ACT Government
Health

Ref FOI18-22

Mr Alistair Coe MLA
coe@parliament.act.gov.au

Dear Mr Coe

I refer to your application under section 30 of the *Freedom of Information Act 2016* (the Act), received by the ACT Health on 23 April 2018, in which you sought access to the interim accreditation report by the Australian Council on Healthcare Standards reported on by The Canberra Times on 18 April 2018.

I am an Information Officer appointed by the Director-General under section 18 of the Act to deal with access applications made under Part 5 of the Act.

ACT Health was required to provide a decision on your access application by 22 May 2018.

Decision on access

I have decided to grant access to the document requested, as detailed in the attached Schedule.

Charges

Processing charges are not applicable for this request because less than 50 pages of documentation is being provided.

Online publishing – disclosure log

Under section 28 of the Act, ACT Health maintains an online record of access applications called a disclosure log. Your original access application, my decision and documents released to you in response to your access application will be published in the ACT Health disclosure log not less than three days but not more than 10 days after the date of decision. Your personal contact details will not be published.

You may view the ACT Health's disclosure log at http://www.health.act.gov.au/public-information/consumers/freedom-information/disclosure-log.

ACT Government
Health

Ombudsman review

My decision on your access request is a reviewable decision as identified in Schedule 3 of the Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601

Via email: ombudsman@ombudsman.gov.au

ACT Civil and Administrative Tribunal (ACAT) review

Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision.

Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

If you have any queries concerning the Directorate's processing of your request, or would like further information, please contact the Freedom of Information Coordinator on 6205 1340.

Yours sincerely

Jane Murkin
Deputy Director-General
Quality, Governance and Risk

18 May 2018

FREEDOM OF INFORMATION REQUEST SCHEDULE

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.

Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.

Information about what is published on open access is available online at: http://www.health.act.gov.au/public-information/consumers/freedom-information

NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	File No
Mr Alistair Coe MLA	The interim accreditation report by the Australian Council on Healthcare Standards reported by The Canberra Times on 18 April 2018.	FOI18/22

Ref No	No of Folios	Description	Date	Status	Reason for non-release or deferral	Open Access release status
1	1-28	The Australian Council on Healthcare Standards National Safety and Quality Health Service (NSQHS) Standards Survey Not Met Report 2018.	28/03/2018	Full Release		Yes
Total No of Docs						
1						

The Australian Council on Healthcare Standards

NSQHS Standards Survey

Not Met Report

ACT Health

Organisation code: 81 00 04

Survey date: 19-23 March 2018

Disclaimer:
The information contained in this report is based on the evidence provided by the participating organisation at the time of the accreditation survey and information that the organisation supplied through the reporting and editing process.

The Australian Council on Healthcare Standards

STANDARD SUMMARY 1: GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.1.1	SM	NM
1.1.2	SM	NM
1.2.2	SM	NM
1.3.1	SM	NM
1.5.1	SM	NM
1.5.2	SM	NM
1.6.1	SM	NM
1.6.2	SM	NM

Action 1.1.1 Core
An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols

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

Surveyor Comment:

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

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

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

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

Surveyor's Recommendation:

1. The organisation review the current governance system to promote the integration of systems and provide clear lines of accountability and reporting.

2. The corporate and clinical governance structures be reviewed to reflect good governance and enable clear lines of accountability.

Risk Level: High

Risk Comments:

The current governance system with lack of clarity, role confusion and poorly defined accountable structures creates a high risk for the organisation.

Action 1.1.2 Core
The impact on patient safety and quality of care is considered in business decision making

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

Surveyor Comment:

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

There was evidence that some business decision making priorities were not aligned to ensure patient safety. This was specifically in areas that have no reporting or accountability to CHHS clinical services. Examples of this include the major delays in rectifying the ligature points in Mental Health after several suicides in the area. Other examples include the kitchen, ongoing high counts of Legionella rates in the Canberra Hospital and the Intravenous Cannula project. These examples highlight the fragmentation within ACT Health and that there are no appropriate processes in place to prioritise business decision making to ensure patient safety.

There was also evidence that there is still a significant work health and safety risk for staff working at the Hume Health Centre where staff are exposed to high levels of smoking by inmates (present rate at 80%).

Surveyor's Recommendation:

1. The Strategic Corporate Plan for ACT Health Directorate be reviewed and then Business Plans with a focus on patient safety and quality be updated and cascade through the organisation.

2. Provide evidence to demonstrate that business decision making considers the impact of decisions on patient safety and quality of care.

3. Immediate action is taken to address the work health and safety risk to staff working at Hume Health Centre.

Risk Level: High

Risk Comments:

Not clearly setting direction, identifying and managing this risk is highly likely to impact on patient safety.

Action 1.2.2 Core
Action is taken to improve the safety and quality of patient care

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

Surveyor Comment:

The current governance system requires approval from a number or areas prior to being approved and the timelines are often extensive with little or no feedback to the area who have raised the issue. Decision making is often lengthy and convoluted when a significant patient safety and quality issue is identified. The organisation is not agile and responsive to significant patient incidents. An example of this is the failure to address the major risk of ligature points with well over a year since the last event and three years since the first suicide in the unit.

Surveyor's Recommendation:

1. Ensure that action is taken to improve the safety and quality of patient care in a timely and responsive manner.

2. Clear accountability lines be established at senior executive and above to ensure more timely and effective decision making processes are in place to improve patient safety.

Risk Level: High

Risk Comments:

The significant delays in decision making and interventions could significantly impact on patient safety.

Action 1.3.1 Core
Workforce are aware of their delegated safety and quality roles and responsibilities

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

Surveyor Comment:

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

Surveyor's Recommendation:

1. Ensure that the workforce is aware of the delegated safety and quality roles and responsibilities.

2. Develop ongoing strategies to clearly inform staff of their accountabilities and responsibilities in Safety, Quality and Risk at all levels of the health service workforce.

Risk Level: Moderate

Risk Comments:

Not identifying and managing risk could impact on patient safety.

Action 1.5.1 Core
An organisation-wide risk register is used and regularly monitored

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

Surveyor Comment:

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

Surveyor's Recommendation:

1. The current risk register be reviewed to ensure an effective and transparent system for monitoring risks across the health service.

2. Provide evidence that an organisation-wide risk register is used and regularly monitored.

Risk Level: Moderate

Risk Comments:

Not fully utilising management tools such as a risk register creates a moderate risk of financial loss and could impact on patient safety.

Action 1.5.2 Core
Actions are taken to minimise risks to patient safety and quality of care

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

Surveyor Comment:

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

Surveyor's Recommendation:

Implement a consistent organisation wide system of quality improvements to mitigate currently known risks to patient safety and quality of care across the heath service.

Risk Level: Moderate

Risk Comments:

Not identifying and managing this risk could impact on patient safety and the consequence is moderate with some of the current known risks.

Action 1.6.1 Core
An organisation-wide quality management system is used and regularly monitored

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

Surveyor Comment:

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

Surveyor's Recommendation:

1. The new quality framework be implemented with supporting plans and education.

2. Provide evidence that an organisation-wide quality management system is in use and regularly monitored.

Risk Level: Moderate

Risk Comments:
The background work undertaken to implement a new system assists in improving the risk of this rating to moderate consequence and unlikely.

Action 1.6.2 Core
Actions are taken to maximise patient quality of care

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

Surveyor Comment:

There was a new quality strategy launched the week before survey but there is not yet a quality plan to support this framework. Without a clear plan, accountabilities and feedback loop processes the quality process is fragmented and fails to embed across the organisation a culture of ongoing quality improvement and high standards.

Surveyor's Recommendation:

Ensure that action is taken to maximise the patient quality of care.

Risk Level: Moderate

Risk Comments:

The current fragmented approach to quality creates potential risks to establishing a transparent accountable quality system and thus a potential risk to patient safety.

Clinical practice

Ratings

Action	Organisation	Surveyor
1.7.2	SM	NM
1.8.1	SM	NM
1.8.2	SM	NM

Action 1.7.2 Core
The use of agreed clinical guidelines by the clinical workforce is monitored

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

Surveyor Comment:

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

Surveyor's Recommendation:

Provide evidence of the monitoring of the use of agreed clinical guidelines by the clinical workforce.

Risk Level: Moderate

Risk Comments:
If clinical pathways are not monitored it creates a potential for inconsistency in practice and lack of evidence based care.

Action 1.8.1 Core
Mechanisms are in place to identify patients at increased risk of harm

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

Surveyor Comment:

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

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

Surveyor's Recommendation:

CHHS commission an immediate independent external review of all Mental Health Inpatient Units, Alcohol and Drug, and Justice Health facilities to assess the level of safety and risk to consumers of the service.

Risk Level: Extreme

Risk Comments:

The delay in immediate actions post suicides and the delay in undertaking regular ligature point audits and implementing the results of the engineer's report into ligature points, places the patients/consumers at extreme risk.

Action 1.8.2 Core
Early action is taken to reduce the risks for at-risk patients

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

Surveyor Comment:

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

Surveyor's Recommendation:

1. Immediate action be taken to reduce the high risk of ligature points.

2. Establish a Mental Health Review Advisory body which incorporates the Alcohol & Drug and Justice Health to oversees the review and the implementation of the subsequent recommendations.

Risk Level: Extreme

Risk Comments:

The delay in immediate actions post suicides and the delay in undertaking regular ligature audits and implementing the results of the engineer's report into ligature points places the patients/consumers at extreme risk.

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.4	SM	NM
1.11.1	SM	NM
1.13.1	SM	NM

Action 1.10.4 Core
The system for defining the scope of practice is used whenever a new clinical service, procedure or other technology is introduced

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

Surveyor Comment:

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

Surveyor's Recommendation:

Provide evidence that the system for defining scope of practice is used whenever a new clinical service, procedure and/or technology is introduced.

Risk Level: Low

Action 1.11.1 Core
A valid and reliable performance review process is in place for the clinical workforce

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

Surveyor Comment:

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

Surveyor's Recommendation:

Ensure that a valid and reliable performance review tool is in place and appropriate for the clinical workforce.

Risk Level: Low

Action 1.13.1 Core
Analyse feedback from the workforce on their understanding and use of safety and quality systems

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

Surveyor Comment:

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

Surveyor's Recommendation:

Provide evidence that feedback from the clinical workforce on their understanding and use of safety and quality systems is analysed.

Risk Level: Low

Incident and complaints management

Ratings

Action	Organisation	Surveyor
1.14.2	SM	NM
1.14.4	SM	NM
1.16.1	SM	NM

Action 1.14.2 Core
Systems are in place to analyse and report on incidents

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

Surveyor Comment:

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

Surveyor's Recommendation:

Ensure that systems are in place to enable robust analysis and reporting on incidents.

Risk Level: Low

Action 1.14.4 Core
Action is taken to reduce risks to patients identified through the incident management system

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

Surveyor Comment:

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

Surveyor's Recommendation:

Ensure that action is taken to reduce the risks to patients identified through the incident monitoring system.

Risk Level: Low

Action 1.16.1 Developmental
An open disclosure program is in place and is consistent with the national open disclosure standard

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

Surveyor Comment:

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

Surveyor's Recommendation:

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

Risk Level: Low

Patient rights and engagement

Ratings

Action	Organisation	Surveyor
1.18.2	SM	NM

Action 1.18.2 Core
Mechanisms are in place to monitor and improve documentation of informed consent

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

Surveyor Comment:

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

Surveyor's Recommendation:

Strengthen the governance of consent processes across all areas through the identification of a senior individual who would have responsibility for maintaining the integrity of the consent system and ensure continuous improvement.

Risk Level: Low

STANDARD SUMMARY 2: PARTNERING WITH CONSUMERS

Consumer partnership in service planning

Ratings

Action	Organisation	Surveyor
2.1.1	SM	NM
2.2.1	SM	NM

Action 2.1.1 Developmental
Consumers and/or carers are involved in the governance of the health service organisation

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

Surveyor Comment:

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

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

Surveyor's Recommendation:

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

Risk Level: Low

Action 2.2.1 Developmental
The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation

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

Surveyor Comment:

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

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

Surveyor's Recommendation:

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

Risk Level: Low

The Australian Council on Healthcare Standards

STANDARD SUMMARY 3: PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Governance and systems for infection prevention, control and surveillance

Ratings

Action	Organisation	Surveyor
3.1.3	SM	NM
3.1.4	SM	NM

Action 3.1.3 Core
The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation

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

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

Surveyor's Recommendation:

Ensure that non-compliance with policy and procedures and key safety indicators related to significant infection control key performance be regularly reviewed and risk rated at the highest level of governance.

Risk Level: High

Risk Comments:

Considering the vulnerable patient's cohort in Building One and lack of evidence around action of disinfection and progress against risk mitigation the risk is rated as high. An event might occur and the consequence would be high with potential of significant infections to vulnerable patients.

Action 3.1.4 Core
Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols

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

Surveyor Comment:

In addition to those risk discussed in 3.1.3, there were other key infection control indicators that have had ongoing poor performance or slow progress against action plans. It was very evident that local action plans to address concerns were developed and executed at the local clinical service level. Progress against actions at the local level were very well documented, however there was little evidence at survey of governance support at a higher level with problems of non-compliance or actions that required executive decision making. Examples of poor performance include medical staff hand hygiene at 62-64 % for all quarters of 2017, poor compliance with AMS recommendations by the gastroenterology and orthopaedic specialties, and poor progression of actions against the Food Safety Audit dated August 2017 that required higher delegation.

Surveyor's Recommendation:

The effectiveness of infection control and prevention systems be made more visible and be supported by governance frameworks with clear accountability and timely action.

Risk Level: Moderate

Risk Comments:

There is level one evidence to support poor governance and visibility results in significant adverse events and negatively effects patient safety. This results in moderate risk to the service.

Infection prevention and control strategies

Ratings

Action	Organisation	Surveyor
3.8.1	SM	NM

Action 3.8.1 Core
Compliance with the system for the use and management of invasive devices in monitored

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

Surveyor Comment:

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

Surveyor's Recommendation:

Monitor compliance with the system for the use and management of invasive devices and demonstrate that identified risks and quality improvement plans have timely actions and progress at each level of governance.

Risk Level: Low

Cleaning, disinfection and sterilisation

Ratings

Action	Organisation	Surveyor
3.15.1	SM	NM
3.15.2	SM	NM
3.15.3	SM	NM
3.16.1	SM	NM

Action 3.15.1 Core
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

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

Surveyor Comment:

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

Surveyor's Recommendation:

A comprehensive quarterly report on environmental cleaning, including air sampling, hepa filter maintenance and water testing be presented at the HAI committee on at least a quarterly basis and variances reported to the highest level of governance to ensure appropriate risk management.

Risk Level: Low

Action 3.15.2 Core
Policies, procedures and/or protocols for environmental cleaning are regularly reviewed

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

Surveyor Comment:

The linen audit provided showed excellent compliance with contract requirements.

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

Surveyor's Recommendation:

A full review is undertaken against the storage and workflow of linen management at Canberra Hospital with a focus on the maintenance of infection control and OHS standards.

Risk Level: Low

Action 3.15.3 Core
An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly

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

Surveyor Comment:

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

Surveyor's Recommendation:

1. Review and improve the general cleaning schedule and work flow in the kitchen
2. Progress the remaining work in a timely manner against the Food Safety Audit conducted in August 2017.
3. Ensure the project to redesign workflow and replace the washer in the cleaning rinse area progress without further delay against a clear timeframe and Gannt chart.

Risk Level: Moderate

Risk Comments:

There is a moderate to high risk of infection associated with poor hygiene practices and food preparation, hence diligent response to food safety concerns are imperative.

Action 3.16.1 Core
Compliance with relevant national or international standards and manufacturer's instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored

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

Surveyor Comment:

There is little evidence that the gap analysis is sufficient against Advisory 16/10 as it did not show:
1. A comprehensive gap analysis with met items against revised AS/NZ 4187
2. compliance by having a detailed GANNT and clear deliverables for the recognised gaps by the required time frame.

Surveyor's Recommendation:

Ensure full compliance with Advisory 16/10 which requires a comprehensive gap analysis and completed GANNT that demonstrates progress.

Risk Level: Moderate

Risk Comments:

There is moderate financial, strategic and operational risk associated with poor planning for major capital work as the consequence can be disrupted operations and clinical care for patients.

STANDARD SUMMARY 4: MEDICATION SAFETY

Medication management processes

Ratings

Action	Organisation	Surveyor
4.10.1	SM	NM
4.10.3	SM	NM
4.11.1	SM	NM

Action 4.10.1 Core
Risks associated with secure storage and safe distribution of medicines are regularly reviewed

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

Surveyor Comment:

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

Surveyor's Recommendation:

The organisation review the storage of medications within the operating room to ensure that this is consistent with CHHS policy and legislative requirements.

Risk Level: Moderate

Risk Comments:

The risk is moderate as it was considered a possible event with minor consequences given the nature of the medications available. It would have been considered high (consequence moderate) if the drug propofol had not been removed from the open shelving.

Action 4.10.3 Core
The storage of temperature-sensitive medicines is monitored

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

Surveyor Comment:

The drug fridges and cool room in the central pharmacy and the Oncology pharmacy are monitored electronically and warning alarms to the engineering services and on call pharmacist. The drug fridges in the rest of the hospital are currently dependent on manual checking of temperature using free standing monitors which record the current temperature as well as the maximum and minimum since last reset. The audits of this process demonstrated variable compliance with some wards having poor compliance with the daily checks. In the report of the last survey, the similar finding of inconsistent compliance was reported and that this was to be remedied by a central monitoring system. While the survey team was shown an implementation plan for such a central monitoring system this was only in the early stages of implementation. A recommendation has been made to ensure this is completed.

Surveyor's Recommendation:

The organisation ratify and implement the Draft Medication fridge temperature Wi-Fi Monitoring Project.

Risk Level: Moderate

Risk Comments:

The risk of an event is possible but the consequence is low with moderate financial loss from medications and vaccines needing to be discarded.

Action 4.11.1 Core
The risks for storing, prescribing, dispensing and administration of high-risk medicines are regularly reviewed

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

Surveyor Comment:

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

Surveyor's Recommendation:

The organisation ensure there is a robust process for the safe storage and distribution of concentrated potassium solutions.

Risk Level: Moderate

Risk Comments:

The current risk is moderate due to the mitigating strategies that have already been put in place.

Continuity of medication management

Ratings

Action	Organisation	Surveyor
4.12.4	SM	NM

Action 4.12.4 Core
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

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

Surveyor Comment:

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

Surveyor's Recommendation:

Ensure that 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.

Risk Level: Low

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
4.14.1	SM	NM

Action 4.14.1 Developmental
An agreed medication management plan is documented and available in the patient's clinical record

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

Surveyor Comment:

CHHS provided insufficient evidence of developing a Medication Management Plan in partnership with patients and carers to warrant a rating of SM.

Surveyor's Recommendation:

CHHS develop an Medication Management Plan in partnership with the patients.

Risk Level: Low

The Australian Council on Healthcare Standards

STANDARD SUMMARY 5: PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Identification of individual patients

Ratings

Action	Organisation	Surveyor
5.1.2	SM	NM
5.2.2	SM	NM

Action 5.1.2 Core
Action is taken to improve compliance with the patient identification matching system

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

Surveyor Comment:

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

Surveyor's Recommendation:

1. CHHS embed the practice of using 3 points of ID across all clinical areas of CHHS.

2. The practice of using Medicare cards as an identifier in ED needs to stop in order to comply with policy.

3. CHHS review all handover documentation to ensure compliance with this standard.

Risk Level: Moderate

Risk Comments:

Although a number of areas practice the use of 3 identifiers and reportable events remain low there is still a moderate risk of errors occurring due to the inconsistencies in practice across the organisation.

Action 5.2.2 Core
Action is taken to reduce mismatching events

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

Surveyor Comment:

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

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

Surveyor's Recommendation:

CHHS undertake a review and implement the changes required to reduce all specimen labeling errors across CHHS.

Risk Level: Moderate

Risk Comments:
This is rated as Moderate risk due to the ongoing work and strategies being introduced to reduce the risk but there is still a potential for an error although unlikely there would be moderate consequences.

Processes to match patients and their care

Ratings

Action	Organisation	Surveyor
5.5.3	SM	NM

Action 5.5.3 Core
Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation

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

Surveyor Comment:

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

Surveyor's Recommendation:

CHHS achieve 100% completion compliance of the Surgical Safety Checklist in accordance with the organisations policy as soon as possible.

Risk Level: High

Risk Comments:

The risk of an event is possible but the consequence is high with potential of extensive injury from a wrong site surgery.

STANDARD SUMMARY 6: CLINICAL HANDOVER

Governance and leadership for effective clinical handover

Ratings

Action	Organisation	Surveyor
6.1.1	SM	NM
6.1.2	SM	NM

Action 6.1.1 Core
Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored

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

Surveyor Comment:

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

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

Surveyor's Recommendation:

CHHS review the current competency level of staff in the use of ISBAR, the subsequent training needs and implement the required actions in order to embed the practice of using ISBAR across all clinical areas of CHHS.

Risk Level: Moderate

Risk Comments:
The risk of an event could occur at some time and the consequence is moderate with potential of poor communication between clinicians

Action 6.1.2 Core
Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols

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

Surveyor Comment:

Inpatient discharge summaries completion rates are below CHHS target of completion within 48 hours of discharge. In one area, Mental Health, there are 235 uncompleted discharge summaries from 2017 and over 200 that are more than 90 days overdue since discharge. Some issues that have impacted on completion rates have been problems with different computer system integration, staff turnover and workloads. A recent CHHS directive that all discharge summaries be completed in one computer system, CRIS, should help alleviate any computer system interface problems.

Surveyor's Recommendation:

1. Review the processes of completing discharge summaries and implement the required changes needed to reach the organisation's 48 hours post inpatient discharge compliance level.

2. Review all outstanding discharge summaries from 2017 and implement the required actions needed.

Risk Level: High

Risk Comments:

The risk of an error occurring due to a timely lack of hand over to the GP might occur at some time with a moderate consequence due to the potential for requiring additional medical intervention. This therefore rates the risk as high.