program for RNs to undertake a six-month rotation through TVU has enhanced the assessment, care planning, effective management and communication of care of pressure injuries.

Surveyor's Recommendation:

No recommendation

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

In relation to patient deterioration, recognition and response systems are well-developed with a formal Rapid Response committee and individual structured feedback to clinicians. Basic life support training has been provided to all staff identified by a risk assessment process supported by a policy officer. ICT systems support educational competency recording and expiry alerts. Clinical record documentation concerning deterioration occurs systematically.

There was a strong policy matrix supporting the reporting of deterioration and documentation of observations. Escalation pathways for care escalation were clear across a variety of settings, including extended care and community settings. The MEWS scoring system was well understood by clinical staff. This included specialist settings such as paediatric, mental health and obstetrics. A rigorous process for auditing MET calls in acute inpatient care is commended. There is also a system for family augmentation of an escalation of patient concerns. This includes formal and informal feedback to consultants and treating teams concerning deteriorating patients, advance care planning (not for resuscitation orders) and patient outcomes. Deaths are consistently reviewed including “missed” opportunities for Medical Emergency Team response calls. Data and synthesised feedback are available to both the treating team and other quality and safety committees within the hospital, including orientation and continuing education processes. Orientation programs for junior medical officers have been strengthened on the basis of past ‘missed’ MET calls (i.e. ‘failure to escalate’ cases).

Recognising clinical deterioration and escalating care

A standard track and trigger inpatient chart of observations is used, according to organisational policy. Charts are appropriate to clinical areas, including paediatrics and obstetrics and spinal injury. In certain areas, such as the mental health extended care unit, there is policy endorsement for a decreased frequency of physical observations (the model of care involves >8-12 months inpatient stay). The standard chart documents respiratory rate, temperature, blood pressure, heart rate and oxygen saturation (the latter as necessary) along with measures of consciousness. Thresholds are clearly depicted in colour shades unlikely to be missed even by individuals with red green colour blindness. The algorithm for calculating the Medical Early Warning Score is clearly delineated and provides for adjustment for pre morbid BP. The observation chart contains general advice to seek medical review. The thoroughness of regular and complete observations is regularly audited by the quality and safety team who provide feedback to the treating teams. Every MET call triggers a documentation audit of completeness of recorded observations with feedback to the treating nursing team that collected the observations. Also, after a MET call, dedicated MET nurses review the patient (if not in ICU) every eight hours and chart the response to the initial MET call.

A number of mechanisms are in place to escalate care and call for emergency assistance in the case of physically unwell patients. This includes a dedicated telephone line, a general switchboard number, a mobile phone number for family and friends to alert staff and wall-mounted emergency alarms. In the case of mentally unwell patients, escalation of care in the acute inpatient setting is available through duress alarm, location mapping of staff during incidents and the availability of security staff to attend and assist to provide containment. Failed MET call opportunities (e.g. trigger crossing without escalation) are regularly audited. They appeared to demonstrate a decreasing trend over time. Orientation in continuing clinical staff education emphasises the professional responsibility and clinical necessity of calling for MET assistance as soon as triggers are crossed.

Responding to clinical deterioration

Organisation-wide policies for triggering an emergency assistance call were evident (e.g. in the track and trigger MEWS observation chart). Each Medical Emergency Team call is audited by a dedicated nursing workforce, including a documentation audit, reported to rapid response committee and fed back to the clinical units.

Basic life support is not pervasively present in the clinical workforce. Instead, basic life support training is provided according to a homogeneous risk rating. There was no evidence of adverse patient outcomes through usage of that methodology.

With respect to physically unwell patients, there was evidence of 24 hour access to clinicians with advanced life support skills, albeit immediate assistance from appropriately credentialed specialist trainees. With respect to mentally unwell patients in the acute TCH facility, there was evidence of ability to access the above service through the MET team located in the main hospital building.

Communicating with patients and carers

There was evidence of information provided to patients, families and carers concerning the availability of self-initiated requests for escalation of apprehended deterioration. Interpreting services, as required, were provided to convey that information, as well as some multilingual publications. Patients, carers and families were involved in care planning to the extent possible, including bedside rounds in a number of settings (but not all). Information concerning deterioration was also provided with respect to discharge planning and post discharge deterioration. An advance care directives coordinating committee involves consumer collaboration with two consumers on the committee. There was adequate documentation in clinical records of treatment limiting orders. There was evidence of a dedicated, publicly advertised help line for escalating care and alerting clinical staff of deterioration. The nature and urgency of the calls is regularly reviewed. Staff were able to recount a life-saving episode from utilisation of that mode. A formal evaluation is planned to commence shortly.

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

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:

At the time of survey there was strong evidence of training in basic life support for most clinicians (nursing, allied health and medical). There were however some senior medical staff for whom a local decision had been made that training would not be necessary - based on a risk assessment associated with those clinicians' practice. Accordingly this action has been rated at the Transitional level, consistent with the Commission's Advisory No AS13/08.

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

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

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

There is evidence of good governance structures and executive accountability to support ACT Health in implementing systems to prevent falls and minimise the harm from falls. There is a multidisciplinary Falls Prevention Committee that is responsible for falls management and has executive sponsorship and terms of reference. Audits and action plans are reviewed at each meeting with discussion on outcomes. This committee reports to the National Standards Steering Committee and reports are also tabled at the Quality and Safety Committee. There is a framework for Preventing Falls and Harm from Falls.

Falls policies and procedures are available electronically on SharePoint for all clinical and non-clinical staff to access and specific falls prevention procedures have been developed. The procedure has been reviewed and is based on the national standards. Compliance with policy and procedure is monitored through practice and file audits to reflect this, e.g. completion of falls screening.

There was a clear protocol for reporting falls through the electronic incident system, RiskMan, and these were identified by severity, outcome and near misses were also reported. Trended incident reports were fed back to all wards and evidence of minutes demonstrated regular reporting to senior executive via the Tier 1 Safety and Quality Committee.

Falls resulting in injury or death are entered onto RiskMan and an in-depth analysis is undertaken with action plans and controls in place to mitigate these risks in the future. This includes a medical review of all patients who fall, the use of bedside audits and regular communication from all disciplines involved in care including medical, nursing and allied health. Multidisciplinary consultation occurs on all falls with education to staff and education to patients and carers on how to prevent falls. Review of falls data drives the improvement activities and includes the use of equipment. The availability of equipment such as lifters, appropriate chairs, hilo beds and mobility aids is excellent and available through the Central Equipment Store that is able to provide requested equipment within a short timeframe. There is a loan service for equipment use post discharge and for the community.

Screening and assessing risks of falls and harm from falling

ACT Health has implemented the Patient Care and Accountability Plan that is multidisciplinary and a standardised assessment tool that includes a falls risk assessment. The falls assessment tool is based on a validated tool from Victoria and an assessment is completed on admission, after a fall, if there is a change in condition. Feedback on the tool was positive as it includes cognitive screening and patient and environmental factors and has raised the profile on screening and intervention. If no fall risk factors are identified then the documented standard minimum strategies are implemented for all patients. These include patient orientation to surroundings, use of a call bell, mobility aids in reach and use of appropriate footwear and clothing.

For non-admitted patients that attend the emergency department a risk screen is completed. The assessment tool screens for "at-risk" patients and triggers the clinician to complete a full falls risk management tool on patients identified at-risk. The falls risk management tool incorporates a full assessment and if any criterion identifies a risk then the risk factor and intervention process is implemented with explanation to the patient/carer and signed by the staff.

The survey team was presented with a suite of audit results that provided confidence that the “at-risk” patient was being prioritised across all sites. Overall, the results demonstrate greater than 90% compliance for assessments and for bedside interventions when required.

The mental health, justice and alcohol service is also demonstrating high levels of compliance with screening for falls risks and a there is a focus on minimising falls across all service delivery settings.

Preventing falls and harm from falling

The attention to falls prevention is a common thread throughout all ACT Health with more awareness on how staff think about falls, standardised assessment and management of falls, simplified strategies to reduce falls and the interdisciplinary cooperation through all wards and areas. Multi-factorial falls prevention and harm minimisation plans are documented within the patient clinical records, utilising the falls risk management tool. These were observed to be in place for a selection of patients identified with a history of falls at the time of survey. Audits on the risk factors and intervention component of the Patient Care and Accountability Plan demonstrated good compliance. An action plan is developed for a patient regarding falls prevention and is also a component of the clinical handover with discharge planning and transfer tools in place. Referral to appropriate allied health and other disciplines occurs while in hospital with timely actions for review of home environment and referral to community services that may be required post discharge.

The patient journey white boards have an excellent emphasis on falls. Information on falls risk is part of the referral to a community health service, general practitioner, allied health practitioner or family or carer and there is post-discharge follow up if needed. The number of reported patient falls has increased however there has been a decrease in the number of falls resulting in a fracture or serious injury. The ACT Health falls guideline includes post falls management and audits on this have shown there is room for improvement and further education has demonstrated this is occurring.

An exceptional action taken to reduce and minimise harm from falls are the falls minimisation rooms in wards. These are usually four bed rooms where patients identified as having a very high risk of falling are cared for under constant supervision. As well as the usual strategies to decrease harm such as hilo beds, bells in reach, walking aids and medication reviews there is a staff member(i.e.AIN) in the room at all times and this is supported by the introduction of Team Nursing. Given the high turnover of patients in some areas and wards that care for patients with very high falls risk the staff across the organisation were positive and believe there is more learning and awareness about falls that is shared across all divisions and has resulted in a change across ACT Health.

Communicating with patients and carers

The survey team viewed brochures on falls prevention that are available for informing patients and their carers on ways to prevent falls and minimise harm. These brochures are reviewed by consumers for feedback on the format and information it contains so it may be understood by consumers. The consumer on the committee highlighted that falls prevention goes beyond the hospital boundary to the community and the general public get more information. There are better referrals to the community and feedback to GPs has improved.

Patients and carers are informed of the identified risks from the falls risk assessment and are engaged in the development of a falls management plan in conjunction with staff. There is evidence of patient/carer involvement with their falls prevention interventions. Education and information is given to patients and carers on completion of the falls risk assessment and of any interventions implemented.

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

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	MM
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	MM
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	MM
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	SM	SM

	unexpected deterioration in health status		
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	MM
1.14.3	Feedback on the analysis of reported incidents is provided to the workforce	SM	MM
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	SM	SM

	level of governance in the organisation		
1.16.1	An open disclosure program is in place and is consistent with the national open disclosure standard	SM	SM
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	MM
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	MM
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	MM
2.2.2	Consumers and/or carers are actively involved in decision making about safety and quality	SM	MM
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	MM
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 • surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases • provision of risk assessment guidelines to workforce • exposure-prone procedures	SM	SM
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	SM	SM

	organisation		
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 • waste management within the clinical environment • laundry and linen transportation, cleaning and storage • appropriate use of personal protective equipment	SM	SM
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	SM	SM

	medical devices		

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	NM

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

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	NM

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

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	MM

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	SM	SM

	documented in the patient clinical record		
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

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

Recommendations from Current Survey

Standard: Preventing and Controlling Healthcare Associated Infections
Item: 3.19
Action: 3.19.2 Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience

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

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

Standard: Medication Safety
Item: 4.15
Action: 4.15.2 Action is taken in response to patient feedback to improve medicines information distributed by the health service organisation to patients

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

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

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Item: 9.6
Action: 9.6.1 The clinical workforce is trained and proficient in basic life support

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

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

Recommendations from Previous Survey

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Governance and quality improvement systems
Action: 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

Recommendation: OWS 1112.2.1.2#1 **High Priority:** No

Recommendation:

Develop and produce suites of key performance indicator reports from the incident reporting system RiskMan.

Action:

A suite of safety and quality key performance indicators for the organisation are currently under development. Organisation wide indicators will be complemented by Divisional specific indicators and will measure the quality of service provided to consumers of health services. Data will be sourced from a diverse range of data collections, including but not limited to admitted patient care data, audits, clinical records and RiskMan. Data for Divisional specific indicators will be provided through reports to CHHS Scorecard meetings, and organisation wide reports to ACT Health's Tier 1 Quality and Safety meeting.

Reports to these committees will include analysis of the results by quality and safety officers and the provision of recommendations around potential investigations, with decisions around investigations and actions allocated by the relevant Committee. Staff will also be able to access data through the Performance Information Portal for use in Divisional Safety and Quality meetings to further inform quality improvement activity.

Completion Due By: 31/12/2014

Responsibility: Phil Ghirardello

Organisation Completed: Yes

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

ACT Health has established a comprehensive suite of KPIs that are now used regularly to inform informative scorecards.

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Governance and quality improvement systems
Action: 1.2.2 Action is taken to improve the safety and quality of patient care

Recommendation: OWS 1112.3.2.2#1 **High Priority:** No

Recommendation:

ACT Health continue to implement the action plan to address the remaining recommendations from the Electrical Safety Audit as a matter of urgency.

Action:

The ACT Health Electrical Safety Committee has now been disbanded as all audit actions have been completed, with the exception of one high risk electrical board in the food services area which is due for replacement in 2015. The high risk board in food services is noted on the risk register - Risk No #372

The ongoing management of electrical boards now falls within the Capital Upgrades program as boards are replaced and improved in every upgrade process.

Completion Due By: 30/04/2015

Responsibility: Rosemary Kennedy

Organisation Completed: Yes

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

The Electrical Safety Audit recommendations have all been actioned.

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Governance and quality improvement systems
Action: 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

Recommendation: OWS 1112.3.2.5 **High Priority:** No

Recommendation:

Review analysed data needs to inform the education requirements on aggression and violence management training across the organisation.

Action:

Violence and aggression data is reported quarterly to ACT Health's Security Committee and Tier 1 Work Health and Safety Committee. The reports detail the origin and form of violence and/or aggression, staff position reporting the incident, staff accident and clinical incidence reports for occupational violence by incident and Division, and investigations and controls implemented. If no investigation or controls are provided for the incident, a report is sent to the responsible Executive Director for follow up.

The quarterly report for the 4th quarter of 2014 identified that the majority of incidences occurred in the Division of Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS). A working group has been formed, reporting to the Tier 1 Committee to deal with incidences of violence and aggression. As part of this process MHJHADS has been tasked to review procedures and any necessary training requirements.

Completion Due By: 31/07/2014

Responsibility: Liesl Centenera

Organisation Completed: Yes

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

The risks posed by aggression and violence to staff and consumers have been addressed. Education is provided regularly. Incidents of aggression and violence are monitored, reported and changes made where needed.

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Governance and quality improvement systems
Action: 1.4.4 Competency-based training is provided to the clinical workforce to improve safety and quality

Recommendation: OWS 1112.3.2.5#1 **High Priority:** No

Recommendation:

Review analysed data needs to inform the education requirements on aggression and violence management training across the organisation.

Action:

This is a duplication of the previous recommendation.

Completion Due By:

Responsibility:

Organisation Completed: Yes

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

See previous comment.

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Governance and quality improvement systems
Action: 1.5.1 An organisation-wide risk register is used and regularly monitored

Recommendation: OWS 1112.2.1.2#2 **High Priority:** No

Recommendation:

The Enterprise Risk Register be reviewed as a matter of priority.

Action:

The Enterprise Risk Register has been reviewed since 2012, and continues to be comprehensively reviewed on an annual basis by ACT Health's Executive, most recently through an Executive workshop conducted in September 2014. Extensive consultation was held with Divisional Executives both prior to and after the workshop and the risk register was updated in response to the outcomes of the workshop. As a result of the workshop, three risks were escalated to the Executive Directors Council for consideration, five risks were permanently closed, seven were closed though subject to review within 12 months, and nine were assigned to accountable Executives for appropriate management.

Quarterly status reports are provided to the Audit and Risk Management Committee and the Executive Directors Council.

Completion Due By: 31/07/2014

Responsibility: Sarwan Kumar

Organisation Completed: Yes

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

This recommendation has been addressed satisfactorily with actions taken described in the pre-survey documentation.

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Governance and quality improvement systems
Action: 1.5.2 Actions are taken to minimise risks to patient safety and quality of care

Recommendation: OWS 1112.2.4.1#1 **High Priority:** No

Recommendation:

At Bimberi Youth Justice Centre, young people being released be offered condoms at the discretion of the doctor.

Action:

Mental Health, Justice Health and Alcohol and Drug Services, the primary health service provider for Bimberi, in collaboration with Youth Justice have instituted as process whereby a discharge pack is provided to the young person by Health prior to leaving Bimberi. This commenced in October 2013 and the pack includes condoms.

Completion Due By: 01/10/2013

Responsibility: Katrina Bracher

Organisation Completed: Yes

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

A bag of useful items and information is provided to Bimberi residents upon release. This recommendation is closed.

Recommendation: OWS 1112.3.2.1#1 **High Priority:** No

Recommendation:

ACT Health review the use of space in The Canberra Hospital Emergency Department with a view to removing any unnecessary clutter and identifying alternate storage options with a view to maximising the space available for staff. In particular, the resuscitation room should have clutter removed.

Action:

The use of space in the Emergency Department has been reviewed and equipment stored with a view to maximising space. Where appropriate, items have been removed to an alternate location. Trolleys have been purchased to store equipment more effectively and restocking procedures have been streamlined. The storeroom layout has been changed to maximise space and efficiency when restocking trolleys. Labels are in use to assist in restocking in a consistent manner.

As part of the ACT Government's Health Infrastructure Program, ACT Health is redeveloping and upgrading a number of areas at Canberra Hospital. As part of this program, on 1 December 2014, the ACT Government announced that it will be investing $23 million in the expansion of the Emergency Department at Canberra Hospital. When the expansion and refurbishment is complete, the additional floor area will deliver an extra one thousand square metres and will improve the department's layout, create efficiencies and provide more space for storage of equipment.

Completion Due By: 01/12/2014

Responsibility: Mark Dykgraaf

Organisation Completed: Yes

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

This recommendation has been addressed satisfactorily with actions taken described in the pre-survey documentation. Current arrangements are temporary pending the planned expansion of the Emergency Department.

Recommendation: OWS 1112.3.2.2 **High Priority:** No

Recommendation:

ACT Health review the Clinical Engineering Service with a view to developing a comprehensive internal governance framework that is linked to the ACT Health Directorate governance framework and will support the effective management of:

- Policies and procedures for medical technology, device management and maintenance systems;
- Communication networking with other stakeholders such as IT staff, clinicians and other key staff;
- Future service equipment requirements;
- Workforce recruitment, management and development; and
- Collaborative equipment purchasing and ongoing maintenance.

Action:

The Clinical Engineering Service has been renamed Biomedical Engineering and as part of a governance restructure moved from the Business and Infrastructure Division to a newly created Clinical Support Services Division in August 2013.

The Clinical Support Services Division brought together:

- Biomedical Engineering
- Medical Physics and Radiation Engineering
- Chief Allied Health Office
- Acute support, and
- Nursing Operational Support, including Ward Services.

A governance framework for the management of healthcare technology is being developed in line with Clinical Support Services and organisation wide requirements. The framework covers the management, operation and maintenance of technology from planning through to disposal, including consultation with and allocation of responsibilities to other staffing groups as appropriate.

Completion Due By: 31/07/2014

Responsibility: Adrian Scott

Organisation Completed: Yes

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

A comprehensive new governance framework for the management of healthcare technology has been developed. The final component of the governance framework has been delayed as a consequence of the impact of the new NS3551 requirements of the monitoring of systems rather than individual items and this requires changes to the IT system used by the new Biomedical Engineering Service. This matter is discussed further in the Standard 1 summary. This recommendation is closed.

Recommendation: OWS 1112.3.2.2#3 **High Priority:** No

Recommendation:

ACT Health evaluate the signs used in the facilities to ensure they meet international standards and the diverse needs of the patients, community members and staff.

Action:

In July 2013, a specialist signage design consultant with extensive experience with major hospital projects, Ann Gordon Design (AGD) was
commissioned to undertake a review of existing signage and develop a way-finding strategy for the Canberra Hospital (TCH). The study included a national and international review of existing codes, guidelines and best-practice way finding strategies, a physical review of existing TCH signage and identification of areas of deficiencies, and recommended solutions for a way finding strategy, including an external and internal signage package of works for TCH.

The study was completed by AGD in August 2013. The concept design was approved by the Canberra Hospital and Health Services Steering Committee and ACT Health Redevelopment Committees in December 2013. Design was finalised during 2014 and a development application for the capital works submitted to the ACT Planning and Land Authority and approved. Capital works for external signage commenced in November 2014 and as of March 2015, was nearing completion, and installation of internal signage is to commence shortly.

ACT Health stakeholders, a number of representatives from the Health Care Consumers Association and other stakeholder groups, have been consulted throughout the process. Extensive work was undertaken to incorporate legibility guidelines from Vision Australia to ensure the printing on the signs was a legible to as many users as possible.

Completion Due By: 05/05/2015

Responsibility: Paul Carmody

Organisation Completed: Yes

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

ACT Health has sought specialist advice on best practice signage and the recommendation has been addressed. Consumers and volunteers have played a major role in advising and evaluating the signage throughout the organisation.

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Governance and quality improvement systems
Action: 1.6.1 An organisation-wide quality management system is used and regularly monitored

Recommendation: OWS 1112.2.1.1 **High Priority:** No

Recommendation:

ACT Health complete the review and implementation of the Safety and Quality Framework by March 2013.

Action:

ACT Health developed a new Quality and Clinical Governance Framework 2015 – 2018 to replace the Safety and Quality Framework. The Framework aims to embed patient safety, clinical effectiveness, a culture of quality and continuous improvement, and patient and family centred care within the health service culture. It provides a shared vision for clinical governance of the organisation, including the organisational structure and lines of accountability for all staff to ensure quality of services for all patients.

Completion Due By: 30/04/2015

Responsibility: Deborah Browne

Organisation Completed: Yes

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

The ACT Health Safety and Quality Framework has been reviewed and replaced with a comprehensive new framework.

Recommendation: OWS 1112.3.2.2#2 **High Priority:** No

Recommendation:

ACT Health develop a system for monitoring compliance with point-of-care testing equipment against all relative standards, legislation and manufacturers' recommendations.

Action:

The Pathology Point-of-Care Testing (POCT) Policy and Standard Operating Procedure governs the implementation and use of POCT devices and systems, ensures that equipment is approved, appropriate and standardised throughout ACT Health, and is complaint with relevant standards, legislation, manufacturers, and accreditation requirements. POCT is performed in compliance with the quality requirements of the relevant National Association of Testing Authorities and National Pathology Accreditation Advisory Council accreditations standards, Therapeutic Goods Administration Regulations, ISO 15189, ISO 22870 and the ACT Pathology Quality Management System.

A POCT Coordinator is responsible for monitoring staff compliance with the Policy and SOP, maintenance of the POCT equipment inventory and maintenance schedule, managing training and competency requirements, and undertaking quality control activities and risk assessments. The Coordinator reports to the Executive Director, Pathology and the POCT Management Group.

Completion Due By: 30/12/2014

Responsibility: Peter Collignon

Organisation Completed: Yes

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

The management of point-of-care (POC) equipment is now managed in accordance with a new POC policy and procedure.

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Clinical practice
Action: 1.8.1 Mechanisms are in place to identify patients at increased risk of harm

Recommendation: OWS 1112.1.2.2 **High Priority:** No

Recommendation:

Review the coordination of the various management strategies and functions involved in patient flow across the hospital, including mental health, to ensure the patient journey is seamless and any blockages are minimised. This needs to be monitored by patient flow indicators at various points on the patient journey through the hospital, with some specific divisional indicators such as mental health.

Action:

In May 2013, Project Venturi, a three year project providing a whole of hospital approach to improving patient flow through Canberra Hospital and Health Services commenced. The project comprises a number of different phases of work, including analysis, problem identification and improvement test cycles across the hospital. Data and evidence to identify key delays to discharge and appropriate receipt of treatment has been gathered and audits to garner information of current practice, challenges and bed capacity have been conducted. Priority areas are being identified, with all staff involved in developing appropriate and practical solutions.

Patient flow and access through health services is reported, monitored and discussed at monthly divisional Scorecard meetings, through the provision of reports on access and quality data. These meetings are attended by Divisional Executives, clinical management teams and the Deputy Director-General, Canberra Hospital and Health Services with robust discussion occurring and actions identified to improve patient access to, and flow through services.

Scorecard reports include divisional specific indicators. Mental Health, Justice Health and Alcohol and Drug Services scorecard reports include specific mental health indicators including admissions/discharges, transfers in/out, utilisation, occupancy and length of stay for specific mental health wards and services.

ACT Health also receives Health Roundtable data, with capacity for reports to be generated on specific patient flow indicators at each Division and unit level, including comparisons with other hospitals and identification of ways to improve operational practice.

Completion Due By: 31/07/2014

Responsibility: Ian Thompson

Organisation Completed: Yes

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

Recommendation has been resolved through the actions described in the pre-survey documentation. This recommendation is closed.

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Clinical practice
Action: 1.9.2 The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards

Recommendation: OWS 1112.1.1.5 **High Priority:** No

Recommendation:

Develop a consistent approach to the documentation of the expected date of discharge in the clinical notes that facilitates analyses of any variances to be able to identify where improvements can be made.

Action:

The Patient Care and Accountability Plan has been recently developed following review of the Patient Assessment and Clinical Care Plan and has a section for a discharge checklist on the front based on the checklist tested on 7B (see previous recommendation) this checklist has a section for the Planned Day of Discharge and any changes to the original date. The development of an electronic Bed Management Tool by the Business Intelligence Unit has a section for PDD/EDD, this will be tested on 7B prior to rollout across the hospital. It is envisaged that this will provide a record in ACTPAS and in the clinical record, both of these methods will allow variance analysis.

Completion Due By: 30/04/2015

Responsibility: Ronnie Croome

Organisation Completed: Yes

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

Recommendation has been resolved.

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Performance and skills management
Action: 1.10.5 Supervision of the clinical workforce is provided whenever it is necessary for individuals to fulfil their designated role

Recommendation: OWS 1112.2.2.3 **High Priority:** No

Recommendation:

Implementation of an organisation-wide Clinical Supervision Policy progress as quickly as possible and at the same time as expedited the development of supporting frameworks, skills and compliance monitoring.

Action:

ACT Health has considered the development of a Clinical Supervision Statement in place of an organisation wide Clinical Supervision Policy. The work completed through Health Workforce Australia (HWA) has provided a framework and an evidence-based toolkit which is readily available for use within ACT Health.

The National Clinical Supervision Competency Resource released by HWA is a comprehensive document outlining skills/attributes required to be deemed 'foundational', 'intermediate' or 'advanced' in clinical supervision.
HWA has also released a Clinical Supervision Self Assessment Tool which has been distributed across ACT Health to support compliance monitoring.

Completion Due By: 30/04/2015

Responsibility: Ronnie Croome

Organisation Completed: Yes

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

ACT Health has developed and implemented an overarching Clinical Supervision Policy and has additionally implemented supervision for all professional groups including Junior Medical Officers, Allied Health and Nursing staff, and staff with limited registration or conditions. Senior medical staff have undertaken leadership training through the Royal Australasian College of Medical Administrators to contribute to meaningful supervision.

A snapshot of this process was evidenced in the minutes of the ACT Network Meeting September 2014.

Standard: Medication Safety
Criterion: Governance and systems for medication safety
Action: 4.1.2 Policies, procedures and/or protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines

Recommendation: OWS 1112.1.5.1#1 **High Priority:** No

Recommendation:

Proper documentation of S8 drug usage include all the legally required elements, including the name of the prescriber, the ability to identify the person administering the drug, and the amount of drugs discarded.

Action:

Proper documentation of S8 drug usage is mandated by legislation and reinforced through ACT Health medication related policies, procedures, and education and training programs that are governed by the Medication Safety Standard Group.
ACT Health has developed an overarching Medication Handling Policy that consolidates best practice principles and as in accordance with Australian Commission on Safety and Quality in Health Care standards on medication procurement, possession, storage, prescribing, dispensing, supplying, administering and recording, within the requirements of the Medicines, Poisons and Therapeutic Goods Act (ACT) 2008 and the Medicines, Poisons and Therapeutic Goods Regulation (ACT) 2008.
The administration of medication across health services is monitored through regular audits. The following audit tools are used to confirm compliance with medication safety policies: Medication Administration, Medication Safety Schedule 8 Drug Register, The Medication Reconciliation S4D/S8, and Medication Safety Walk Around Audit tool.

The Medication Reconciliation S4D/S8 and Medication Safety Schedule 8 Drug Register tools confirm proper documentation of S8 drug usage, including legally required elements. The Audit covers:
- The name of the medication and dosage
- Name of the prescribing medical officer documented on the medication chart and register
- Signature of the person administering the drug and the witness, and

- Whether any of the medication has been discarded and if so, the amount.

If patient safety issues are identified during the audit, auditors and staff are required to take immediate action to rectify the issue and if necessary, escalate through management.

Completion Due By: 30/03/2015

Responsibility: Veronica Croome

Organisation Completed: Yes

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

There is evidence that a quality improvement activity was implemented to ensure this recommendation was addressed. A review of drug registers used in the wards and departments during the current survey showed that there were only a two instances found when the name of the prescriber was not documented.

Standard: Medication Safety
Criterion: Medication management processes
Action: 4.10.1 Risks associated with secure storage and safe distribution of medicines are regularly reviewed

Recommendation: OWS 1112.1.5.1 **High Priority:** No

Recommendation:

If the patient's own S8 drugs are kept under the custody of the ward, they should be subject to a more robust system of checking with the aim of minimising the risk of diversion.

Sample drugs be directed to the pharmacy and not be kept in the drawers of the clinicians.

Action:

Schedule 8 drugs are managed through a robust accountability and monitoring system to minimise the risk of diversion.

ACT Health's Medication Handling Policy mandates that all Schedule 8 medications must be stored in a locked vault or ward safe, which is affixed to a solid wall, as per requirements in the Medicines, Poisons and Therapeutic Goods Regulation 2008, including a patient's own Schedule 8 medication and Schedule 8 medication labelled for supply to a patient on discharge. Schedule 8 medications must be stored apart from all other medications and any other goods. Access to the safe is strictly controlled by the registered nurse/midwife in control of the patient care area or authorised prescriber. The registered nurse/midwife in charge of the patient care area is also responsible for ensuring that strict medication transaction criteria is followed, a record is kept of all Schedule 8 medication transactions in a drug register, and a signature register is maintained.

The administration of S8 medication is monitored through regular audits and through the use of the following audit tools: Medication Administration, Medication Safety Schedule 8 Drug Register, The Medication Reconciliation S4D/S8, and Medication Safety Walk Around Audit tool.

Completion Due By: 30/04/2015

Responsibility: Veronica Croome

Organisation Completed: Yes

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

Patients are requested to send their own S8 medications home, however, if this is not possible they are placed in a bag, labelled, entered into a specific S8 drug register in the ward and locked into a secure cupboard. In regards to drug samples in doctors' personal office drawers the SOP has been enforced and pharmacy staff have informed all drug company representatives that they must register with pharmacy when coming into the hospital.

Standard: Medication Safety
Criterion: Medication management processes
Action: 4.10.3 The storage of temperature-sensitive medicines is monitored

Recommendation: OWS 1112.1.5.1#4 **High Priority:** No

Recommendation:

Review pharmaceutical refrigerators in the Community Health Centres for storage of pharmaceuticals only, temperature control and an alarm for malfunctions. Ensure that partially used injections are not stored in the refrigerator.

Action:

The Medication Standard Safety Group (MSSG) has implemented a system to monitor medication fridges in a consistent manner and a template has been developed in line with the national standards and guidelines. Rollout of the new template occurred through Divisional Directors of Nursing. Nursing staff are required to check the temperature range for any medication refrigerators in their clinical area daily and complete a quarterly report submitted through the Divisions Assistant Director of Nursing and Director of Nursing, noting any issues and associated action taken in addressing any them. Divisional Executive Directors report quarterly to MSSG to ensure compliance against Standard 4 – Medication Safety.

In June 2014 recommendations from a review of the status of the monitoring of fridges across ACT Health services was submitted to the Information and Communication Technology Committee. The review included consideration of vaccine refrigerators in community health centres and identified that all fridges are regularly serviced and checked as per ACT Health's Vaccine Cold Chain Management Policy, which includes temperature monitoring requirements.

A specific stock take and review of community health centre fridges was also undertaken to check medication storage, temperature control and alarm systems. Medication fridges in community health centres are used by the Mental Health and Maternal and Child Health areas and are managed in accordance with cold chain guidelines and regularly monitored through a procedure, checklist and audit tool. Health Protection Service temperature loggers are used for monitoring temperatures of refrigerators and procedures are in place to manage any breaches.

Completion Due By: 30/04/2015

Responsibility: Denise Lamb

Organisation Completed: Yes

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

Where community health centres have medication fridges installed these are monitored each day of operation and checked on the next day of operation that there has been no failure during the hours the centre was closed.

Standard: Clinical Handover
Criterion: Governance and leadership for effective clinical handover
Action: 6.1.1 Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored

Recommendation: OWS 1112.1.1.5#1 **High Priority:** No

Recommendation:

Implement the short term strategy in the action plan by the end of 2012 to ensure the 2006 discharge planning policy is updated to reflect current best practice and immediately followed by the implementation of the long term strategy in the action plan for a more comprehensive review of the discharge process.

Action:

Following a comprehensive review of discharge and clinical handover policies and procedures, the Canberra Hospital and Health Services Clinical Handover Procedure was created to replace the 2006 Discharge Planning Policy. The Procedure reflects current best practice and complies with the clinical handover standard of the National Safety and Quality in Health Service Standards. The procedure provides staff with a standardised process in relation to the transfer of patient care between health care clinicians and facilitates consistency in essential information in handover and at discharge, to ensure patient safety.

The Procedure includes guidelines, tools and templates to assist staff to develop handover and discharge processes in specific clinical areas and includes utilisation of ISBAR (Identify, Situation, Background, Assessment and Recommendation) and ISOAP (Introduction, Subjective information, Objective information, Analysis/action/advice, Plan).

Completion Due By: 30/04/2015

Responsibility: Veronica Croome

Organisation Completed: Yes

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

The 2006 Discharge Planning Policy has been replaced with a new procedure written upon best practice guidelines consistent with the Standard 5 Guide. This recommendation is closed.

Standard: Clinical Handover
Criterion: Governance and leadership for effective clinical handover
Action: 6.1.3 Tools and guides are periodically reviewed

Recommendation: OWS 1112.1.1.5#2 **High Priority:** No

Recommendation:

The review of the discharge process be in conjunction with a review of the 2005 discharge toolkit to ensure there are tools that support the process.

Action:

The Clinical Handover Procedure also replaced the discharge toolkit.
The General Practitioner Liaison Unit conducted a Discharge Summary Quality Audit in October 2014 at the Canberra Hospital. The audit compared 50 GP electronic discharge summaries completed for discharges between 1 and 3 April 2014 against 2013 results and the target of completion of discharge summaries within 48 hours of discharge. The audit recommended amendments to the electronic discharge summary process and additional training for junior medical officers around what information to include on the summary. Work has commenced to implement some enhancements to the system and JMO training reflects this.
ACT Health has introduced new tools, a Discharge checklist and Patient Journey Board, to support the discharge process as part of Project Venturi, and in conjunction with trials conducted on Wards 7B and 7A. The Discharge checklist requires the following information to be addressed and documented in the discharge process:

- Planned discharge date,
- Discharge criteria,
- Provision of information around planned date of discharge to the patient,
- Discharge medications,
- Pathology/blood tests,
- Paperwork – discharge summary, and
- Any changes e.g. change in discharge date.

The Patient Journey Board provides a focal point for patient care and discharge planning on each ward. The Board includes columns for key areas of patient care with different colours to indicate where the patient is up to in their stay e.g. green is for care completed and patient ready for discharge. Each member of the treating team has a role in updating the board and communicating what is happening with each patient.

Completion Due By: 30/04/2015

Responsibility: Veronica Croome

Organisation Completed: Yes

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

An extensive variety of activity has occurred to enhance discharge practices. The tool alluded to in this recommendation has been superseded with new tools and policies, a new discharge checklist and the implementation of patient journey boards. This recommendation is closed.

Recommendation: OWS 1112.1.1.5#3 **High Priority:** No

Recommendation:

The work commenced in the Division of Medicine in relation to the use of the expected date of discharge as a discharge planning tool that provides a structure to care planning and delivery and discharge planning tasks continue and be evaluated to demonstrate effectiveness of the discharge process. The strategies adopted then be implemented hospital-wide.

Action:

Ward 7B in the Division of Critical Care which has medical and surgical patients has tested a Planned Day of Discharge (PDD) mechanism to enhance communication and planning for patient discharge. The PDD is developed by the Multidisciplinary Team (MDT) taking into consideration the patient's clinical and social situation, as well as expected length of stay for a particular diagnosis. The PDD is not developed until a clear assessment of the patient by the medical, allied health and nursing teams has been conducted and the patient is physiologically stable. It is then discussed with all members of the MDT regularly to ensure barriers to discharge are progressed or escalated and the day is realistic.
The PDD is not developed until a clear assessment of the patient by the medical, allied health and nursing teams has been conducted and the patient is physiologically stable. It is then discussed with all members of the MDT regularly to ensure barriers to discharge are progressed or escalated and the day is realistic.
The patient and their family are also included in the communication with testing of Patient Information Boards at the patient bedside. The PDD may be altered depending on the patient's condition, however the aim is to have the PDD confirmed with the patient 24/48 hours prior to discharge. Testing is underway on 7B and 7A including measurement of completion of PDD on discharge checklists and Patient Whiteboards as well as patient and family feedback about the Patient Information Board.
Once testing on wards 7B and 7A have been completed, the strategy will be considered for adoption across Canberra Hospital and Health Services.

Completion Due By: 30/04/2015

Responsibility: Veronica Croome

Organisation Completed: Yes

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

Work associated with planned date of discharge has been extensively described in the pre survey documentation. There are a variety of mechanisms used to inform the planned date of discharge date and these include communication strategies with the patient and family. The patient information boards being used throughout the hospital now provide a focus for achieving expected date of discharge.

Organisation: ACT Health
Orgcode: 810004

Standards Rating Summary Report

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**

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**

Core

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**

Developmental

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**

Combined

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**

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**

Standard	SM	MM	Total
Standard 1	39	5	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	19	1	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**203**	**6**	**209**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	1	1	0	2
Standard 4	1	5	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	**2**	**45**	**0**	**47**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	6	5	11
Standard 3	1	0	1
Standard 4	5	0	5
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	**40**	**5**	**45**

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	1	40	0	41	Met
Standard 4	1	36	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	**2**	**254**	**0**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	48	5	53	Met
Standard 2	10	5	15	Met
Standard 3	40	0	40	Met
Standard 4	36	0	36	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	23	1	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**243**	**11**	**254**	**Met**