NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

ACHA Health

Bedford Park, SA

Organisation Code: 32 00 11
Health Service Organisation ID: Z1010011
Assessment Date: 02/09/2019 to 06/09/2019

Accreditation Cycle: 1

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Preamble

How to Use this Assessment Report
The ACHS assessment report provides an overview of quality and performance and should be used to:

1. provide feedback to staff
2. identify where action is required to meet the requirements of the NSQHS Standards
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.

The Ratings:
Each **Action** within a Standard is rated by the Assessment Team.

A rating report is provided for each health service facility.

The report will identify actions that have **recommendations** and/or comments for each health service facility.

The rating scale is in accordance with the Australian Commission on Safety and Quality in Health Care's Fact Sheet 4: Rating Scale for Assessment:

Assessor Rating	Definition
Met	All requirements of an action are fully met.
Met with Recommendations	The requirements of an action are largely met across the health service organisation, with the exception of a minor part of the action in a specific service or location in the organisation, where additional implementation is required.
Not Met	Part or all of the requirements of the action have not been met.
Not Applicable	The action is not relevant in the health service context being assessed.

Suggestions for Improvement
The Assessment Team may provide suggestions for improvement for the health service to consider implementing. They are not required to be implemented for an action to achieve a met rating. Suggestions for improvement are documented under the criterion level.

Recommendations
Not Met/Met with Recommendation rating/s have a recommendation to address in order for the action to be rated fully met. An assessor's comment is also provided for each Not Met/Met with Recommendation rating.

Risk ratings are applied to actions where recommendations are given to show the level of risk associated with the particular action. A risk comment is included if the risk is rated greater than low. Risk ratings are:

1. E: **extreme (significant)** 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

Executive Summary

Introduction

ACHA Health underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 02/09/2019 to 06/09/2019. The NS2 OWA required six assessors for a period of five days. ACHA Health is a Private organisation. ACHA Health was last assessed between 5th – 8th September 2016. Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier
Ashford Hospital	100433
Flinders Private Hospital	101434
Memorial Hospital, The	101435

General Discussion

Adelaide Community Healthcare Alliance (ACHA) Health is a community-led organisation providing private hospital and health care to the people of Adelaide, South Australia. Each of its three hospitals is relatively autonomous and a complex governance arrangement exists whereby the three hospitals each has a separate Safety and Quality Committee reporting through the ACHA Patient Care Committee to the ACHA Executive Committee.

In a contractual arrangement Healthscope Pty Ltd provides systems, support and analysis for ACHA Health to assist the Board, Chief Executive Officer (CEO) and Executive staff to meet their clinical governance policy and statutory responsibilities. The Board is keen and committed to the organisation, as is the Medical Advisory Committee, comprising Visiting Medical Officers (VMOs) who take their responsibilities in regard to quality and safety seriously.

In a past assessment these complex arrangements led to numerous recommendations regarding strengthening of governance, each of which has been addressed. This most recent assessment has identified further areas for improvement relating to governance. The Board and Executive were accepting of the several recommendations and suggestions made and have already taken some to steps to address issues where governance was deemed to be sub-optimal.

What stood out for assessors was the pride and commitment of staff working at all three hospitals – Flinders Private Hospital, Ashford Hospital and The Memorial Hospital. The latter hospitals are undergoing significant redevelopments which has been a testing time for staff and patients alike. Despite the inconvenience of the building programs (which has been well managed) all staff and patients were comfortable, felt cared for, and were happy with the way the organisation was managing the situation.

Each hospital undertakes very complex surgery. In Flinders Private Hospital's case it provides cardiac catheter laboratory services for both private and public patients through a relationship with Flinders Medical Centre (FMC). The catheter lab was an extremely busy and energetic place when visited by assessors.

As an organisation, ACHA Health has generally very good outcomes for its patients despite the complexity of procedures it performs, testifying to good risk management and patient selection.

Again, its relationship with FMC assists in managing the sickest patients who may require transfer to a tertiary facility.

Areas for concern were identified in regard to medication safety. ACHA Health was very responsive, alongside its private pharmacy provider, in addressing major issues during the assessment. Consequently, recommendations in regard to Standard 4 have been made to ensure changes made during assessment are sustained in the future.

The assessment team was provided with comprehensive self-assessment documentation and had access onsite to policies, procedures and other relevant documents. All relevant clinical areas were visited, including partnering organisations such as Pharmacy, Pathology and Medical Imaging services to determine the effectiveness of the interface between.

Staff and patient survey results show high levels of satisfaction.

The recommendations from the previous assessment were reviewed and have all been closed. Staff have steadily improved processes associated with the ten National Standards and all Actions have been Met on this occasion. Eighteen (18) Met with Recommendations and several suggestions have been made to assist the organisation in continuing its safety and quality journey.

Summary of Results

ACHA Health achieved a Met rating for all **applicable** Actions in all Standards that were assessed and has achieved Accreditation (3 Years).

ACHA Health achieved a Met rating for all facilities in all Actions and therefore there is no requirement for a follow up assessment.

Further details and specific performance to all of the actions within the standards is provided over the following pages.

ACHA Health

Sites for Assessment

Sites for Assessment - ACHA Health

ACHA Health HSO ID:Z1010011
Address: ACHA Health Bedford Park SA 5042
Under the Australian Health Service Safety and Quality Accreditation Scheme, there is no requirement to assess at this address

Ashford Hospital HSF ID:100433	
Address: 55 Anzac Highway ASHFORD SA 5035	Visited: Yes

Flinders Private Hospital HSF ID:101434	
Address: 1 Flinders Drive BEDFORD PARK SA 5042	Visited: Yes

Memorial Hospital, The HSF ID:101435	
Address: Sir Edwin Smith Ave NORTH ADELAIDE SA 5006	Visited: Yes

ACHA Health

Reports for Each Standard

Standard 1 - Clinical Governance

Governance, leadership and culture

Action 1.1	
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.2	
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.3	
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.4	
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 1.5	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.6	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health has a complex governance arrangement with three hospital facilities each having a separate Safety and Quality (S&Q) Committee reporting through the ACHA Patient Care Committee to the ACHA Executive Committee. The ACHA Health Board is the governing body of ACHA Health and receives and reviews safety and quality reports through this clinical governance framework. The Board has a number of sub-committees including Finance and Audit; however, there is no Board S&Q Sub-Committee. This means that the Board takes full responsibility for deliberations in relation to S&Q matters and relies on the accuracy and completeness of the reporting from the CEO and Executive in undertaking their role. Of note in the ACHA Board Constitution, there are no specific roles outlined in relation to clinical safety and quality.

Healthscope Pty Ltd, in a contracted arrangement, provides systems, support and analysis for ACHA Health to assist the Board, CEO and Executive staff to meet their clinical governance policy and statutory responsibilities.

The CEO has a well-supported and attended Medical Advisory Committee (MAC) which receives reports from the ACHA Clinical Advisors, the Clinical Review Committee, and MAC Craft Group Sub-Committees. The Clinical Review Committee is a privileged committee operating under the auspices of Part 7 of the SA Health Act 2008. This privilege requires that the committee not release information except in particular circumstances as listed in the Act, for example: "…to the extent necessary for the proper performance of the authorised activity; or …in pursuance of any reporting requirements of a prescribed kind to a governing body of an entity; or …to the extent necessary for the proper performance of the authorised activity; or …in pursuance of any reporting requirements of a prescribed kind to a governing body of an entity…".

The Terms of Reference for the Clinical Advisory Committee outline that the committee, "…is appointed by and pursuant to the rules of the ACHA Board of Directors". Further, there are a number of roles of the committee in the Terms of Reference which require that the Board and CEO are fully appraised, for example:

- To analyse and review data obtained in relation to the safety and quality of services with the objective of recommending quality improvement initiatives.
- To analyse data and information about systemic safety and quality issues and provide advice on strategies for system improvement.
- Review recommendations and action taken to respond to relevant safety and quality issues as identified and disseminate recommendations to health services state-wide.
- Provide advice to the CEO via the Medical Advisory Committee, and other relevant bodies on matters relevant to the safety and quality of health care.

Even though the Clinical Advisory Committee has substantial responsibilities for undertaking safety and quality reviews and making recommendations and providing advice, the Board and CEO currently only receive an annual report, which is the minimum frequency of reporting required by the Act. A recommendation has been made in relation to S&Q reporting under Action 1.9.

During assessment, it was noted by the assessment team that the Hospital Standardised Mortality Rate (HSMR) which was provided by Healthscope to ACHA Health for the 2018 calendar year, differed for Ashford Hospital between a funnel plot graph of the rates and the tabulated data presented to the Medical Advisory Committee (MAC). On the funnel plot, the HSMR approximated 120 and was shown to be very close to the 95% confidence interval above the normalised value of 100. In the table presented to the MAC the figure shown was 89.76. This is more than 30 points difference on one of the most significant indicators for review by the MAC and subsequently the Executive, CEO and Board.

Further, when the original tabulated Healthscope data was provided to the assessment team it shows that for one quarter in 2018, the actual deaths were almost twice the number of expected deaths and the HSMR for that quarter was 193 and beyond the 99% confidence interval. The error was identified by ACHA Health as a transcription error in the reporting. However, it highlights a failure of clinical governance in that one of the primary indicators of a hospital's performance was not fully reviewed and the error was not picked up during that review process. The error also highlights that the Governing Body must be provided data which is sourced externally in its raw form without transcription, not only to prevent transcription error, but also to enable a more detailed analysis of the data. Aggregation which negates seasonal and other variations will potentially hide variations and make evaluation of any variance and the instigation of safety and quality initiatives more difficult. Provision of the raw data does not negate the possibility of analysis and commentary to be provided based on local analysis to compliment the raw reporting. A comment will be provided both here and a recommendation in Action 1.9 in relation to improving reporting.

The assessment team noted during assessment that compliance across a number of areas related to the National Standards showed poor compliance across a number of audits. For example, medication management, antimicrobial stewardship, clinical documentation, responding to variations in the observation chart outside the white zone, and blood chart completion. In all these areas there is no ACHA Health committee or other body which has responsibly for the National Standard requirements and ACHA Policy compliance in that area. For areas which have a responsible committee, for example infection control, the compliance and processes are much more consistent.

The areas of poor compliance will be outlined in more detail in the relevant standards in this report and recommendations in relation to governance will be outlined.

The assessment team noted that for some of the areas where policy compliance was poor, the risk register noted the risk as 'low' with the effectiveness of the controls documented as 'excellent'. This assessment is at odds with the audit results in many areas which have shown consistent low levels of compliance. This indicates that the governance around risk assessment is not providing assurance that the clinical risks noted are being reflected accurately in the register and potentially not being actioned according to the actual risk to ACHA Health. These issues will be outlined in Action 1.10 and recommendations made to address the inconsistency. A suggestion will be provided here that risk assessments, allocation of the risk level and the assessment of the effectiveness of controls is undertaken collectively rather than by individual risk managers or those with access to RiskMan, and subsequently endorsed by the ACHA Health CEO or Executive allocated responsibility for mitigating the risk.

ACHA Health has had a number of organisational and building upheavals in recent times and the S&Q KPIs indicate that the organisation has continued to focus on the safe care of patients. In general, clinical outcomes are sound.

The ACHA Health clinical governance structure now involves consumers in the deliberations and the assessment team were able to confirm with the consumer consultants that they feel valued and included in this process. This will be expanded further under Standard 2.

ACHA Health has developed the Reconciliation Action Plan (RAP) and this will guide work to ensure that Aboriginal and Torres Strait Islander (ATSI) peoples are part of the journey to develop as an organisation. The RAP outlines cultural and other goals for the improvement of the organisation in relation to providing ATSI people with culturally appropriate care; however, the goals are broad in nature and do not specifically outline targets for the improvement of the health of ATSI consumers. A recommendation will be made in relation to developing more specific strategies and targets to enhance the implementation process further.

ACHA Health satisfactorily meets all the requirements of the Australian Commission of Safety and Quality in Health Care Advisory AS 18/04.

Staff are provided with safety and quality roles on their position descriptions and responsibilities are reinforced during orientation. Those with specific S&Q responsibilities are provided support to undertake their roles.

Suggestions for Improvement:

Risk assessments, allocation of the risk level and the assessment of the effectiveness of controls is undertaken collectively, rather than by individual risk managers or those with access to RiskMan, and subsequently endorsed by the ACHA Health CEO or Executive allocated responsibility for mitigating the risk.

Action 1.4
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: Even though ACHA Health has developed and implemented the Reconciliation Action Plan which outlines cultural and other goals for the improvement of the organisation in relation to providing Aboriginal and Torres Strait Islander (ATSI) people with culturally appropriate care, the goals are broad in nature and do not specifically outline targets for the improvement of the health of ATSI consumers.
Recommendation:
Develop, in consultation with the Aboriginal and Torres Strait Islander (ATSI) Community, specific health related strategies and targets with appropriate monitoring and reporting systems for the goals in the Reconciliation Action Plan.
Risk Rating:
Moderate
Risk Comment:
The proportion of ATSI peoples who utilise the service are low and specific health issues may be difficult to ascertain; however, this does not preclude an analysis of available data to determine if there are any clinical risks with this population.

Patient safety and quality systems

Action 1.7	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.8	
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.9	
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 1.10	
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 1.11	
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework6 b. Monitors and acts to improve the effectiveness of open disclosure processes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.14	
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Action 1.15	
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.16	
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Assessment Team Summary:

ACHA Health has a comprehensive policy and procedure framework which outlines the policy and procedural requirements to standardise key processes. These documents outline the requirements across the organisation and link well with the National Standards and related legislation. Comments in relation to procedural compliance will be made in the relevant standards areas in this report.

The quality improvement systems have been described above and will not be elaborated upon further; however, the suggestion which was made under governance, leadership and culture also applies here.

As stated previously, the S&Q reporting both internal and external is very comprehensive; however, onerous auditing and reporting which may be prescribed by external bodies which does not directly relate to risks as assessed by ACHA Health may result in audit fatigue and loss of confidence in staff that the audit effort is producing value through improved patient outcomes. This will be expanded upon under Action 1.10.

As stated earlier a recommendation in relation to the operation and reporting by the ACHA Clinical Review Committee will be made.

ACHA Health has a corporate risk register and risk registers for their three facilities. The risk policy and systems are sound and there is evidence that risks are identified, assessed and managed and the risk system integrates with incident, complaint and other S&Q systems.

However, the assessment team identified areas in audit results where compliance was low and the risks on the risk register were assessed as low, with the effectiveness of the controls described as excellent. If there is poor compliance in consecutive audits, the controls cannot be assessed as excellent and the risk level must then reflect the actual clinical risk of the non-compliance.

Further, the assessment team identified clinical risks around medication management, antimicrobial stewardship, clinical documentation, responding to variations in the observation chart outside the white zone, and blood chart completion where there was no specific manager, group or committee who had oversight of the activity and risks in these areas to take responsibility for addressing the non-compliance.

A recommendation in relation to risk assessment systems, including the governance of the risks to assure their mitigation will be made.

Incidents and complaints are well managed utilising the RiskMan system and open disclosure is provided when adverse events occur. ACHA Health use the Healthscope Sentinel Event list which is very comprehensive.

Patient experience feedback is obtained and provided to staff in a very timely fashion and is now displayed on S&Q Boards in wards for all staff, patients and visitors to see. Feedback is very positive and above targets.

Diversity is recognised and strategies are in place to ensure that those from diverse backgrounds are treated with respect and resources are available to assist staff in caring for those with communication difficulties, those from non-English speaking backgrounds, and for ATSI peoples.

ACHA Health utilises a fully paper-based clinical record which is comprehensive and available at the point of care. WebPAS is the patient administration system and it is evolving to include clinical modules to support care, such as those which enable GP Discharge Summaries from the ER. The records are audited for compliance in relation to ACHA policy requirements and also for documentation requirements such as those in the ACHA Health Medical Services Regulations. These audits have shown highly variable, but generally poor documentation compliance by medical officers over subsequent audits and this may inhibit the understanding of diagnosis and treatment, especially if there is a clinical escalation or emergency where clinicians, not familiar with a patient and have to provide emergent treatment. Further, poor documentation also inhibits accurate coding and classification which may have a financial impact and contribute to the attribution of conditions to the facility when they may have been present on admission.

ACHA Health is well progressed in appropriately accessing the My Health Record and providing some limited information into the My Health Record. This is tightly controlled and in accordance with the requirements and timeframes outlined in the Australian Commission of Safety and Quality in Health Care Advisory AS 18/11.

Action 1.9

The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

ACHA Health has undergone significant changes to the organisation and this includes the review of governance and committee structures and reporting. One committee, the Clinical Review Committee, has wide terms of reference to assess and evaluate the quality of services provided by ACHA Health and to provide advice to the Chief Executive Officer and the Medical Advisory Committee and 'other relevant bodies' (presumably the Board) on matters relevant to the safety and quality of healthcare. As this is a privileged committee, reporting has only been made annually which is the minimum required by the Act. This does not keep the CEO or the Board appraised in a timely manner about what may be matters of significant clinical risk.

Recommendation:

Review the operation and reporting process of the Clinical Review Committee to ensure that the Board and the CEO receive timely reports on any data of concern, any reviews undertaken, and the outcomes of any such reviews. This needs to be additional to the Annual Report from the committee which is the minimum prescribed by the legislation.

Risk Rating:

Moderate

Risk Comment:

The CEO and Board may not be fully appraised of significant safety and quality issues for which they are accountable, and this is a risk to them and the organisation.

Action 1.10

The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

ACHA Health has a corporate risk register and risk registers for their three facilities. The risk policy and systems are sound and there is evidence that risks are identified, assessed and managed and the risks system integrates with incident and complaint systems.

However, the assessment team identified areas in audit results where compliance was low and the risks on the risk register were assessed as low, with the effectiveness of the controls described as excellent. If there is poor compliance in consecutive audits, the controls cannot be assessed as excellent and the risk level must then reflect the actual clinical risk of the non-compliance.

Further, the assessment team identified clinical risks around medication management, antimicrobial stewardship, clinical documentation, responding to variations in the observation chart outside the white zone, and blood chart completion where there was no specific manager, group or committee who had oversight of the activity and risks in these areas to take responsibility for addressing the non-compliance.

Recommendation:

Review the risk management systems in place to ensure that actions which are planned and undertaken as a result of the identification of a non-compliance with policy requirements are allocated a risk level and time frame for action that is appropriate for the non-compliance identified.

This review should include the governance and formal committee structure across ACHA Health which provides assurance that compliance is monitored, and action taken to address non-compliance across all the requirements outlined in ACHA Health policy and the National Safety and Quality Health Service Standards.

The Terms of Reference of any oversight committees must clearly outline the responsibility and escalation where compliance remains below requirements.

Risk Rating:

Moderate

Risk Comment:

Risk management systems are in place; however, their capacity to address non-compliance is limited by either an erroneous assessment of the adequacy of the controls and/or ineffective oversight due to a lack of the clear governance responsibility.

Action 1.16

The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

Annual record audits indicate that medical staff compliance with the documentation requirements outlined in the ACHA Health Medical Services Regulations is highly variable and generally poor.

Even though audits demonstrate compliance is poor and has been so for several years, the evidence that the risk has been escalated and tighter controls implemented is not apparent.

Recommendation:
Medical staff compliance with the documentation requirements outlined in the ACHA Health Medical Services Regulations is enforced and action taken which is appropriate for the level and frequency of non-compliance.
Risk Rating:
Moderate
Risk Comment:
Poor medical staff documentation inhibits the understanding of diagnosis and treatment, especially if there is a clinical escalation or emergency where clinicians not familiar with a patient have to provide treatment. Poor documentation also inhibits accurate coding and classification which may have a financial impact and contribute to the attribution of conditions to the facility when they may have been present on admission.

Clinical performance and effectiveness

Action 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 1.20	
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 1.21	
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 1.22	
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 1.23	
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.24	
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.27
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care

Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.28	
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health has systems in place to describe the role and responsibilities for safety and quality for its staff. The Board's role in quality and safety is outlined in the Board Governance and Governance Roles and Key Relationships 0.028. Of note, the policy does not explicitly state the quality and safety roles of the Board (see commentary in item 1.25). Members of the Board receive Induction by the Clinical Risk/Quality Manager of ACHA Health, outlining the general Clinical Governance System at ACHA Health, but not specifically their role in ensuring and monitoring quality and safety.

Orientation is also provided to all new employed staff. Ashford Hospital Nursing Orientation Booklet was viewed by assessment team, and compliance with Orientation training was over 92% for the organisation. Orientation for rotational junior medical staff from Flinders Medical Centre is expected as part of the service agreement. Orientation on-boarding pack is provided to all new VMOs.

ACHA Health Mandatory Training Policy 4.10 outlines the appropriate staff training required based on the competency requirements of the employed medical, nursing, midwifery and allied health workforce. Online training platform ELMO supports online training packages and monitoring of training compliance. The assessment team viewed compliance rates for mandatory training across various training programs and professional groups, with mostly high compliance rates.

ACHA Health has implemented targeted training in high-risk casesmix, for example Obstetrics, with the Obstetric Safety Mid+Safe web-based interactive learning program, including electronic foetal monitoring. Oncology nurses in Marion ward at Ashford complete Antineoplastic Drug Administration Course (ADAC) training for Chemotherapy administration.

Of note, ACHA Health does not currently outline a Mandatory Training Framework for VMOs. The assessment team with members of the Medical Advisory Committee, who noted that approximately 75% of the VMOs also hold appointments at public hospitals, which require mandatory training, and VMOs may be open to a mutual recognition process for recognising the training performed at the public hospitals.

ACHA Health has recently implemented a cultural awareness and sensitivity learning package, incorporating ATSI training. Of note, the package development has not involved the Aboriginal Consumer to date. The assessment team viewed compliance with training of 49% completion across ACHA Health.

ACHA Health Performance Review and Development Process 4.14 defines the requirements for members of the workforce to review their performance. Performance appraisal completion is monitored across all three sites, with high compliance within the employed nursing and allied health staff. Assessors discussions with many clinical staff across the organisation confirmed that performance appraisals were performed annually. Assessor discussions with Critical Care Unit Medical Officer noted that they were yet to undertake performance appraisal this year. Performance development and review of the rotational medical officers from Flinders Medical Centre is performed by the Flinders Medical Centre.

Medical Services Regulations for VMOs does not currently outline a Performance Review Framework. Discussions with Medical Advisory Committee confirmed that there is currently no Performance Management Framework for VMOs. Clinical cases are reviewed within the Clinical Review Committee, and any VMO performance issues identified within the Clinical Review Committee are referred to Medical Advisory Committee.

ACHA Health has frameworks for credentialing and defining scope of clinical practice for clinical staff and VMOs. The Registration Nurses, Allied Health Professionals and Security Officers Policy, and VMOs and Accredited Health Professionals Credentials policy 1.20, and Medical Services Regulations outlines the frameworks. Standard application forms for VMOs and Surgical Assistants are managed by the Office of the General Manager using the cGov electronic platform. All VMO specialties have defined credentialing requirements and scopes of practice. Administrative assistants demonstrated high levels of competence with the cGov system for Assessors at both Flinders Private and Ashford Hospital.

Nursing and Allied Health credentialing is performed on appointment by the local area Manager, as outlined in the above Policy. ACHA Health does not employ any advanced practice nursing or allied health. Agreements with the Flinders Medical Centre requires credentialing to be performed by Flinders Medical Centre for the rotational Intensive Care and Coronary Care Medical Officers.

Endoscopy, Angiography were visited by Assessors and viewed the WebPAS for confirming authorised VMOs scope of practice. The WebPAS interface with cGov ensures up-to-date availability for clinical staff on the wards. Of note, the WebPAS only lists the primary specialty for the VMO, and not the full detail of the Scope of Practice. Colorectal Surgeons performing Colonoscopies are currently listed as Gastroenterologists in the WebPAS for colonoscopy credentialing (see commentary and suggestion in item 1.28 relating to credentialing for Colonoscopy Clinical Care Standard). It was also noted at Flinders Private Angiography suite, where the suite also provides services to the Flinders Medical Centre, that there was a very high patient load through the three suites with a large number of staff members entering the suite. Assessors raised the risk of tracking staff attendance in Flinders Private Angiography suite with the NUM at the time.

Robotic Assisted Surgery is a recent example of the introduction of a New Technology, with credentialing framework approved via the Medical Advisory Committee. The framework was viewed by the assessment team. Audits against scope of clinical practice were conducted in Bariatric Surgery, ENT and Breast surgery in the Safety and Quality Plan.

ACHA Health monitors credentialing of Surgical Assistants and Visiting Medical Staff, with May 2019 audits conducted by Healthscope of VMO credentialing and Allied Health Practitioners, viewed by the assessment team. Spot audits of scope of practice and credentialing documentation was viewed at both sites by Assessors. Improvements to the credentialing system are overseen by the Credentialing Team meeting via Healthscope in June 2019, with planned introduction of a Dr Lookup function to allow viewing access to Scope of Practice register across the organisation.

Nursing credentialing audits are conducted by ACHA Health. Healthscope processes also audit the compliance with Allied Health credentialing.

ACHA Health has proposed to introduce a Dr Lookup function within cGov to improve the visibility of scope of practice for clinical areas.

ACHA Health documents the role and responsibilities for safety and quality in the Position Description in a standard template. The ACHA Health Board's role in quality and safety is outlined in the Board Governance and Governance Roles and Key Relationships 0.028. Of note, the policy does not explicitly state the quality and safety roles of the Board. The Mandatory Training framework provides education for all staff in their quality and safety roles. Examples of communication to the organisation include the Quality Education Boards throughout all sites, and the ACHA Doctor news which includes expectations of medical staff roles including Standing Orders, Colonoscopy Clinical Care Standards, Medication Telephone orders and Credentialing. Performance Review and Development Process 4.14 defines the requirement to review performance against effective patient care and customer service.

ACHA Health Supervision framework is implemented via key leadership positions across the organisational Nurse Unit Managers who provide frontline supervision for nursing care. Position descriptions for Nurse Unit Managers outline their role to ensure that the delivery of nursing care within the unit/ward is at optimal level, evidence based, efficient and meets the needs of the patient. The Medical Services Regulation defines the supervision requirements for Surgical Assistants under the admitting Medical Practitioner. Performance appraisals across the sites are conducted according to the Performance Review and Development Policy. The Duty Medical Officer in Critical Care Unit is supervised by ACHA Health Intensivists, and to provide care as guided by VMOs. Assessors discussed with the Critical Care Unit medical officers, who outlined clear escalation and supervision by Intensivists in the role. Credentialed Surgical Assistants are supervised in theatre by credentialed VMOs and are unable to perform surgery independently. Nursing student supervision framework is outlined in the agreements with the Flinders University.

ACHA Health has processes to provide clinicians with access to best-practice guidelines and decision support tools via the Intranet and the Library. ACHA Health utilises Doctors Standing Orders as the framework to embedding evidence-based practice into clinical care, outlined in the Doctors Standard Orders Policy 5.525. The policy specifies a Standing Orders Form, Process for approval via the ACHA Health Document Controller, and review at 3 yearly intervals.

The 2018 ACHA Annual patient safety quality plan noted 696 standing orders from 115 VMOS across ACHA Health. Assessors viewed a number of standing orders for Cardiologists, in alignment with the Acute Coronary Syndrome Clinical Care Standard. Of note, not all Cardiologists had Standing orders documented on the Intranet site, and there was variability amongst the criteria for the differing VMOs.

ACHA Health has evidence of compliance with the Colonoscopy Clinical Care Standard. Assessors viewed the AS18/12 Colonoscopy Clinical Care Standard ACHA Action Plan and the Colonoscopy – Pre and Post Care Policy 8.664 addresses all elements of the Standard; however, currently only lists Gastroenterologists as authorised to perform Colonoscopies. The cGov system does not currently list Colonoscopy as a Scope of practice option for General Surgeons with Colorectal Surgical scope of practice. The Endoscopy suites at Ashford and Flinders Private have implemented the Standard, including credentialing, scope of practice and collecting data via the Provation system. The Colonoscopy Clinical Care Standard was included in the recent ACHA Doctors newsletter July 2019.

ACHA Health has systems in place to monitor variation in practice against expected health outcomes and against external measures. The ACHA Annual Safety and Quality Plan outlines the full suite of clinical indicators that are measured across the organisation, benchmarked via ACHS Clinical Indicators. The ACHA Executive committee review reports on Hospital Acquired Complications, Clinical Indicators, CHBOI Report. The hospital-based outcome indicators (CHBOI) and Hospital standardised mortality ratio (CHBOI HSMR) 2018 was approximately 120 for Ashford and under 100 for Memorial and Flinders Private. ACHA Health clinicians participate in a number of registries (ANZICS, Orthopaedic Joint Registry, SA Audit of Surgical Mortality). Assessors were provided with the Audit of Surgical Mortality report, with a number of clinical indicators at Flinders Private unfavourable compared to national comparison (postoperative complications 42%, unplanned returns to theatre 22.3%, unplanned admissions to ICU 27.9%). Of note, the outcomes of the reports are received by the VMOs (Assessors were provided with communication from Vascular surgeon receiving his registry results from ANZ Society of Vascular Surgery) and discussed at the Medical Advisory Committee (Minutes of April 2018 noted Australasian Cardiac Outcomes Registry Transcatheter Aortic Valve Implantation (ACOR TAVI) Registry presented); however, this is not currently reported to the Executive.

Clinicians are supported to take part in the clinical review of their practice via the Clinical Review Committee, and the Clinical Advisor roles for each specialty. Subcommittees for the Medical Advisory Committee include Anaesthetic Advisory Committee, Cardiac Care Committee, Endoscopy Committee, General Medicine Committee, Women's and Children's Health Committee.

There was evidence that some risks identified via the review of unwarranted clinical variation are documented in the Risk Management System, with the Flinders Private Risk Register noting "Inadequate management of Antimicrobial stewardship" as a low risk. However, as noted in Action 3.16, the compliance with prescribing against Therapeutic guidelines is low. Ashford Risk Register has also listed "failure to facilitate management of CODE STEMI" as a moderate risk. STEMI (ST-elevation myocardial infarction).

Suggestions for Improvement:

ACHA Health to review the agreement for rotation of Medical Officers with Flinders Medical Centre to ensure there are opportunities for ACHA Health to participate in providing feedback on the performance of Medical Officers during their rotation to ACHA Health.

That Flinders Private Hospital Angiography Suite consider mechanisms for ensuring only credentialed clinicians attend Angiography Suite.

The assessment team support the planned introduction of the DR Lookup function in cGov as this will allow Theatre and other key areas to view Scope of Practice of the VMOs.

That ACHA Health review the Board Governance and Governance Roles and Key Relationship Policy 0.028 to include the quality and safety roles and obligations of the Board.

ACHA Health to develop a framework to ensure the Doctors Standing Orders comply with the Clinical Care Standards, and that there is an auditing, monitoring and evaluation framework for ensuring compliance with ACSQHC Clinical Care Standards.

ACHA Health to update the cGov scope of practice definitions for Colorectal Surgery to include Colonoscopy and Endoscopy as a specific scope of practice. ACHA Health to update the Colonoscopy policy to include General Surgeons with Colonoscopy credentials as authorised to perform Colonoscopies.

ACHA Health to integrate reports from clinical registries into the reporting schedule at Executive committees and ensure any variations in clinician practice or themes are identified and actioned.

ACHA Health to review clinical risks on the Risk Register that relate to Clinical Care Standards, and for risks that have demonstrated poor compliance or significant variations in practice; that the ratings appropriately reflect the level of risk.

Action 1.19

The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

The Board's role in quality and safety is outlined in the Board Governance and Governance Roles and Key Relationships 0.028. Of note, the policy does not explicitly state the quality and safety roles of the Board (see commentary in item 1.25). Members of the Board receive Induction by the Clinical Risk/Quality Manager of ACHA Health, outlining the general Clinical Governance System at ACHA Health, but not specifically their role in ensuring and monitoring quality and safety.

Recommendation:

ACHA Health include explicit outline in the Board orientation of their specific role in quality and safety, and the expectations of their role as Board Director for ensuring quality and safety within ACHA Health.

Risk Rating:

Moderate

Risk Comment:

The introduction of explicit statements on the Boards Quality and Safety Roles will assist to reduce this risk.

Action 1.20

The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

ACHA Health does not currently outline a Mandatory Training Framework for VMOs, and it is not included in the Medical Services Regulations. The assessment team met with members, including the Chair of the Medical Advisory Committee, who noted that approximately 75% of the VMOs also hold appointments at public hospitals, which require mandatory training, and VMOs may be open to a mutual recognition process for recognising the training performed at the public hospitals.

Recommendation:

ACHA Health implement a Mandatory Training framework for VMOs that supports mutual recognition of appropriate training performed at other health services, and also develops specific Mandatory Training required of VMOS whose sole hospital appointment is with ACHA Health.

Risk Rating:

Moderate

Risk Comment:

Introduction of a mandatory training framework for VMOs would significantly reduce this risk and would assist at improving compliance with other criteria that relate directly to medical staff roles e.g. appropriate antimicrobial prescribing.

Action 1.21

The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

ACHA Health has recently implemented a cultural awareness and sensitivity learning package, incorporating ATSI training. Of note, the package development has not involved the Aboriginal Consumer to date. The assessment team viewed compliance with training of 49% completion across ACHA Health.

Recommendation:

ACHA Health seek guidance from the Aboriginal Consumer on the appropriateness of the Cultural awareness and sensitivity learning package and ensure active engagement from Aboriginal consumers in further enhancements to the program.

Risk Rating:

Low

Risk Comment:

Consultation with the Aboriginal Consumer would assist to reduce this risk.

Action 1.22

The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

Medical Services Regulations for VMOs do not currently include a Performance Review Framework. Discussions with the Medical Advisory Committee confirmed that there is currently no Performance Management Framework for VMOs. Clinical cases are reviewed within the Clinical Review Committee, and any VMO performance issues identified within the Clinical Review Committee are referred to Medical Advisory Committee.

Recommendation:
ACHA Health implement a Performance Review framework for VMOs and Surgical Assistants that is linked to clinical outcomes and compliance with Medical Services Regulations.
Risk Rating:
Moderate
Risk Comment:
Performance Review Framework for VMOs and Surgical Assistants would assist to reduce this risk.

Safe environment for the delivery of care

Action 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.30	
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.32	
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health provides a safe environment for care through the use of an effective workplace health and safety system complemented by effective maintenance systems. In recent times there have been a number of building works undertaken and ACHA Health has been able to safely maintain services and provision of clinical care throughout. These works are still in progress and the maintenance staff should be congratulated on their efforts.

ACHA Health has undertaken the processes necessary to self-insure for workplace health and safety and this has resulted in a very comprehensive risk management approach. This approach has reduced workplace injuries and the number of staff on return-to-work programs. Return-to-work has been more rapid than previously which further demonstrates the value of the systems. The compressive risk management approach to workplace safety may be a model for ACHA Health to replicate for clinical safety.

All ACHA Health facilities have areas of calm refection for staff, patients and visitors. Even though there are no specific mental health services provided and the proportion of challenging clients is low, all facilities have the capacity to manage these patients effectively.

Signage and way finding for patients is challenging through the building works and consumer consultants have been used to review and improve signage.

ACHA Health has flexible visiting arrangements where it is clinically appropriate.

ACHA Health has recently commissioned ATSI artworks which reflect the local environment, and these have been tastefully placed to make the entrance areas for the facilities more welcoming for Aboriginal and Torres Trait peoples. The requirements of Advisory AS18/04 are met or well advanced with recommendations and suggestions as required.

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action 2.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The Community Engagement Plan and Partnering with Consumer Framework together with policy and procedures provide the structure and direction to manage consumer engagement and participation in the service planning of the health service. It was evident that quality improvement was at the centre of all decision making and with consumer consultants engaged in the design and delivery of quality projects and with the Consumer Advisory Committee reporting directly to the Quality and Safety Committee.

Consumer representatives are appointed to operational and clinical committees and contribute to the transparency of process in the service planning and decision making. Consideration for appointment may include specific interests, experience and capacity to engage with the organisation and with the patient population. Consumer consultants attended the SA Consumer Focus Group, The Health Expo – Kids Tour Downunder and Christmas Carols, and this is an opportunity engage with the general community and to represent and promote ACHA Health.

Consumer Advisory Committee members participate in the review of incidents, consumer feedback, the development and review of patient information, identify risks and areas for improvement. Evidence presented to the assessment team confirming a structured and systematic approach to evaluation and review and with alignment to the Consumer Engagement Plan.

Consumer representatives attend ACHA Health Orientation at commencement and are offered opportunities to participate in ongoing education.

ACHA Health consumer consultants may present lived experience stories as part of the orientation of newly recruited clinical staff and address the Executive and Board on invitation. The development of multi-media information adds value and scope of information for delivery to new and current staff. The consumer consultants/representatives interact with patients, clinical and operational staff as part of their communication role and informally share knowledge and experience. This a valued resource, and with examples of where it has been, the driver of changed practice.

Partnering with patients in their own care

Action 2.3	
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights16 b. Easily accessible for patients, carers, families and consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.4	
The health service organisation ensures that its informed consent processes comply with legislation and best practice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.5	
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.6	
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.7	
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

Consent processes are underpinned by policy and procedure and with evaluation of audits identifying areas for improvement. The avenues for obtaining of patient consent for procedure are dependent on the patient pathway to their planned procedure. Consent may be obtained by the consulting specialist in their rooms prior to admission, at the time of patient registration and admission to hospital at which time Financial Consent is obtained in accordance with the requirements of AS 18/10. Consent audit results confirmed that 100% of patients were consented prior to commencement of all procedures and with Surgical Safety Checklists and Team Time Out audit results confirming compliance with safe practice for the obtaining of patient consent, although inconsistencies were noted across the three hospitals and a suggestion has been made to improve this element.

Systems exist for patients who do not have capacity to make decisions themselves and with staff able to articulate examples of supporting the patient, family/carer through the of process of making an informed decision. The Chaplains at each hospital provide emotional and holistic support for patients, family and staff and are valued members of ACHA Health. It was evident to the assessment team that clinical staff were skilled and invested in engaging patients/families to participate in shared decisions about their health care journey.

The assessment team visited inpatient wards at each hospital and observed clinical staff engagement with patient and families and with patients actively participating in the care decisions and preferences including at the clinical handover of their care. This was observed at staff shift change, returning from theatre, admission to the ward and with medical, nursing and allied health staff active participants in the process.

Suggestions for Improvement:

In the Operating Suites across the three hospitals consistent measures to flag as yet unsigned consent forms/amendments to consent forms should be introduced as the process differs in each facility.

Health literacy

Action 2.8	
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.9	
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.10	
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Consumer Consultants are integral to the development and ongoing review of patient and carer published health care information. The "Consumer Approved Publication" logo confirms that the consumer consultants have been part of either the development and/or review process.

The Top Ten Tips – Caring for ATSI Peoples developed in consultation with ATSI consultants and is available in the entrance and throughout the hospitals.

The ATSI consumer representative is a key contributor in the development and publication of information for ATSI consumers and in the design and placement of ATSI Art Works and plaques throughout the ACHA Health facilities.

ACHA Health utilise the National Interpreter Service when necessary. The diversity of the population is monitored to identify changes to the population demographics of the patient population and with reporting through the Safety and Quality Committee. Cultural inclusion is a key influencer in the provision of clinical services and with written and verbal communication delivered that is easily understood and consistent with improving patient care.

Partnering with consumers in organisational design and governance

Action 2.11	
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.12	
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.14	
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Consumer feedback, complaint and compliments together with incident reviews contribute to service business planning development and outcomes. Consumers are consulted and participate in the evaluation and review of complaints and incidents and the development of quality improvement activities. The Safety and Quality Committee is the conduit for Consumer Group reporting to the Executive and the Board.

ACHA Health has responded to the challenge of undertaking major building works at Ashford and The Memorial Hospital while continuing to provide quality and safe patient care. The Consumer Consultants and Volunteers provide ACHA Health with formal and informal feedback relating to the impact and comfort of patients, carers, families and the public during the infrastructure upgrades.

Staff can access patient/consumer feedback obtained in the clinical setting from the Ward Unit Communication Book and, if appropriate, view on the ACHA Health Facebook page.

Identification of improvements and reduction or risks were presented as consumer-initiated quality and safety improvements. An example presented to the assessor team at the Flinders Private Hospital related to the lack of a defined/safe road crossing from the Car park to the Hospital entrance. Consultation with the local Council Authority resulted in the installation of safe and marked pedestrian access. The Consumer consultants were also integral to taste-testing and approving the reviewed Patient Menus, advising on new bedding and beds, assessing cleanliness, the evaluation of complaints and compliments and with reporting to the Safety and Quality Committee. The mobility impaired consumer evaluated, trialled and improved the mobility of disability equipment, hence adding value to staff and patient manual handling safety.

ACHA Health values and recognises the many volunteers that contribute to enhancing the patient experience, undertake administration and transport support, evaluation and monitoring of safety and risk identification.

ACHA Health patient registration provides the opportunity for consumers to voluntarily identify as Aboriginal and/or Torres Strait Islander.

“In 2017, Healthscope formed a National Aboriginal & Torres Strait Islander Working Group comprising hospital based clinical and non-clinical staff, as well as Aboriginal and non-Indigenous consumers to provide a forum for discussion and coordination of our reconciliation activities”.

ACHA Health celebrated the launch of their Aboriginal and Torres Strait Islander Reconciliation Action Plan in 2019. Supporting documentation describes activity to achieve deliverables in the action areas for relationships, respect and opportunities. However, it was not clear that there is a strategy or inclusion that the health needs of ATSI consumers have been identified. ATSI engagement was noted as a standing agenda item on the Patient Care, Safety and Quality and Executive Committee meeting minutes and with activity aligned with the aims and objectives described in the Reconciliation Plan.

The recommendation applied to Standard 1 Action 1.4 defines actions to identify, implement and monitor health improvement strategies. This recommendation aligns with the intent of Standard 2 Action 2.13. “The Health Service organisation works in partnership with ATSI communities to meet their healthcare needs”.

The ACHA Consumer consultants collect, review and evaluate feedback provided by the consumers and patients of the health service and are a conduit for informal community feedback. Their views and lived experience journeys may be incorporated for presentation at Staff Orientation and Training and present updates to the Safety and Quality and Executive Committees.

Suggestions for Improvement:

The Adelaide Community Health Alliance refer to the Australian Commission on Safety and Quality in Health Care “Advisory AS18/04: Advice on the applicability of ATSI specific actions” and determine if the Requirements for Compliance apply.

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Action 3.1	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.4	
The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that: a. Collects data on healthcare-associated infections and antimicrobial use relevant to the size and scope of the organisation b. Monitors, assesses and uses surveillance data to reduce the risks associated with healthcare-associated infections and support appropriate antimicrobial prescribing c. Reports surveillance data on healthcare-associated infections and antimicrobial use to the workforce, the governing body, consumers and other relevant groups	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health has policies and procedures that are provided through a Healthscope contract with an expert private company Healthcare Infection Control Management Resources (HICMR) and these are current, evidence based and encompass the priority areas for infection prevention and control. They are regularly reviewed and risk assessed. The ACHA Health Infection Control Committee provides the clinical governance structure to manage risks associated with Healthcare Associated Infections (HAI). This multidisciplinary committee has representation from medical, nursing, microbiology, pharmacy, environmental and the ward champions. The most significant risk identified related to the major building works currently underway across the three hospitals. These will be further discussed in Action 3.12. There is an Infection Control Nurse Manager at each site who liaise closely and meet regularly.

A range of quality improvement initiatives has been implemented to improve the identified risks that include potential risks associated with the heater / cooler system for cardio thoracic surgery and Loan sets that arrive from suppliers with contaminated material still on the instruments. There are approved brochures available for patient information that have had ACHA Health consumer reps review for appropriateness and health literacy. Nurses explain to the patient what is in the brochure and obtain feedback that they understand. The assessors spoke with consumer reps who reiterated they are involved in their care.

Surveillance is not mandated for private hospitals in South Australia; however, ACHA Health has implemented a comprehensive electronic system for the capture of surveillance data that also incorporates the Healthscope program. The pathology service forwards a real time report on organisms of significance to the Infection Control Nurses who review these, notify the ward and medical officer and advise a plan of care if required. The results are collated to comply with the set surveillance parameters, have action plans developed and these are then reported three-monthly to the ACHA Health Infection Control Committee and the Medical Advisory Committee. Audit results seen by the assessors show very few infections and there is a steady downward trend. Infection data is also forwarded and reported through the ACHS Clinical Indicator Program.

Infection prevention and control systems

Action 3.5	
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.6	
Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs to manage infection risks d. The need to control the environment e. Precautions required when the patient is moved within the facility or to external services f. The need for additional environmental cleaning or disinfection g. Equipment requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.7	
The health service organisation has processes for communicating relevant details of a patient's infectious status whenever responsibility for care is transferred between clinicians or health service organisations	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.8	
The health service organisation has a hand hygiene program that: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.9	
The health service organisation has processes for aseptic technique that: a. Identify the procedures where aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.10	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare[18]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.11	
The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements – that: a. Respond to environmental risks b. Require cleaning and disinfection in line with recommended cleaning frequencies c. Include training in the appropriate use of specialised personal protective equipment for the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.12	
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings c. Handling, transporting and storing linen	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.13	
The health service organisation has a risk-based workforce immunisation program that: a. Is consistent with the current edition of the Australian Immunisation Handbook[19] b. Is consistent with jurisdictional requirements for vaccine-preventable diseases c. Addresses specific risks to the workforce and patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

HICMR policies direct the standard and transmission-based precautions and these meet current guidelines and legislative requirements. Patients presenting with or acquiring infections are identified promptly and receive necessary management and treatment. There is an electronic alert entered on WebPAS, the patient management system, to identify those with an identified infection so appropriate screening, precautions and placement may be commenced. The infectious status is also identified at clinical handover. The signage used for these precautions are those provided by the Commission and the assessors sighted occasions when precautions were in place with good compliance.

The communication when patients need to be transferred in or between service facilities is well documented to minimise exposure. This communication occurs between the clinical areas via the transfer forms and clinical handover.

Hand Hygiene audit reports across ACHA Health reflect consistently better than 85% compliance. Medical staff compliance demonstrated a need for improvement and strategies include informing them immediately of hand hygiene requirements, information in the medical newsletters and discussion at MAC. The latest report identifies medical rates at 70%. Hand Hygiene reports are tabled at MAC and the Safety and Quality Committee. Consumers are aware they may ask clinicians about hand hygiene practice and feedback from them is positive.

Audits, schedules, training, training records and compliance data was presented on the invasive devices and aseptic technique programs across the organisation which all met the requirements. A risk assessment was completed on each area identified as the procedures where aseptic technique applies and include intravenous therapy, simple dressings, urinary catheterisation and the management of vascular access. An annual aseptic technique audit to measure compliance with practice demonstrated excellent results. The completion of aseptic training for all the clinical workforce is consistently around 100%.

Cleaning practices at ACHA Health are based on the Cleaning Standard for South Australian Healthcare Facilities 2014 and HICMR policies and procedures. These are supported by work schedules, internal cleaning audits, chemical management and workforce training. During assessment, assessors commented on the high standards of cleaning across the organisation in high visibility areas, but back of house the paint chips and marks on walls are a potential risk and a preventative and general maintenance program would mitigate the risk. There is a suggestion to emphasise and address the risk. Food services audits demonstrate a safe environment for food handling and supported by the audit processes. The management, storage and distribution of linen is compliant with Australian Standards.

ACHA Health is undergoing significant building works across all hospitals including high-risk areas that continue providing a service. Of note was the upgrade to the CSSD and operating theatres at Memorial Hospital. The infection control processes to evaluate and manage these risks has been substantial. The use of the HICMR Construction/Renovation of Healthcare Facilities – IPC Risk Management Toolkit and the accompanying Action Plan provided the basis for control. There are daily reviews of the works by the Nurse Unit Manager and the contractors with regular input from the Infection Control Nurse Manager. Non-compliance or concerns are discussed and responses documented. Those involved have managed the risks well, as to date there have been no infections recorded specific to the building works.

Workforce immunisation is a pre-requisite of employment for all staff, clinical, non-clinical and new staff must meet all the requirements. Existing staff are offered the program and risk assessed if they work in high-risk areas. Immunisation and occupational exposure management are supported by policy, procedures and workforce training.

Suggestions for Improvement:

A preventative and general maintenance program to repair and maintain the walls in the “back of house” corridors would assist with infection risk mitigation.

Reprocessing of reusable medical devices

Action 3.14	
Where reusable equipment, instruments and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The Central Sterilising & Supply Departments (CSSDs) across ACHA Health were reviewed and found to be compliant with requirements for managing the reprocessing and sterilisation of reusable devices. Although major renovation was being undertaken at the Memorial Hospital CSSD, the practices followed processes to meet the standards. HICMR audits of the three hospitals in April 2019 showed greater than 90% compliance. A manual tracking system is used in two of the CSSDs and they will be implementing an electronic system when all the software and computers are available. All staff who reprocess reusable medical devices have completed the recommended training or are undertaking the program.

Endoscopy and the reprocessing of scopes follows the recommended manufacturing guidelines. All staff who reprocess reusable devices have completed the required education and undertake regular updates. The assessors sighted cleaning of these devices and noted practices meet the requirements of relevant policies and procedures.

As per Advisory AS18/07 (August 2019) a gap analysis on the reprocessing of reusable medical devices in healthcare organisations was sighted by the assessors. The progress to date on the implementation of the accompanying action plan has been met to current arrangements and evidence was provided of progress.

Antimicrobial stewardship

Action 3.15	
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard[20]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.16	
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health has a system for antimicrobial stewardship (AMS), as outlined in the Antimicrobial Prescribing and Management 18.53 policy, with reference to the Clinical Care Standard. Access to Therapeutic Guidelines are available to the workforce via the ACHA Health intranet site. The organisation is compliant with AS 18/08 although recognises that compliance requires ongoing vigilance and each hospital has ongoing work to do in this regard. A recommendation has been made.

Flinders Private Hospital 2017/2018 report demonstrated that ICU and 4 South are the highest users of high cost restricted antimicrobials, mostly orthopaedic infections. High use of Gentamicin across the hospital is likely due to urological surgery.

A restricted antimicrobial list was implemented in 2016 and reviewed and updated in 2018.

Audits conducted by the Hospital Pharmacy Service against the Therapeutic Guidelines identified in August 2019 Flinders Private Hospital, only 27.3% of results demonstrated antibiotic prescribed meets the recommended Therapeutic Guidelines and Ashford only 53.3% met the recommended Therapeutic Guidelines. The results have been escalated to the Medical Advisory Committee and published in the VMO newsletter.

Action 3.16

The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

A restricted antimicrobial list was implemented in 2016 and reviewed and updated in 2018.

Audits conducted by the Hospital Pharmacy Service against the Therapeutic Guidelines identified in August 2019 that at Flinders Private Hospital, only 27.3% of results demonstrated Antibiotics prescribed meets the recommended Therapeutic Guidelines and at Ashford Hospital only 53.3% met the recommended Therapeutic Guidelines. The results have been distributed to the Medical Advisory Committee and published in the VMO newsletter.

Recommendation:

ACHA Health to ensure compliance with its Antimicrobial Stewardship Framework.

Risk Rating:

Moderate

Risk Comment:

Improvements to the compliance with the Antimicrobial Stewardship Framework will reduce the risk related to this Action.

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action 4.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 4.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 4.3	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.4	
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The assessment team found it difficult to identify a formalised governance structure for the establishment of safe processes for the governance of medicines and to manage associated risks. The NSQHS Medication Safety Standard indicates that organisations are expected to have a governance group and this usually takes the form of a committee that will provide direction to meet the Standard and monitor the risks associated with medication safety. There are stand-alone Medication Safety Working Party / Sub-Committees at each hospital; however, it was difficult to determine the reporting lines for these committees. During assessment, the assessors discussed these concerns with ACHA Health senior management and a Medication Governance Action Plan, specific to each hospital, was provided to assist with the implementation of a governance structure and the mitigation of risks. A recommendation has been made in relation to governance under Action 4.1.

The assessment team also considered whether the risk recognition and mitigation strategies meet the demands of high-risk safety and quality requirements. A recommendation has been made to risk assess how a formal Medication Governance Committee would meet these safety and quality requirements for medication safety.

The Medication Safety Governance Policy provides the guiding principles for medication management and numerous instances of non-compliance to the policy were observed throughout ACHA Health. These included consistent reporting from the contracted pharmacy - HPS Pharmacy, imprest management, locking of drug room doors and storage of high-risk medications. The Medication Governance Action Plan has an action to implement a Medication Safety Walk Around Audit to review these inconsistencies and includes high-risk medicines, patient's own medicines, storage, incident review and general issues. Initial and ongoing audits will be conducted and reported.

There is routine collection and monitoring of data for compliance with medication safety and to assist with quality improvement. Complete documentation of all the components associated with medicines demonstrated inconsistency when the annual audit was conducted on the National Standard Medication Chart (NSMC) under the "Medical Record – Paper-Based Documentation" audit. Results viewed by the assessors showed low levels of compliance in some sections of these audits and the ongoing monitoring for effectiveness, and performance of medication safety could be strengthened to provide assurance of risk reduction. There is a recommendation for a proactive response to these shortfalls.

Medication incidents are reported in RiskMan and clinical staff are aware of the reporting requirements. The assessors reviewed incidents reported and the ensuing investigation and feedback. ACHA Health has a Medication Reflection Tool where managers and nurses reflect on incidents/near misses and talk through what happened, how it could be improved and lessons learned. The Healthscope "Shared Learning Reports" are generated following an event of significance and debrief and is sent to all Healthscope facilities for learning opportunities.

Patients reported their involvement in their medication management and care meets their requirements. The information provided either during admission when a new drug is prescribed or on discharge is explained in detail and they are asked if they understand.

Clinicians prescribe, dispense and administer medication in line with their scope of practice and their qualifications are verified. The Medication - Orders and Administration Policy describes the process and the accompanying procedure outlines the responsibilities for each clinician.

Action 4.1

Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

The assessment team found it difficult to identify a formalised governance structure for the establishment of safe processes for the governance of medicines and to manage associated risks. The establishment of a governance group with responsibility for comprehensive management, usually a Medication Safety Committee (or similar), provides direction to meet the NSQHS Standard and monitor the risks associated with medication safety through regular review of audits and provide action plans to improve compliance and completion. Following discussion with ACHA Health senior management a Medication Governance Action Plan, specific to each hospital, was provided to assist with the implementation of a governance structure and the mitigation of risks. It would be beneficial for the outcomes of these plans to be reported as an ACHA Health report as many of the identified measures were relevant to each hospital.

Recommendation:

1. Implement the measures identified in the Medication Actions Plan with ongoing monitoring and outcomes reported to the relevant committee.

2. As per the recommendation in Action 1.10, conduct a risk assessment as to whether a more formal Medication Governance Committee would provide assurance to the organisation to meet the safety and quality requirements of the Medication Standard.

Risk Rating:

Moderate

Risk Comment:

While there are some risk management processes in place, they are not sufficient to manage and provide governance for the Standard.

Action 4.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

The monitoring of medication incidents and the auditing of compliance with medication safety assist with quality improvement and safety. Complete documentation of all the components associated with medicines demonstrated inconsistency when the annual audit was conducted on the National Standard

Medication Chart. Results viewed by the assessors showed low levels of compliance in subsections of these audits and the ongoing monitoring for effectiveness and performance of medication safety could be strengthened to provide assurance of risk reduction.

Recommendation:

Review the audit process for medication safety to provide assurance that low levels of compliance are identified, actioned, monitored, reviewed and outcomes reported in a timely manner.

Risk Rating:

Moderate

Risk Comment:

Some results of audits on documentation require further action and monitoring in a timely manner.

Documentation of patient information

Action 4.5	
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.6	
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.7	
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.8	
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.9	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Assessment Team Summary:

There are policies for obtaining a Best Possible Medication History (BPMH), Medication Reconciliation and Alerts. The ward nurses obtain the patients BPMH and this commences on admission. The history includes both prescribed and non-prescribed medications and is correlated to medicines documented in the Patient Health Questionnaire completed before admission. A flowchart explains the "Patients at risk of medication related harm" and if one or more risks are identified the action required is documented. This may indicate a referral to the Clinical Pharmacist for a medication review.

There are processes for completion of the Medication Management Plan for admission, numerous handover situations and discharge. The National Standard Medication Chart (NSMC) is checked by clinicians at handover for completion and patients are asked if they have any questions about the medicines that have been prescribed. Reconciliation of medicines is completed using the medicines brought in by patients or confirmation from the GP or patient's pharmacist. The BPMH and reconciled list is used by the medical officer to prescribe the medications on the National Standard Medication Chart. There are times when a telephone order for a medication is required by the nursing staff and these require the medical officer to sign the order within 24 hours. Audits have shown poor compliance by the medical officers. An action plan was implemented and discussed with the doctors, and processes have been implemented for improvement, and subsequent audits confirm this with ongoing prompting.

There is education provided to staff by the pharmacists to ensure these processes are conducted in accordance with policy and legislation and stressing the importance and need of accurate information.

Information is obtained at admission to ascertain any drug allergies and adverse drug reactions (ADR). These are recorded on the Alert Sheet available in every history and contains the drug, the effect, source and signature of person entering information. ADRs are also entered into WebPAS. All patients wear white identification bands to ensure that clinicians ask the patients if they have any allergies at administration of medications. Should a patient experience an ADR during admission it is documented in the medical record and a RiskMan record is completed. The patient is informed of the allergy and given information about what happened and what to report in future admissions. Their GP is also notified. A policy for reporting an ADR to the Therapeutic Drugs Administration explains the requirements and the pharmacist is involved in the reporting.

Continuity of medication management

Action 4.10	
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

At ACHA Health there is one pharmacist available at each hospital under the agreement with HPS. Medications are discussed during clinical handovers and the multidisciplinary meetings and reviewed when necessary. There is an effective process for a formal review by the pharmacist based on clinical need and this review is documented in the medical history. The KPIs reported by HPS showed that the majority of their time is taken with reconciling and generating a current discharge medication list for all patients. HPS have a computer program to generate the discharge medication lists. If the medications are low risk, the nurses may provide explanation of the list; however, for discharge medication lists that contain new or high-risk medications, the pharmacist sees the patient.

The pharmacist liaises with the community pharmacy if the patient requires a Webster pack and if there have been changes in medications during admission.

Discharge medication summary is part of the medical summary sent to the patient's GP and if the GP will be visited before the medical summary is completed, the pharmacist sends a fax of discharge medications. All International Normalised Ratio (INR) results and current Warfarin dose is faxed to the GP. Appropriate information is provided to patients about their medicines needs and risks.

Medication management processes

Action 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.14	
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.15	
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health has information and decision support tools available electronically at the point of care. These include the Therapeutic Guidelines, Monthly Index of Medical Specialties (MIMS) online, Australian Injectable Drugs Handbook and Antimicrobials Guidelines. Ongoing education is provided on their use and monitored.

The assessment team observed issues with the safe and secure storage of medicines. The medication rooms have swipe access with controls on who may enter; however, one ward had key access and the room was kept unlocked. This was addressed prior to end of the assessment. Each hospital has a pharmacist technician responsible for maintaining the imprest stock in the medication rooms. However, the assessors observed expired stock, storage baskets with multiple strengths of the same medicine, ampoules of potassium chloride and excessive stock in the medication rooms. This has been included in the Medication Governance Action Plan with identified actions required that include regular auditing and consistent reporting by HPS.

The Controlled Drugs – Storage and Administration of Policy directs how high-risk medicines are safely managed. The assessment team identified situations where the identification, storage and strategies to reduce the risks associated with high-risk were inconsistent across the organisation and did not follow this policy. Mostly high-risk medicines are managed well, such as for chemotherapy. There are daily medical and pharmacy reviews for all chemotherapy and the time out procedure checklist has prevented errors. The practices for the management of Schedule 4 and 8 drugs complies with policy and the assessors observed that the checking process in the operating suite meets legislative requirements.

The capacity for some clinical members to identify high-risk medicines and therefore recognise the risks associated with their use, storage, access to and administration requires review and education of work practices. The anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants (APINCH acronym) is used at ACHA Health to identify these medicines and is prominently displayed throughout the wards. Of note was the storage of potassium chloride ampoules that was inconsistent at all hospitals and not in line with the Policy for Potassium Chloride - Storage and Administration. A structured framework is required for the monitoring and review of high-risk medicines and there is a recommendation to implement and develop a framework.

Action 4.15

The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely

This recommendation applies to all Health Service Facilities within this Health Service Organisation

Assessor Rating: Met with Recommendation

Assessor Comment:

The assessment team identified situations where the identification, storage and strategies to reduce the risks associated with high-risk medications were inconsistent across the organisations and did not follow policies and procedures. The capacity for some clinical members to identify these medicines and therefore recognise the risks associated with their use, storage, access to and administration requires review and education of work practices. Of note was the storage of potassium chloride ampoules that was inconsistent at all hospitals and not in line with the Policy for Potassium Chloride –Storage and Administration.

Recommendation:

Develop and implement a structured framework for the monitoring and review of high-risk medicines.

Risk Rating:

Moderate

Risk Comment:

Some high-risk medicines are managed well but inconsistencies occur that may influence all these drugs.

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

Action 5.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.4	
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.5	
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.6	
Clinicians work collaboratively to plan and deliver comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health has in place safety and quality systems to support clinicians to provide comprehensive care that is aligned to the patient's goals and minimises patient harm. Evidence-based policy and procedures are in place to guide practice. Organisation wide screening and assessment processes are in place. Clinical audit results along with the data from clinical incidents captured on RiskMan is reviewed monthly by the Directors of Nursing and quality managers to identify training needs of the workforce. The care plans reflect the patients physical, mental and cognitive care needs.

The delivery of comprehensive care is monitored and reported back to the workforce through Quality and Clinical Committee minutes and Shared Learnings. Staff were able to discuss improvement activities that had been introduced, for example the introduction of the Patient Board and asking the patient as part of the care planning what their goals of care were and having this documented on the care plan.

Review of the patient's experience is undertaken and ACHA Health consumers were able to discuss with assessors the work they undertake in talking to patients and carers about the care they receive and feeding this back to the clinical leadership. Assessors witnessed on multiple occasions during clinical handover the inclusion of the patient and their carer in shared decision making. Copies of the Australian Charter of Healthcare Rights were prominently displayed in lifts and public areas. Department based quality plans demonstrated the staff's commitment and involvement to implementing quality action plans.

A Healthscope Comprehensive Care Plan that is aligned to the National Standards is in place and is used in conjunction with the Comprehensive Risk Screening form. It supports shared decision making with the patient and carer and identifies the members of the multidisciplinary team involved in providing care. Case Managers play a vital role in discharge planning and ensuring the patient is able to access timely referral to resources within the community. At assessment, the Case Management team provided examples of how they work with patients and carers to access services including through the National Disability Scheme.

It was evident at the assessment that processes are in place to support clinicians develop, document and communicate comprehensive care plans in partnership with patients and carers. Multidisciplinary huddles and morning multidisciplinary team meetings were witnessed during assessment. Patient Boards detailing members of the multidisciplinary team, plan for the day and discharge are in place.

Developing the comprehensive care plan

Action 5.7	
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.8	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.9	
Patients are supported to document clear advance care plans	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.10	
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Action 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.13	
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health's processes for integrating timely screening, assessment and risk identification of their patients begins with the pre-admission screening process. There are a number of risk assessments completed on and throughout admission, for example Nutrition Screen, Falls Risk Assessment and Pressure Injury Risk Assessment. At assessment, assessors were able to view risk assessment screening being undertaken in the clinical areas including emergency department which identified risks that influenced both accommodation selection and comprehensive care planning. A gap analysis as per the requirements of the Australian Commission on Safety and Quality in Health Care Advisory 18/14 has been complied with.

ACHA Health's admission documentation asks if patients identify as being of Aboriginal and/or Torres Strait Islander origin. Admission staff have been provided with Asking the question – Are you of Aboriginal or Torres Strait Islander decent education package. 2018 demographic data shows 0.49% of ACHA Health admissions identify as Aboriginal and/or Torres Strait Islander.

Policy documents about end-of-life care and information for patients and carers that includes advance care planning are in place. As part of the pre-admission process patients are asked if they have an Advance Care Directive. ACHA Health has the resource of onsite Chaplin service as part of a multidisciplinary care team to support patients with documenting advance care plans.

As part of the admission process, patients have a falls, pressure injury, malnutrition, cognitive/delirium and Venous Thromboembolism risk assessment. This provides clinicians with the baseline information to develop the care plan and refer to members of the multidisciplinary team. Based on the risk assessment care decisions will be made for, example, a pressure relieving mattress for the patient with pressure injury risk or a single room for the patient with infection control risks. Any alerts are recorded on the Alert Form which is filed in the front of the patients' medical record. Changes in condition, for example, a patient fall will initiate a repeat risk assessment. Information for families or carers on how to escalate a concern when changes in the patient's condition occurs are displayed on the patient's board in their room.

ACHA Health uses an ISOBAR (identify–situation–observations–background–agreed plan–read back) Care Plan that supports shared decision making, is person centred and goal directed. A gap analysis of the Care Plan has recently been undertaken and a revised care plan was introduced in July 2019. Ongoing auditing of the ISOBAR Care Plan is in place. The workforce receives education on the requirements of the care plan. The requirements of the Australian Commission on Safety and Quality in Health Care Advisory 18/15 have been complied with.

Delivering comprehensive care

Action 5.14	
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.15	
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.16	
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.17	
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Action 5.19	
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 5.20	
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The ISOBAR Care Plan is accessible by the multidisciplinary team at the point of care. The current care plan was introduced in July 2019 and is currently being evaluated. Assessors witnessed clinical staff using the care plan as part of the clinical handover. Members of the multidisciplinary team were able to detail to the assessors how they monitored and reviewed the care plan as needed.

ACHA Health has in place a Last Days of Life Toolkit that is referenced to the National consensus statement: essential elements for safe and high quality end-of-life care provides guidance on recognising dying; care planning; and care after dying for adult patients. ACHA Health has processes in place for clinicians to refer to access specialist palliative care advice while the patient is in hospital and strong community links to refer patients to community palliative care services.

While there is an Advance Care Directives Policy in place, individual hospitals are yet to develop their own local management plan as detailed within the policy. A recommendation has been made.

An Employee Assistance Program is available for staff. Hospitals have quiet rooms available for staff and patients/carers use should they need a private room for reflection. The Chaplin service as part of the multidisciplinary team, provide support for staff and patients.

While all deaths in hospital are reviewed, there is not a process in place for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care. A recommendation has been made.

Action 5.17
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment:
The ACHA Health Advance Care Directive Policy states all ACHA hospitals are required to develop a local policy to inform staff on the appropriate management of patients who have an Advance Care Directive in place. A local policy has not been developed.
Recommendation:
Develop processes to receive, document and provide access to Advance Care Directives.
Risk Rating:
Moderate
Risk Comment:
Without processes to receive, document, and provide access to the patients Advance Care Directive ACHA Health risks not complying with the patients documented treatment directions, wishes and values.

Action 5.19
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment:
ACHA Health has a Last Days of Life Tool Kit in place that assists clinicians providing end-of-life care and documents there should be a daily review of care with the patient and/or family. Data about the safety and quality of end-of-life care at ACHA Health is not collected and reviewed to ensure it aligns with the patient's goals of care.
Recommendation:
Implement processes for evaluating the safety and quality of end-of-life care.
Risk Rating:
Moderate
Risk Comment:
Without evaluation processes the end-of-life care provided at ACHA Health is at risk of not meeting the patients goal of care.

Minimising patient harm

Action 5.21	
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.22	
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Action 5.26	
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.28	
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.29	
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard47, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Action 5.30	
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.31	
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.32	
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.34	
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.36	
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health has policies and procedures to prevent and manage pressure injuries. Screening tools using the Braden Score are in place. The workforce has access to a comprehensive inventory of aids and products in both prevention and treatment. Patients who are admitted with a pressure injury have the pressure injury photographed once consent has been obtained. A review of care plans within the clinical area demonstrate daily review. A wound consultant is available. Education material for patients and carers was viewed at assessment.

All patients admitted to ACHA Health undergo a falls risk assessment. Policies and procedures are in place. A range of education is provided to patients, for example Falls Prevention brochure detailing strategies patients can initiate to reduce the chance of falling. Incidents of falls are entered into RiskMan and a review of falls risks and interventions is undertaken after any fall. A range of aids to assist in preventing falls is available at all hospitals.

The Malnutrition screening Tool identifies patients at risk of malnutrition at admission. Referral to a Dietitian is available. A range of specialised diet codes to identify specific allergies, intolerances and dietary requirements are in place. Patients identified as being at risk of dysphagia are referred to Speech Therapy.

A large body of work has been undertaken in reviewing policies, resources and risk assessment tools in the management of cognitive impairment and delirium. Clinicians at assessment were able to discuss with assessors the newly introduced Cognitive Impairment Screening Pathway and the Management of Patients with Cognitive Impairment requiring specialling education package that has been made available to them. Education tools for example Cognitive Impairment brochure is available for carers.

A policy is in place to guide the management of patients at risk of self-harm which includes the upward transfer of the patient. Staff education packages, for example Workplace Aggression and Violence are in place. Code Black training is provided. Code Black incidents are recorded into RiskMan. Assessors witnessed staff within the clinical area using de-escalating strategies with an aggressive patient. Duress alarms are in place at front reception, emergency department and clinical areas. One nurse to one patient 'Specialling' is the first line option to minimise the use of restraint. Consultation with carers and family of patients with challenging behaviour is recorded in the Family and Nursing Collaboration form. ACHA Health eliminates the need for seclusion by transferring affected patients to more appropriate facilities.

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action 6.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.3	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.4	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Assessment Team Summary:

It was evident that there are suites of ACHA Health policies and procedures to support timely and effective communication of clinical information. Communication for patient safety is well embedded in the clinical governance framework.

There is evidence of improvements in patients consenting prior to procedure and with current audit results achieving 100% compliance. Patients are consented prior to commencement of all procedures. Surgical Safety Check Lists and Team Time Out audit results confirmed compliance with the obtaining of patient consent and that 100% of patients were matched with the consented procedure.

Systems that monitor the effectiveness of communication for patient safety includes audits of the patient clinical records, evaluation of patient surveys, complaints management and the audit of bedside clinical handover. Audit outcomes are communicated to staff at Ward Meetings, Multidisciplinary Clinical Meetings and through the Safety and Quality Committee to the Executive.

Outcomes from “You Said – We Did” initiative are displayed throughout the hospitals and demonstrate the organisations response to patient/consumer concerns and suggestions for improvement.

Planning for Patient Discharge commences on admission and with the electronic summary updated through the patient journey. Patients are invited to provide feedback on their discharge experience 24 hours post discharge and with outcomes informing changes and improvements to the process. Patient transfer within the health service, consulting clinicians, multidisciplinary teams and/or discharge to another service is consistent with the ISOBAR methodology.

Correct identification and procedure matching

Action 6.5	
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.6	
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Patient registration information is obtained on admission to the health service and ACHA Health protocol requires that at a minimum four identifiers are recorded for every patient.

There are several checkpoints throughout the patient journey to confirm patient identification. The assessment team observed ward clinical handovers at each hospital and in differing settings, and with four approved identifier used Patient Identification, the Annual Compliance audits for all the hospitals were between 95% and 100%. Inpatient Wards audit their Clinical Handover processes, confirm compliance or identify deficits with communication to staff through the Ward Communication, at the time of Staff Handover or post on the Staff Facebook Page. ACHA Health does not have a consistent approach to the number of identification bands or the application of patient identification bands and this differs for each hospital. Whilst there is evidence to support this methodology, in practice there was no evidence of improved safe practice.

There is a procedure matching system in place and recent audits demonstrate compliance with process. While the Surgical Safety Checklist and Team Time Out audit results have high level compliance it is common practice that the identification bands are removed for specific surgical procedures, an ID label is applied to the patient and with the bands re-applied post-surgery.

Suggestions for Improvement:

ACHA Health consider standardising systems for application of the number of Patient Identification bands applied to each patient. There was no evidence that variations to the number of Patient Identification Bands applied to a patient have impacted the delivery of safe patient care. This would align process with the Australian Commission on Safety and Quality in Healthcare requirements. An exception to process is the transfer of Flinders Public Hospital patients to the Flinders Private Hospital if there is an intent that the patient will return at the completion of their treatment.

Communication at clinical handover

Action 6.7	
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.8	
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Clinical Handover at the Bedside is planned, scheduled and managed by the Nurse Unit Manager. There are variances to the staff briefing prior to the bedside component commencing and these may include a Team Huddle, Manager Briefing and/or may be multidisciplinary and include a Clinician and/or Allied Health staff.

The assessment team observed bedside clinical handover at each site. ISOBAR is the standard for the patient clinical handover process and it was evident that staff are trained and committed to engaging patients in their goal setting and care preferences.

Evaluation of the Patient Clinical Record Clinical Handover documentation confirms between 95-100% compliance across all the ACHA Health hospitals. Audits are scheduled annually, and with a re-audit scheduled when actions for improvement are identified and completed.

Patient discharge from the Emergency Department (ED) to community service was described as challenging at times. Printed transfer/discharge information accompanies the patient and with the ED clinical staff monitoring the patient journey to arrival and admission to the intended service.

Patients are supported to document questions for their treating clinician and with outcomes and/or changes recorded in the Clinical Record Care Plan.

The Patient Bedside Clinical Handover is well managed, consultative and with patients engaged in the process.

The ACHA "Back to Bedside" project no longer supports the use of the hourly round form. The policy relating "Hourly Rounding" has been amended to reflect the change and now better meets individual patient needs.

Suggestions for Improvement:

ACHA Health audit and evaluate documentation in the patient clinical record for the transfer of care in all the differing settings where the transfer of a patient occurs.

Communication of critical information

Action 6.9	
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.10	
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The introduction of "Care Boards' for each inpatient of ACHA Health is a new initiative and is proving effective as a pathway for the patient's, family/carers to identify and record their observations and to escalate their concerns to the nursing and medical staff.

Patients are supported by the nursing staff to document their concerns for discussion with their treating medical officer. This method is reported as a catalyst for informative and productive discussions which may be informal or recorded in the patient medical record.

The hard copy patient Clinical Record follows the patient throughout their journey. Operating suites, Day Procedure and Intensive Care Units are examples of where critical and current documentation is specific for the current procedures and episodes of care and is later collated into the Clinical Record.

Patients are invited to provide Feedback on their hospital experience within 24 hours of discharge. 80% of patients indicated they were satisfied with all aspects of their stay.

Training is scheduled annually across ACHA Health for "Recognition and Response to Clinical Deterioration" (1343 enrolments, 91% completion - remainder not started, in progress, exempt or recompletion required) and Recognition and Response to Medical Emergencies (194 enrolments, 85% completion - remainder not started, in progress, exempt or recompletion required).

The Procedure for the Escalation of Patient Care has a number of steps to escalate concerns and with nursing staff stating that the Medical Officers respond rapidly to urgent calls. Basic Life Support (BLS) is a mandatory competency for nursing staff and with an Advanced Life Support (ALS) trained nurse on each ward shift.

ACHA hospitals have 24 hour on-call Medical Officers and with the Medical Emergency Team (MET), the first responders for a patient medical emergency.

Documentation of information

Action 6.11	
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health uses a paper medical record system which is underpinned by policy and procedure. Medical record audits are scheduled annually. When audit evaluation identifies areas for improvement, staff education to improve documentation is undertaken and a re-audit scheduled.

Nurse initiated electronic Patient Discharge Summaries are reviewed throughout the patient journey and with copies sent to the consulting medical officer on patient discharge.

A number of medical record departments were visited. Medical record departments have restricted access and with systems in place for secondary storage and archiving. Current patient records were stored at nurse's station and with relevant sections of the patient record available at point of care.

There is no evidence of intent as yet to implement an electronic patient health record and the current paper-based system appears adequate to meet clinician need.

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action 7.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 7.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health has a decentralised approach to the management of blood and blood products and does not have a specific governing committee; instead relying on site specific processes to oversight local practice underpinned by a suite of ACHA-wide policies. These policies include the key policy Blood Transfusion – management of patient, blood and blood products; and others guiding massive transfusion, emergency use of un-crossmatched red cells and patients refusing blood/blood products.

Safety and quality systems are in place to monitor compliance with the various policies and manage associated risks particularly in relation to the high-risk nature of the clinical profiles at Ashford Hospital, Flinders Private Hospital and The Memorial Hospital.

Risk management relating to blood and blood product practice, haemovigilance activities and blood waste monitoring are the remit of individual hospitals via each facility's Quality Managers. Blood and blood product incidents are negligible in number, and appropriately reported and investigated across the three sites. The organisation participates in haemovigilance activities although transfusion reactions and incidents are rare. In Action 1.10 a recommendation was made regarding the introduction of formal structures to perform these functions in a more coordinated and comprehensive manner. Accordingly, a recommendation has been made under Action 7.1 to conduct a risk assessment as to whether a more formal committee structure would provide assurance to the organisation to meet the safety and quality requirements of Standard 7.

Expert guidance and support are provided by three private Pathology providers which offer an effective 24-hour service to ensure continuous blood supply to ACHA hospitals. Additional support is available from a specialist haematologist from Flinders Medical Centre which is co-located with Flinders Private Hospital.

An effective training program in regard to blood management is in place. At the time of assessment, all relevant clinical staff had undertaken the online BloodSafe module with training rates being 100% in almost all clinical areas.

Several examples of quality improvement activities were noted by assessors. Porters/wards persons are trained in the safe transportation of blood. Specimen errors have been significantly reduced through education and a zero-tolerance policy by private Pathology providers.

A Massive Transfusion Protocol is in place and has been effectively instigated on a number of occasions.

The organisation has a number of resources available to provide information and communicate with patients and carers.

Information regarding consent, and answers to common questions related to blood transfusion were available in most wards via specific blood transfusion forms. Medical patients (who are most likely to receive blood via elective process) provide informed consent in this manner.

Audits demonstrate that patients who receive a blood transfusion generally feel that communication has been appropriate and that they understand the risks involved in transfusion.

Action 7.1
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: Each facility within ACHA Health has different processes and varying degrees of effectiveness in governing Standard 7.
Recommendation:
In reference to the recommendation in Action 1.10, conduct a risk assessment as to whether a more formal committee would provide assurance to the organisation to meet the safety and quality requirements of Standard 7.
Risk Rating:
Moderate
Risk Comment:
A more formalised structure with appropriate terms of reference would reduce quality and safety risks in regard to Standard 7.

Prescribing and clinical use of blood and blood products

Action 7.4	
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.5	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.6	
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 7.7	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.8	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Assessment Team Summary:

Blood management policy at ACHA Health describes requirements for documentation of patient information and an audit program is in place to monitor compliance. A comprehensive checklist has been in place on the Transfusion Pathway to promote accurate recording of information although this is no longer in use at all three sites as alternative mechanisms have been introduced in an effort to better capture required information for safe transfusion.

Audit results on comprehensive completion of documentation are variable and it is noted that the sample sizes are lower than would be considered optimal. Improvements could be made in regarding to the recording of consent (particularly for surgical patients), cessation of transfusion and fluid balance charting. A recommendation has been made in this regard. Observations during transfusion are generally well documented.

The monitoring of adverse reactions is well done and appropriate reporting is in place. Reaction numbers are low but the system defines mechanisms for reporting to service providers, blood service or product manufacturer as warranted.

Many processes relating to management of the need for, and minimisation of inappropriate use of blood and blood products are conducted outside of ACHA Health's control through individual medical clinician's practices. However, increasingly patients are attending day procedure centres for iron infusion and other blood sparing procedures. Patients undergoing major surgery are monitored by physicians and anaesthetists to identify and manage patients with increased risk of bleeding and in determining clinical need for blood, where processes appear to be robust.

Effective systems of control are in place in regard to the receipt, storage, collection and transport of blood and blood products, all of which takes place from either of the three contracted Pathology services. A risk management approach is taken in this regard, and there is evidence of quality activities aimed at mitigating identified risks. Haemovigilance is well understood and activities are in accordance with the national framework.

Action 7.6
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: Audit results demonstrate poor compliance with prescribing and administration documentation in some areas, including recording of consent. Evidence provided indicated that while the timing of audits is in accordance with the audit schedule, very few patient records are audited.
Recommendation:
Ensure compliance with policy in regard to appropriate documentation associated with prescribing and administration of blood and blood products and in accordance with the audit schedule.
Risk Rating:
Low

Managing the availability and safety of blood and blood products

Action 7.9	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.10	
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health has processes in place that comply with manufacturer's directions, legislation and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely. The three contracted Pathology Services actively partner with the organisation to achieve this and ACHA now receives regular reports from two of the three providers to assist in so doing.

Pathology services are on site at each of the three hospitals to ensure that blood and blood products can be traced from entry into the organisation, to transfusion, discard or transfer. Each hospital now has a written agreement with Blood Move to safely facilitate the return of unused blood in a timely manner for use elsewhere. All staff who spoke with assessors were aware of their obligations in this regard and blood wastage since the introduction of this system has been negligible.

Centralisation of blood at each of the Pathology laboratories on site or co-located with the three hospitals ensures that avoidable wastage is kept to a minimum and that there is an adequate response in times of shortage.

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action 8.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 8.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health has safety and quality systems in place for implementing policies and procedures for recognising and responding to acute deterioration, outlined in the Clinical Deterioration, Recognising and Responding to Policy. The peak governing bodies responsible for Clinical Deterioration are the Executive and Medical Advisory Committee. Primary responsibility of care lies with the primary VMO.

Of note, there is no separate Committee for Clinical Deterioration, although there are a number of risks on the risk register relating to the Standard (see commentary later), high numbers of Rapid Response calls compared to benchmark hospitals (see commentary later), concerns from the Medical Advisory Committee regarding failure to escalate calls outside the white zone (see commentary later) and variable compliance from audit results with escalating calls outside the white zone on the Chart (see commentary later).

Risk Registers at the three sites have risks relating to clinical deterioration, including a Moderate Risk on Flinders Private Register for "Inadequate process for Patient Transfer to another Facility", "Delay or Failure to call MET Call" as Moderate Risk, "Inadequate medical record documentation MET Calls" as Moderate Risk, and Moderate risk at Ashford for "Inadequate management of Deteriorating patient", "Inadequate management of Deterioration of patients mental state" at Ashford.

The ALS Adult, and ALS Paediatric Policies outline the framework for training of the workforce on recognising and responding to acute deterioration, including roles which require ALS, BLS and Paediatric Advanced Life Support training.

Monitoring of the rapid response system occurs via auditing, and via monthly reviews of MET call data trends, presented at Hospital based Clinical Practice Meetings. A total of 53 MET calls occurred in July at Flinders Private Hospital, the most frequent ward being 4 South, and most common reason due to a Fall. ACHA also monitors the effectiveness and outcomes of the Rapid response systems via Healthscope CHBOI indicators of Hospital Standardised Mortality Ratio, and Deaths in Low mortality DRGs. ACHA Health is currently not listed as a Hospital Standardised Mortality Ratio (HSMR) outlier according to the 2018 CHBOI (core hospital-based outcome indicators) report; however, Ashford HSMR is 120 and had four deaths listed in the Low mortality DRGs (see Standard 1). These cases are reviewed by the ACHA Clinical Review Committee.

ACHA Health has processes to involve patients in their own care, via the Patient Health Questionnaire including confirmation of any Advance Care Directives on admission, and with completed and signed Advance Care Directives viewed within clinical ward areas.

Action 8.1
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: Of note, there is no separate Committee for Clinical Deterioration, although there are a number of risks on the risk register relating to the standard, high numbers of Rapid Response calls compared to benchmark hospitals, concerns from the Medical Advisory Committee regarding failure to escalate calls outside the white zone, and variable compliance from audit results with escalating calls outside the white zone on the Chart.
Recommendation:
As per the recommendation in Action 1.10, conduct a risk assessment as to whether a more formal Governance Committee would provide assurance to the organisation to meet the safety and quality requirements of the Recognising and Responding to Acute Deterioration Standard.
Risk Rating:
Moderate
Risk Comment:
Consideration of more formalised structures would reduce the quality and safety risks in Recognising and Responding to Acute Deterioration Standard.

Detecting and recognising acute deterioration, and escalating care

Action 8.4	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.5	
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.6	
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.7	
The health service organisation has processes for patients, carers or families to directly escalate care	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Action 8.8	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.9	
The workforce uses the recognition and response systems to escalate care	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health Clinical Deterioration Policy outlines the expectations for measuring and documenting vital sign observations, including frequency for different patient cohorts. The observations are documented on the ACHA Health Rapid Detection and Response Observation Chart, which has clear graphs with Yellow and Red Zones requiring escalation. Adult, paediatric, maternity charts are available. The chart was evident in use across all clinical areas. Documentation audits are evident for compliance with vital sign documentation across all sites.

The response criteria for MET Call include vital sign parameters for escalation, deterioration in mental state, pain or distress that is not able to be managed, worried criteria, and a number of clinical conditions that warrants escalation. The assessment team discussed the broad inclusiveness of the MET response criteria with Intensive Care Specialists. The breadth of the response criteria is a reflection of both the complexity of the patient casemix being managed at the sites, and that the primary VMO is often offsite. The response criteria therefore allow early identification of patients that require medical review, and trigger escalation to the MET. This inclusiveness of the criteria may be contributing to a higher Rapid Response rate at ACHA than peer health services (see below discussion), but was felt to be safe and appropriate by the Intensive Care Specialist given the complexity of the patient cohort.

ACHA Health Clinical Deterioration Policy also outlines the observations required for Mental state and clinical risk assessment. The 4AT Test for Delirium is available within the organisation. ACHA Health provided training in August 2019 to the clinical staff on Cognitive Impairment and management of the acute delirium and deterioration in mental health. The Transfer of a Patient – Inter-hospital Policy outlines the process for patients who require transfer for management of acute mental health issues.

Patient and Carer Escalation (PACE) systems are implemented throughout ACHA Health, with clear directions for PACE outlined in every Patient Care Board. The Consumer Committee consulted on the Patient Care Boards in March 2019. Positive Consumer Feedback has been received regarding the PACE poster in the patient rooms. Consumer Survey in August 2019 was conducted at Flinders Private for awareness of the PACE system.

Escalation of observations outside the white zone to a rapid response team has been highlighted as a concern both via the VMOs in the Clinical Review Panel Annual report to Medical Advisory Committee April 2019, and also in the Ashford Hospital Clinical Deterioration Audit December 2018 with 31% of the medical records audited did not escalate observations outside the white zone. Learnings from Clinical Review Committee have been communicated into the ACHA Doctors news July 2019 and result of the audit have been emailed to the ACHA Quality Manager, site Quality Managers, Directors of Nursing. Assessment team members also observed instances to non-compliance to escalation in Cardiac Surgery Unit at Ashford Hospital.

Action 8.9
The workforce uses the recognition and response systems to escalate care
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: Lack of escalation of observations outside the white zone on the Rapid Detection and Response Observation Chart to a rapid response team has been highlighted as a concern both via the VMO's in the Clinical Review Panel Annual report to Medical Advisory Committee April 2019, and also in the Ashford Hospital Clinical Deterioration Audit December 2018 with 31% of the patient records audited indicating failure to escalate appropriately.
Recommendation:
ACHA Health ensure compliance with the escalation of observations in the white zone of the Rapid Detection and Response Observation Chart, as per the ACHA Health Clinical Deterioration Recognising and Responding to 8.45 Policy.
Risk Rating:
Moderate
Risk Comment:
Improved compliance with escalation to MET calls when criteria are outside of the white zone on the Rapid Detection and Response Chart will reduce the risk relating to this Standard.

Responding to acute deterioration

Action 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

ACHA Health has Rapid Response Teams at all sites, called MET. The MET include clinicians with ALS, including ICU nurse and ICU Senior resident medical officer. ALS training is mandatory training for these roles, and compliant training records were viewed for these roles.

ACHA Health utilises a Rapid Response Team Attendance form 621 to document outcomes of Rapid Response calls.

ACHA Health has procedures for rapid transfer to other health services if required, as outlined in the Transfer Policy. Detention Under the Mental Health Act (Inpatient Treatment Order) Policy outlines the process for transfer to Royal Adelaide Hospital or Flinders Medical Centre. Assessment team discussions with clinicians confirmed their awareness of escalation and transfer; however, instances requiring transfer were very infrequent.

ACHA Health also monitors ACHA Health clinical indicators for Rapid Response rates for both Ashford Hospital rapid response calls (adults) is higher than peers 5.036% compared with 2.595%, as is Flinders Private 3.156% compared with 2.673%. It is reassuring that the Adult patients experiencing cardiopulmonary arrest rate is comparable to benchmark. The Memorial Hospital is currently benchmarking with lower rapid response rates than peer hospitals, but slightly higher cardio-respiratory arrests at 0.077% compared to 0.048% peers.

Suggestions for Improvement:

ACHA Health to consider reviewing the contributing factors to an increased number of Rapid Response calls at Ashford Hospital and Flinders Private Hospital, particular for those clinical specialties or patient cohorts with higher numbers of rapid response calls, to determine targeted improvement strategies to reduce the number of patients experiencing clinical deterioration.

Recommendation from Current Assessment

Standard 1

Organisation: All facilities under membership
Action 1.4: The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people

Recommendation:
Develop, in consultation with the Aboriginal and Torres Strait Islander (ATSI) Community, specific health related strategies and targets with appropriate monitoring and reporting systems for the goals in the Reconciliation Action Plan.

Organisation: All facilities under membership
Action 1.9: The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations

Recommendation:
Review the operation and reporting process of the Clinical Review Committee to ensure that the Board and the CEO receive timely reports on any data of concern, any reviews undertaken, and the outcomes of any such reviews. This needs to be additional to the Annual Report from the committee which is the minimum prescribed by the legislation.

Organisation: All facilities under membership
Action 1.10: The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters

Recommendation:
Review the risk management systems in place to ensure that actions which are planned and undertaken as a result of the identification of a non-compliance with policy requirements are allocated a risk level and time frame for action that is appropriate for the non-compliance identified. This review should include the governance and formal committee structure across ACHA Health which provides assurance that compliance is monitored, and action taken to address non-compliance across all the requirements outlined in ACHA Health policy and the National Safety and Quality Health Service Standards. The Terms of Reference of any oversight committees must clearly outline the responsibility and escalation where compliance remains below requirements.

Organisation: All facilities under membership
Action 1.16: The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used

Recommendation:
Medical staff compliance with the documentation requirements outlined in the ACHA Health Medical Services Regulations is enforced and action taken which is appropriate for the level and frequency of non-compliance.

Organisation: All facilities under membership
Action 1.19: The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation

Recommendation:
ACHA Health include explicit outline in the Board orientation of their specific role in quality and safety, and the expectations of their role as Board Director for ensuring quality and safety within ACHA Health.

Organisation: All facilities under membership
Action 1.20: The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training

Recommendation:
ACHA Health implement a Mandatory Training framework for VMOs that supports mutual recognition of appropriate training performed at other health services, and also develops specific Mandatory Training required of VMOS whose sole hospital appointment is with ACHA Health.

Organisation: All facilities under membership
Action 1.21: The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients

Recommendation:
ACHA Health seek guidance from the Aboriginal Consumer on the appropriateness of the Cultural awareness and sensitivity learning package and ensure active engagement from Aboriginal consumers in further enhancements to the program.

Organisation: All facilities under membership
Action 1.22: The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system

Recommendation:
ACHA Health implement a Performance Review framework for VMOs and Surgical Assistants that is linked to clinical outcomes and compliance with Medical Services Regulations.

Standard 3

Organisation: All facilities under membership
Action 3.16: The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing

Recommendation:
ACHA Health to ensure compliance with its Antimicrobial Stewardship Framework

Standard 4

Organisation: All facilities under membership
Action 4.1: Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management

Recommendation:
1. Implement the measures identified in the Medication Actions Plan with ongoing monitoring and outcomes reported to the relevant committee. 2. As per the recommendation in Action 1.10, conduct a risk assessment as to whether a more formal Medication Governance Committee would provide assurance to the organisation to meet the safety and quality requirements of the Medication Standard.

Organisation: All facilities under membership
Action 4.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management

Recommendation:
Review the audit process for medication safety to provide assurance that low levels of compliance are identified, actioned, monitored, reviewed and outcomes reported in a timely manner.

Organisation: All facilities under membership
Action 4.15: The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely

Recommendation:
Develop and implement a structured framework for the monitoring and review of high-risk medicines.

Standard 5

Organisation: All facilities under membership
Action 5.17: The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record

Recommendation:
Develop processes to receive, document and provide access to Advance Care Directives.

Organisation: All facilities under membership
Action 5.19: The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care

Recommendation:
Implement processes for evaluating the safety and quality of end-of-life care.

Standard 7

Organisation: All facilities under membership
Action 7.1: Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management

Recommendation:
In reference to the recommendation in Action 1.10, conduct a risk assessment as to whether a more formal committee would provide assurance to the organisation to meet the safety and quality requirements of Standard 7.

Organisation: All facilities under membership
Action 7.6: The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria

Recommendation:
Ensure compliance with policy in regard to appropriate documentation associated with prescribing and administration of blood and blood products and in accordance with the audit schedule.

Standard 8

Organisation: All facilities under membership
Action 8.1: Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration

Recommendation:
As per the recommendation in Action 1.10, conduct a risk assessment as to whether a more formal Governance Committee would provide assurance to the organisation to meet the safety and quality requirements of the Recognising and Responding to Acute Deterioration Standard.

Organisation: All facilities under membership
Action 8.9: The workforce uses the recognition and response systems to escalate care

Recommendation:
ACHA Health ensure compliance with the escalation of observations in the white zone of the Rapid Detection and Response Observation Chart, as per the ACHA Health Clinical Deterioration Recognising and Responding to 8.45 Policy.

Rating Summary

Ashford Hospital

Health Service Facility ID: 100433

Standard 1 - Clinical Governance

Governance, leadership and culture

Action	Assessment Team Rating
1.1	Met
1.2	Met
1.3	Met
1.4	Met with Recommendation
1.5	Met
1.6	Met

Patient safety and quality systems

Action	Assessment Team Rating
1.7	Met
1.8	Met
1.9	Met with Recommendation
1.10	Met with Recommendation
1.11	Met
1.12	Met
1.13	Met
1.14	Met
1.15	Met
1.16	Met with Recommendation
1.17	Met
1.18	Met

Clinical performance and effectiveness

Action	Assessment Team Rating
1.19	Met with Recommendation
1.20	Met with Recommendation
1.21	Met with Recommendation
1.22	Met with Recommendation
1.23	Met
1.24	Met
1.25	Met
1.26	Met
1.27	Met
1.28	Met

Safe environment for the delivery of care

Action	Assessment Team Rating
1.29	Met
1.30	Met
1.31	Met
1.32	Met
1.33	Met

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action	Assessment Team Rating
2.1	Met
2.2	Met

Partnering with patients in their own care

Action	Assessment Team Rating
2.3	Met
2.4	Met
2.5	Met
2.6	Met
2.7	Met

Health literacy

Action	Assessment Team Rating
2.8	Met
2.9	Met
2.10	Met

Partnering with consumers in organisational design and governance

Action	Assessment Team Rating
2.11	Met
2.12	Met
2.13	Met
2.14	Met

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Action	Assessment Team Rating
3.1	Met
3.2	Met

Action	Assessment Team Rating
3.3	Met
3.4	Met

Infection prevention and control systems

Action	Assessment Team Rating
3.5	Met
3.6	Met
3.7	Met
3.8	Met
3.9	Met
3.10	Met
3.11	Met
3.12	Met
3.13	Met

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Met

Antimicrobial stewardship

Action	Assessment Team Rating
3.15	Met
3.16	Met with Recommendation

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action	Assessment Team Rating
4.1	Met with Recommendation
4.2	Met with Recommendation
4.3	Met
4.4	Met

Documentation of patient information

Action	Assessment Team Rating
4.5	Met
4.6	Met
4.7	Met
4.8	Met
4.9	Met

Continuity of medication management

Action	Assessment Team Rating
4.10	Met
4.11	Met
4.12	Met

Medication management processes

Action	Assessment Team Rating
4.13	Met
4.14	Met
4.15	Met with Recommendation

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

Action	Assessment Team Rating
5.1	Met
5.2	Met
5.3	Met
5.4	Met
5.5	Met
5.6	Met

Developing the comprehensive care plan

Action	Assessment Team Rating
5.7	Met
5.8	Met
5.9	Met
5.10	Met
5.11	Met
5.12	Met
5.13	Met

Delivering comprehensive care

Action	Assessment Team Rating
5.14	Met
5.15	Met
5.16	Met
5.17	Met with Recommendation
5.18	Met
5.19	Met with Recommendation
5.20	Met

Minimising patient harm

Action	Assessment Team Rating
5.21	Met
5.22	Met
5.23	Met
5.24	Met
5.25	Met
5.26	Met
5.27	Met
5.28	Met
5.29	Met
5.30	Met
5.31	Met
5.32	Met
5.33	Met
5.34	Met
5.35	Met
5.36	Met

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action	Assessment Team Rating
6.1	Met
6.2	Met
6.3	Met
6.4	Met

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Met with Recommendation
7.2	Met
7.3	Met

Prescribing and clinical use of blood and blood products

Action	Assessment Team Rating
7.4	Met
7.5	Met
7.6	Met with Recommendation
7.7	Met
7.8	Met

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Met
7.10	Met

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met with Recommendation
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

Action	Assessment Team Rating
8.4	Met
8.5	Met
8.6	Met
8.7	Met
8.8	Met
8.9	Met with Recommendation

Responding to acute deterioration

Action	Assessment Team Rating
8.10	Met
8.11	Met
8.12	Met
8.13	Met

Org Name : ACHA Health
Org Code : 320011

Flinders Private Hospital

Health Service Facility ID: 101434

Standard 1 - Clinical Governance

Governance, leadership and culture

Action	Assessment Team Rating
1.1	Met
1.2	Met
1.3	Met
1.4	Met with Recommendation
1.5	Met
1.6	Met

Patient safety and quality systems

Action	Assessment Team Rating
1.7	Met
1.8	Met
1.9	Met with Recommendation
1.10	Met with Recommendation
1.11	Met
1.12	Met
1.13	Met
1.14	Met
1.15	Met
1.16	Met with Recommendation
1.17	Met
1.18	Met

Clinical performance and effectiveness

Action	Assessment Team Rating
1.19	Met with Recommendation
1.20	Met with Recommendation
1.21	Met with Recommendation
1.22	Met with Recommendation
1.23	Met
1.24	Met
1.25	Met
1.26	Met
1.27	Met
1.28	Met

Safe environment for the delivery of care

Action	Assessment Team Rating
1.29	Met
1.30	Met
1.31	Met
1.32	Met
1.33	Met

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action	Assessment Team Rating
2.1	Met
2.2	Met

Partnering with patients in their own care

Action	Assessment Team Rating
2.3	Met
2.4	Met
2.5	Met
2.6	Met
2.7	Met

Health literacy

Action	Assessment Team Rating
2.8	Met
2.9	Met
2.10	Met

Partnering with consumers in organisational design and governance

Action	Assessment Team Rating
2.11	Met
2.12	Met
2.13	Met
2.14	Met

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Action	Assessment Team Rating
3.1	Met
3.2	Met

Action	Assessment Team Rating
3.3	Met
3.4	Met

Infection prevention and control systems

Action	Assessment Team Rating
3.5	Met
3.6	Met
3.7	Met
3.8	Met
3.9	Met
3.10	Met
3.11	Met
3.12	Met
3.13	Met

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Met

Antimicrobial stewardship

Action	Assessment Team Rating
3.15	Met
3.16	Met with Recommendation

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action	Assessment Team Rating
4.1	Met with Recommendation
4.2	Met with Recommendation
4.3	Met
4.4	Met

Documentation of patient information

Action	Assessment Team Rating
4.5	Met
4.6	Met
4.7	Met
4.8	Met
4.9	Met

Continuity of medication management

Action	Assessment Team Rating
4.10	Met
4.11	Met
4.12	Met

Medication management processes

Action	Assessment Team Rating
4.13	Met
4.14	Met
4.15	Met with Recommendation

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

Action	Assessment Team Rating
5.1	Met
5.2	Met
5.3	Met
5.4	Met
5.5	Met
5.6	Met

Developing the comprehensive care plan

Action	Assessment Team Rating
5.7	Met
5.8	Met
5.9	Met
5.10	Met
5.11	Met
5.12	Met
5.13	Met

Delivering comprehensive care

Action	Assessment Team Rating
5.14	Met
5.15	Met
5.16	Met
5.17	Met with Recommendation
5.18	Met
5.19	Met with Recommendation
5.20	Met

Minimising patient harm

Action	Assessment Team Rating
5.21	Met
5.22	Met
5.23	Met
5.24	Met
5.25	Met
5.26	Met
5.27	Met
5.28	Met
5.29	Met
5.30	Met
5.31	Met
5.32	Met
5.33	Met
5.34	Met
5.35	Met
5.36	Met

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action	Assessment Team Rating
6.1	Met
6.2	Met
6.3	Met
6.4	Met

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Met with Recommendation
7.2	Met
7.3	Met

Prescribing and clinical use of blood and blood products

Action	Assessment Team Rating
7.4	Met
7.5	Met
7.6	Met with Recommendation
7.7	Met
7.8	Met

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Met
7.10	Met

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met with Recommendation
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

Action	Assessment Team Rating
8.4	Met
8.5	Met
8.6	Met
8.7	Met
8.8	Met
8.9	Met with Recommendation

Responding to acute deterioration

Action	Assessment Team Rating
8.10	Met
8.11	Met
8.12	Met
8.13	Met

Memorial Hospital, The

Health Service Facility ID: 101435

Standard 1 - Clinical Governance

Governance, leadership and culture

Action	Assessment Team Rating
1.1	Met
1.2	Met
1.3	Met
1.4	Met with Recommendation
1.5	Met
1.6	Met

Patient safety and quality systems

Action	Assessment Team Rating
1.7	Met
1.8	Met
1.9	Met with Recommendation
1.10	Met with Recommendation
1.11	Met
1.12	Met
1.13	Met
1.14	Met
1.15	Met
1.16	Met with Recommendation
1.17	Met
1.18	Met

Clinical performance and effectiveness

Action	Assessment Team Rating
1.19	Met with Recommendation
1.20	Met with Recommendation
1.21	Met with Recommendation
1.22	Met with Recommendation
1.23	Met
1.24	Met
1.25	Met
1.26	Met
1.27	Met
1.28	Met

Safe environment for the delivery of care

Action	Assessment Team Rating
1.29	Met
1.30	Met
1.31	Met
1.32	Met
1.33	Met

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action	Assessment Team Rating
2.1	Met
2.2	Met

Partnering with patients in their own care

Action	Assessment Team Rating
2.3	Met
2.4	Met
2.5	Met
2.6	Met
2.7	Met

Health literacy

Action	Assessment Team Rating
2.8	Met
2.9	Met
2.10	Met

Partnering with consumers in organisational design and governance

Action	Assessment Team Rating
2.11	Met
2.12	Met
2.13	Met
2.14	Met

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Action	Assessment Team Rating
3.1	Met
3.2	Met

Action	Assessment Team Rating
3.3	Met
3.4	Met

Infection prevention and control systems

Action	Assessment Team Rating
3.5	Met
3.6	Met
3.7	Met
3.8	Met
3.9	Met
3.10	Met
3.11	Met
3.12	Met
3.13	Met

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Met

Antimicrobial stewardship

Action	Assessment Team Rating
3.15	Met
3.16	Met with Recommendation

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action	Assessment Team Rating
4.1	Met with Recommendation
4.2	Met with Recommendation
4.3	Met
4.4	Met

Documentation of patient information

Action	Assessment Team Rating
4.5	Met
4.6	Met
4.7	Met
4.8	Met
4.9	Met

Continuity of medication management

Action	Assessment Team Rating
4.10	Met
4.11	Met
4.12	Met

Medication management processes

Action	Assessment Team Rating
4.13	Met
4.14	Met
4.15	Met with Recommendation

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

Action	Assessment Team Rating
5.1	Met
5.2	Met
5.3	Met
5.4	Met
5.5	Met
5.6	Met

Developing the comprehensive care plan

Action	Assessment Team Rating
5.7	Met
5.8	Met
5.9	Met
5.10	Met
5.11	Met
5.12	Met
5.13	Met

Delivering comprehensive care

Action	Assessment Team Rating
5.14	Met
5.15	Met
5.16	Met
5.17	Met with Recommendation
5.18	Met
5.19	Met with Recommendation
5.20	Met

Minimising patient harm

Action	Assessment Team Rating
5.21	Met
5.22	Met
5.23	Met
5.24	Met
5.25	Met
5.26	Met
5.27	Met
5.28	Met
5.29	Met
5.30	Met
5.31	Met
5.32	Met
5.33	Met
5.34	Met
5.35	Met
5.36	Met

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action	Assessment Team Rating
6.1	Met
6.2	Met
6.3	Met
6.4	Met

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Met with Recommendation
7.2	Met
7.3	Met

Prescribing and clinical use of blood and blood products

Action	Assessment Team Rating
7.4	Met
7.5	Met
7.6	Met with Recommendation
7.7	Met
7.8	Met

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Met
7.10	Met

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met with Recommendation
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

Action	Assessment Team Rating
8.4	Met
8.5	Met
8.6	Met
8.7	Met
8.8	Met
8.9	Met with Recommendation

Responding to acute deterioration

Action	Assessment Team Rating
8.10	Met
8.11	Met
8.12	Met
8.13	Met

Recommendations from Previous Assessment

Standard 1

Organisation: ACHA Health
Action 1.3: The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality

Recommendation NSQHSS Survey 0916.1.1.2 :
Implement preventative strategies based on data and information analysis.

Organisation Action:

1. *Implement preventative strategies based on data and information analysis.*

Actions

- Strategic and Business Plans are in place, which take into account the impact on patient safety and care; i.e. Brownfields development plans incorporate patient flow and management services which may be affected; this is reviewed and updated annually with the ACHA Board
- Each ACHA hospital has a preventative maintenance schedule in place. It is acknowledged that there is a degree of reactive maintenance occurring, patient safety is taken in account
- Environmental cleaning schedules are in place, which includes patient share bathrooms
- Building and refurbishment works go through extensive consultation; which include Infection Control Managers, Work Health & Safety (WHS) staff, Consumer Consultants and relevant stakeholders
- ACHA Safety and Quality Plan provides Clinical Governance and framework for the hospitals, this is reviewed and updated annually
- ACHA Clinical Risk and Quality Management Program participates in the Healthscope corporate safety and quality program;
- Quality Team Committees
- Policy and Procedure Review - Document Control Process
- Public Reporting Program – our Performance
- Shared Learnings Process
- Safety and Quality KPI’s are set on an annual basis and are reported on quarterly - through the hierarchy of reporting
- Quality strategies are formed from this information which in turn forms a core component of the overall ACHA strategy

- All Safety & Quality information is tabled at each hospitals Safety & Quality meetings, ACHA Executive Committee, ACHA Medical Advisory Committee and the ACHA Board Meeting

Examples;
1. Critical Systems Reviews (CSR) are undertaken to review systems and policy compliance in the event of serious and sentinel events.
2. External agency alerts and notifications are used to evaluate our own practices - i.e. Bankstown-Lidcombe hospital incident where incorrect installation of medical gas pipes led to review of each of the ACHA hospitals gas lines to ensure they had been correctly fitted. 100% compliance was noted.
3. Extra testing for Legionella has been conducted, outside of Preventative maintenance schedule, this was due to SA Health Alert. No Legionella was detected.
4. Review of kitchen practices held as a response to an incident at another hospital related to salmonella outbreak. This shared learning resulted in further education being delivered to kitchen staff.
5. Education was provided by WHS team across each ACHA hospital regarding electrical safety. This included education of the difference between static shock and electric shock. ACHA WHS also conducted an Electrical Safety roadshow across each ACHA hospital in February 2017.

6. A full audit of Central Sterilising Departments have been undertaken by an external Sterilising Company and Architecture. This has been driven by the updated Australian Standards for Sterilising Departments - AS: 4187. HICMR audit results against the standard have supported the gap analysis and action plans as per the requirements of Australian Commission on Safety and Quality Advisory - A 16/03 (amended)

7. Risk assessments are undertaken prior to the commencement of refurbishments or building works, to ensure the hospitals continues to provide a safe environment during the construction process

8. Systems have been put in place for Obstetric and Gynaecologist Specialist credentialing in relation to the recent events for Trans-Vaginal Mesh, and following the guidelines put out by the ACSQHC

9. Credentialing pathways have been developed and implemented for surgeons to provide evidence against when applying for accreditation rights to undertake robotic surgery, bariatric surgery and laparoscopic surgery for level 4, 5 & 6 gynaecological surgery

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The actions taken are appropriate and this recommendation is complete.

Organisation: ACHA Health
Action 1.7: The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements

Recommendation NSQHSS Survey 0916.1.1.1 :
1. Ensure the policies and procedures are developed and reviewed in line with intended work practice expectations.
2. Observe and/or audit work practice against policies and procedures for compliance.

Organisation Action:

1. Ensure the policies and procedures are developed and reviewed in line with intended work practice expectations.

Actions

- Policies are available providing instruction of policy and procedure development and Review;
- ACHA policy 1.07 By-Laws –Policies, Processes and Memoranda
- ACHA policy 1.14 Document Control
- ACHA has a Document Controller, role includes;
- Integrating all documents into ACHA
- Maintaining a formal document spreadsheet
- ACHA Policy Committee reviews all policies, procedures, and documents on a three-yearly schedule or as required, which include;
- Legislative and Standards changes
- External contractual arrangements
- Best practice requirements

External review recommendations by Governing bodies

- Policies are available via the ACHA intranet, updated monthly as per reviewed and adopted policies and procedures
- Policies are developed by ACHA or Healthscope (HSO), ACHA is involved in review of all policies and procedures
- Policy and procedure requires endorsement by the ACHA Executive Committee, and are reported to the ACHA Board
- A process is in place to inform all updated policies and procedures to the work force

There are 1957 documents on the ACHA Intranet. An increase of 2.8% (1929) from 2018/19, this is due to the changes to the NSQHS Standards;

- 805 policies, consisting of;

466 ACHA policies

As at 30 June 2019, 14 policies were either under review or awaiting approval = 97% compliance. All these polices were rated as low risk

338 Healthscope policies adopted in accordance with the ACHA Board Resolutions of October 2010

As at 30 June 2019, 3 policies were under review = 99.1% compliance

ACHA does not influence the Healthscope review time frames, however, does participate in the review process

- 706 doctors standing orders
- 446 forms, information and educational materials
- During 2018/19, 730 documents were reviewed and approved by ACHA Executive, which consisted of;

186 Healthscope documents

544 ACHA documents – following review and recommendation by the ACHA Policy Committee

- Of the 1957 documents on the Intranet, 1921 (98.2%) are in date as of 30 June 2019

All education programs and audit tools are developed against current policies and procedures. Mandatory training is provided according to the policy 4.10 Mandatory Training and audits are conducted as per the policy 2.37 - Audit - Internal - Quality.

Training compliance rates are monitored through the on-line program - ELMO, and Audits are scheduled on a yearly planner, and are monitored through the Quality Quarterly KPI report.

2. Observe and/or audit work practice against policies and procedures for compliance.

Actions

- Audit tools have been developed to measure compliance with policies and procedures
- Observational, retrospective and documentation audits are conducted
- Audits are conducted to identify uptake of relevant policies and procedures and compliance of work practice
- Action plans are developed for audit results that are outside the required Key Performance Indicator (KPI)
- Re-audits are conducted to ensure compliance, consistency and sustainability has occurred

Audit tools are reviewed when changes to policy occur which includes changes to; legislation, best practice guidelines or standards.

Each ACHA hospital has an audit schedule that measures compliance to the National Standards, policies and procedures, and work practices.

The audit schedule is flexible dependent on audit results and site requirements.

Example

Review of Blood Management policy against Blood Product Management at Flinders Private Hospital (FPH), this was conducted alongside the contractual agreement with the Pathology provider. Policy review enabled the integration of both documentation systems in accordance with correct haemovigilance monitoring practices.

This process included the development of a Blood Fridge competency for clinical staff to undertake.

Blood fridge competency is a mandatory requirement for all clinical staff to complete. Existing staff have been provided in-service education and new staff during Hospital Orientation. Blood Fridge audit conducted at FPH continues to show 100% compliance.

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The compliance with policy is monitored and the requirements of this recommendation are complete. A further recommendation in relation to risk for the current assessment touches on this issue.

Organisation: ACHA Health

Action 1.8: The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems

Recommendation NSQHSS Survey 0916.1.6.1:

1. Ensure the frequency of formal, documented monitoring, is relevant to collected data and information, as well as observation of work practice, and contributes to achieving expected outcomes in compliance, within appropriate timeframes.
2. Ensure that the results of audits accurately reflect findings.

Organisation Action:

1. Ensure the frequency of formal, documented, monitoring, is relevant to collected data and information, as well as observation of work practice, and contributes to achieving expected outcomes in compliance, within appropriate timeframes.

Actions

Clinical governance framework is developed and reviewed annually and evaluated against previous plan

ACHA Safety and Quality Plan is in place. Is endorsed annually by the ACHA Executive and reported to the ACHA Board

A policy and procedure is in place for the framework and management of safety and quality

ACHA policy 1.18 Quality Management

An ACHA annual audit schedule is in place, which is set according to the National Standards. Each hospital is to conduct audits according to the schedule

The frequency of the monitoring process; i.e. auditing and observation of work practice, is aligned with the results of data and information analysis and trends

The frequency of the monitoring process is assessed according to outcome

Audits required by the National Standards, where compliance outcomes are achieved are recorded on the Safety & Quality KPI report

Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans

Identified deficits are risk assessed and are re-audited according to the risk assessment

2. Ensure that the results of audits accurately reflect findings.

Actions

Audit schedules are collated and repeated according to the KPI achieved; i.e. if the audit results is less than the required KPI, the results are actioned and the audit repeated. Time frames are set according to the risk assessment

In addition to the organisation-wide annual audit, each hospital has a local formal audit schedule, which reflects the monitoring requirements of that particular hospital. This provides a formal guide for the workforce to follow

- Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcomes

Audit schedules are set annually through the Quality Quarterly KPI report and repeated according to results
Auditing is conducted by dedicated auditors. These are either identified at each ward / department (i.e. ward / department Champions), conducted by the Quality Manager or by an external source

Up to 61 quality audits are scheduled across each site, some are annually, others are biannually or quarterly. A medical record documentation audit and the national medication chart audits are conducted annually

Audits results are required to meet a benchmark target rate, if audit does not meet the target rate further education and auditing is conducted to ensure target rates are achieved

Quality Indicators;

ACHS clinical indicator outliers remain below the maximum KPI for all hospitals

The unplanned readmission rate below the maximum KPI for all hospitals

The reported patient incident rate remains above the minimum KPI for all hospitals

The rate of sentinel events remain below the maximum KPI for all hospitals

SAB rates are decreasing

MRSA rates remain below the maximum KPI for all hospitals

Hand hygiene rates remain above industry targets at all hospitals, this continues even after the target rate increase by ACSQHC in 2018

Patient identification error rates remain below the maximum KPI for all hospitals

Clinical handover error rates remain below the maximum KPI for all hospitals

Provision of discharge summaries within 48 hours has remained above the minimum KPI for all hospitals

Follow up calls post discharge is above the minimum KPI for all hospitals

Adverse outcomes post transfusion events is below the maximum KPI for all hospitals

The rate of hospital acquired pressure injury has stabilised, and remain below industry rates

Patient fall rates have decreased at Flinders Private and Ashford

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Significant work has been undertaken in relation to this recommendation; however, areas of risk due to non-compliance are still apparent.

This recommendation will be closed and another made by the current assessment team to update action to date and make specific recommendations in relation to risk assessment and governance.

Organisation: ACHA Health
Action 1.10: The health service organisation:
a. Identifies and documents organisational risks
b. Uses clinical and other data collections to support risk assessments
c. Acts to reduce risks
d. Regularly reviews and acts to improve the effectiveness of the risk management system
e. Reports on risks to the workforce and consumers
f. Plans for, and manages, internal and external emergencies and disasters

Recommendation NSQHSS Survey 0916.1.5.2:

1. Ensure the organisation-wide risk management system is inclusive, and extends beyond a risk register.
2. Ensure there is timely and appropriate action taken in relation to data and information analysis.

Organisation Action:

1. Ensure the organisation-wide risk management system is inclusive, and extends beyond a risk register.

Actions

A policy and procedure is in place for Integrated Risk Register (IRR) and management of risks, this includes risk rating, setting controls and risk review matrix

ACHA policy 1.34 Risk Management and Integrated Risk Register

ACHA has four Integrated Risk Registers;

ACHA Corporate

Ashford Hospital

Flinders Private Hospital

The Memorial hospital

ACHA has no clinical extreme / high risks, 57.2% of open risks are clinical, 42.8% are non- clinical

Quality planning and projects formally incorporate a documented risk assessment, and include;

External service reports, and subsequent recommendations

Incorporation of a formal documented risk assessment

Manual auditing of incidents indicates the transfer of information to the risk register, and risk rates other incidents to guide the timeframe for completion

- Risks are entered onto the Risk Register as soon as a risk is identified, controls are then put in place to mitigate the risk. Staff are informed through the Safety & Quality meetings

Risks are also identified and managed through the Work Health and Safety Program. The organisation has a Safety Plan which includes undertaking of risk assessments on plant, equipment, materials and work practices.

The organsiation is currently Self-Insured under Work SA, and has been successful in obtaining a full three year accreditation due to well managed risks.

The organisation has a Disaster Management Plan, and education programs are in place for staff regarding the management of emergencies and disasters, including drills for emergencies and evacuations.

A report is provided monthly to the ACHA Board, ACHA Executive and Safety & Quality meetings identifying the organisations performance in identifying risks and outcomes of risk management.

The organisation has a Risk Incident Escalation Protocol and supporting policy's, these include;

1. 1.35 Incident Management

2. 2.02 Sentinel Event Management

3. WHS-PRO-05-1 - Risk Assessment Procedure

4. WHS-PRO-05-4-Safety Observation Procedure

2. Ensure there is timely and appropriate action taken in relation to data and information analysis.

Actions

Risks are identified through key lessons learnt from;

- Sentinel events
- Never events
- Incidents / adverse events
- Near misses
- Hospital and statutory complaints
- Legislation and Standards changes
- External review recommendations
- Risk Assessments
- Risks and actions arising are published quarterly in the Shared Learnings Report
- Shared Learnings appropriate for the hospitals are integrated, and the Risk Register is updated to reflect these
- Integration of the Shared Learnings is audited, and recorded on the Safety and Quality KPI report

These are reported to the hospitals Safety and Quality Committee, ACHA Executive Committee and the ACHA Board

All risks and controls are rated according to the risk matrix noted in policy 1.34 Risk Management and Integrated Risk Register. Each risk is then monitored and reviewed according to the residual rating

*Extreme Risk = immediated management

*High Risk = 0-3 month review

*Moderate =3-6 month review

*Low = minimum 12 month review

Evidence;

1. Healthscope Shared Learnings are used to update Risk Registers at each hospital
2. Identified Risks are demonstrated in policy and procedure.
3. Identified risks from Critical Systems Reviews, complaints and Shared Learning's are communicated to staff through various forums and committees

4. WHS risk assessments are scheduled annually and conducted in every department, the schedule is determined by level of risk

5. Patient incidents can be linked to the appropriate policy and the hospital risk register
6. All TGA Safety Alerts and Product Recalls are reported to Riskman

7. External reviews recommendations are actioned according to risk rating and priority of risk setting

8. Other risks that have resulted in an incident or harm that are external to the organsiation, are also reviewed and actioned to mitigate the risk from occurring within the organisation

Examples;

- Heater-cooler Devices
- Myosure Hysteroscopes
- Trans-vaginal Mesh Products
- Medication Name Changes
- Cladding to exisiting buildings
- Buliding works and refurbishments

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Significant work has been undertaken in relation to this recommendation, however, areas of risk due to non-compliance are still apparent.

This recommendation will be closed and another made by the current assessment team to update action to date and make specific recommendations in relation to risk assessment and governance.

Organisation: ACHA Health
Action 1.16: The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used

Recommendation NSQHSS Survey 0916.1.9.1:
Ensure the completion and accuracy of clinical records.

Organisation Action:

Ensure the completion and accuracy of clinical records.

Actions

Policy's and procedure's are in place for the management, correct information and auditing of documentation of the medical record;

- ACHA policy 2.09 Medical Record – Correction of Information
- ACHA policy 2.27 Medical Record – Documentation Audit
- HSO National Forms Committee reviews all medical record forms to ensure standardisation across the organisation, Medical Records that meet the National Standard
- ACHA Forms Working Party - established in February 2018, to review of all medical record forms against current policy & procedures, legislation and best practice, and in preparation for electronic medical records (which is in the planning phase for the near future)
- Identified deficits are risk assessed and are re-audited according to the risk assessment
- Auditing of clinical records occurs annually;
- National audit tool is used to audit the Medical Record against the National Standards
- Various hospital audit tools are used to audit the current inpatient episode these include;
- Audits of clinical form completion
- Inclusion of appropriate forms
- Access to medical records
- Department Managers conduct spot audits when required
- Where deficiencies or gaps identified in clinical records this is addressed with staff at the time of audit and also communicated with the wider work group at relevant forums
- Audits where compliance outcomes are achieved are recorded on the Safety & Quality KPI report
- Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans
- Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcomes

Current audit results (audits are conducted on and above the annual medical record documentation audit, as per audit schedule;
Patient ID Band: Ashford - 98%, Flinders - 72%, Memorial - 99% - FPH is currently undertaking a further education and audit during July 2019
Blood Consent Form: Ashford - 100%, Flinders - 100%, Memorial - 100%

Consent Medical Treatment: Ashford - 93%, Flinders - 99%, Memorial - 94%
Falls Assessment Tool: Ashford - 82%, Flinders - 73%, Memorial - 97% - ASH & FPH undertaking further education and auditing during July 2019
Pressure Injury Tool; Ashford - 88%, Flinders - 83%, Memorial - 97% - ASH & FPH undertaking further education and auditing during July 2019

Medical Record documentation annual audit;
Medical Patients; Ashford - 75.35%, Flinders - 75.12%, Memorial - 84.63% = ACHA = 78.37%
Day Procedure Patients; Ashford - 85.68%, Flinders - 85.25%, Memorial - 91.16% = ACHA = 87.36%
Surgical Patients; Ashford - 79.14%, Flinders - 79.08%, Memorial - 83.97% = ACHA = 80.73%
ICU Patients; Ashford - 89.10%, Flinders - 91.93%, Memorial - 93.07% = ACHA = 96.07%
Emergency Patients; Ashford Only 87.19% (other sites do not have an Emergency Service

In February 2019 ACHA invited Clinical Documentation Improvement Australia (CDIA) to conduct an audit on clinical documentation and provide a number of education sessions to staff and Visiting Medical Officers on correct documentation in the medical record.
Medical Record Documentation Audit - due to be conducted October 2019

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Significant work has been undertaken in relation to this recommendation, however, areas of risk due to non-compliance are still apparent.

This recommendation will be closed, and another made by the current assessment team to update action to date and make specific recommendations in relation to documentation.

Organisation: ACHA Health
Action 1.20: The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training

Recommendation NSQHSS Survey 0916.1.4.2 :
Ensure that the systems and processes in place enable the health service to consistently maintain formal records on mandatory training attendance, which in turn are able to consistently demonstrate the level of compliance on a timely basis.

Organisation Action:

1. *Ensure that the systems and processes in place enable the health service to consistently maintain formal records on mandatory training attendance, which in turn are able to consistently demonstrate the level of compliance on a timely basis.*

Actions

A policy and procedure is in place for all mandatory training requirements of the work force

-

ACHA policy 4.10 Mandatory Training

- Mandatory training online platform is available to all staff – Electronic Learning Management System (ELMO); appropriate education programs are automatically allocated to staff via individual email accounts by hospitals educators
- Mandatory education required by the National Safety and Quality Health Service Standards (NSQHSS), where compliance is achieved is recorded on the Safety & Quality KPI report
- Non or low compliance are noted on the hospital's Safety and Quality Action Plans
- Attendance records are maintained and accessible for review and auditing
- Education programs are evaluated using the standard evaluation tool template
- A strategy has been developed to ensure that records are able to be retrieved from current and prior systems on request

Some mandatory training is risk rated, and / or targeted to high risk areas, such as Aseptic Technique and Advanced Life Support. These training programs have an action plan, identify the high risk areas and staff required to undertake the training to ensure the full intent of the actions are implemented.

All Hospitals provide relevant data and information in regards to compliance on a quarterly basis, and mandatory training is on an annual performance measure.

Current mandatory training results for each hospital;
CSSD Competencies; Ashford - 100%, Flinders - 98.4%, Memorial - 100% = ACHA = 99.3%

Basic Life Support; Ashford - 93%, Flinders - 89%, Memorial - 91% = ACHA 91%

Advanced Life Support: Ashford - 99%, Flinders - 95.5%, Memorial - 99.3% = ACHA 99%

Aseptic Technique: Ashford - 94% (includes VMO's 100%), Flinders - 86% (includes VMO's 97%), Memorial - 92% (includes VMO's 100%) = ACHA 92% (this includes training of VMO's in high risk areas i.e. ICU, Theatre and Emergency Department)

Hand Hygiene: Ashford - 89% (includes VMO's 68%), Flinders - 87.3% (includes VMO's 61.4%), Memorial - 89% (includes VMO's 79%) = ACHA 88.4% (includes VMO's 69.5%)

Medication - Ashford - 93%, Flinders - 93%, Memorial - 93% = ACHA 93%
Midwife Competencies (Mid+Safe); Ashford - 100%, Flinders - 100% = ACHA = 100%
Manual Handling: Ashford - 93%, Flinders - 85%, Memorial - 92% = ACHA = 90%
Emergency Code: Ashford - 92%, Flinders - 88%, Memorial - 90% = ACHA = 90%

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

ACHA Health Mandatory Training Policy 4.10 outlines the appropriate staff training required based on the competency requirements of the employed medical, nursing, midwifery and allied health workforce. Online training platform ELMO supports online training packages and monitoring of training compliance. The assessment team viewed compliance rates for mandatory training across various training programs and professional groups, with mostly high compliance rates. This recommendation is now closed.

Organisation: ACHA Health

Action 1.20: The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training

Recommendation NSQHSS Survey 0916.1.4.4 :

1. Develop and implement a formal schedule of competency-based training across the health service.
2. Ensure required competency-based training is completed, and documented, on a timely basis and records are maintained accordingly.

Organisation Action:

1. Develop and implement a formal schedule of competency based training across the health service.

Actions

A planned strategy is actioned to ensure a schedule is in place to conduct competency based training

- Mandatory competencies are aligned with the requirements of the National Standards, policy was reviewed and updated in July 2018
- Review of all competencies related to the workforce practice occurs, and updated according to;
  - Legislative changes
  - External contractual arrangements
  - Best practice changes
  - External review recommendations by Governing bodies
- Standardisation of competencies across ACHA is in place
- Analysis of mandatory competency training is undertaken

2. Ensure required competency based training is completed, and documented, on a timely basis; and records are maintained accordingly.

Actions

Department managers from each hospital report progress on competency training on a monthly basis to the ACHA Executive

- Competencies are signed off by the department manager, and recorded on successful completion
- All completed competencies recorded are to be accessible for auditing
- Records of training are both electronic and paper based

Audits are conducted as scheduled on each ACHA hospitals Safety and Quality KPI report

All Hospitals provide relevant data and information in regards to compliance on a quarterly basis, and mandatory training is on an annual performance measure.

Current mandatory training results for each hospital;
CSSD Competencies; Ashford - 100%, Flinders - 98.4%, Memorial - 100% = ACHA = 99.3%

Basic Life Support; Ashford - 93%, Flinders - 89%, Memorial - 91% = ACHA 91%

Advanced Life Support: Ashford - 99%, Flinders - 95.5%, Memorial - 99.3% = ACHA 99%

Aseptic Technique: Ashford - 94% (includes VMO's 100%), Flinders - 86% (includes VMO's 97%), Memorial - 92% (includes VMO's 100%) = ACHA 92% (this includes training of VMO's in high risk areas i.e. ICU, Theatre and Emergency Department)

Hand Hygiene: Ashford - 89% (includes VMO's 68%), Flinders - 87.3% (includes VMO's 61.4%), Memorial - 89% (includes VMO's 79%) = ACHA 88.4% (includes VMO's 69.5%)

Medication - Ashford - 93%, Flinders - 93%, Memorial - 93% = ACHA 93%
Midwife Competencies (Mid+Safe); Ashford - 100%, Flinders - 100% = ACHA = 100%
Manual Handling: Ashford - 93%, Flinders - 85%, Memorial - 92% = ACHA = 90%
Emergency Code: Ashford - 92%, Flinders - 88%, Memorial - 90% = ACHA = 90%

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

ACHA Mandatory Training Policy 4.10 outlines the appropriate staff training required based on the competency requirements of the employed medical, nursing, midwifery and allied health workforce. Online training platform ELMO supports online training packages and monitoring of training compliance. The assessment team viewed compliance rates for mandatory training across various training programs and professional groups, with mostly high compliance rates. ACHA has implemented targeted training in high-risk cases-mix, for example Obstetrics, with the Obstetric Safety Mid+Safe web-based interactive learning program, including electronic fetal monitoring. Oncology nurses in Marion ward at Ashford complete ADAC training for Chemotherapy administration. This recommendation is now closed.

Organisation: ACHA Health
Action 1.22: The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system

Recommendation NSQHSS Survey 0916.1.11.1 :
Ensure a valid and reliable performance review process is in place for the clinical workforce, which demonstrates consistent compliance across the health service, within specified timeframes.

Organisation Action:

Ensure a valid and reliable performance review process is in place for the clinical workforce, which demonstrates consistent compliance across the health service within specified timeframes.

Actions

A performance review policy and procedure is in place;

- ACHA policy 4.14 Performance Review and Development
- ACHA policy 4.05 Performance and Conduct Management

- The performance review process has been reviewed, this included;
  - Individual professional development plans
  - System-wide tracking of participation in reviews
  - Audit of clinical workforce with completed performance reviews
  - Audit of work practice against policies and procedures

- A review of the systems for tracking, a review of the frequency of audits, and the attainment of expected compliance across the health service is occurring
- Audits where compliance outcomes are achieved are recorded on the Safety & Quality KPI report
- Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans

Results are reported to the ACHA Executive and reported to the ACHA Board
Performance Appraisal review process was reviewed and updated in June 2017.
This included the redevelopment of appraisal forms for - Managers, clinical staff and non-clinical staff, which were endorsed by the ACHA Executive Committee in August 2017
Managers are required to report to each hospitals Executive on a monthly basis on Performance Appraisal completion rates.

The process implemented has been evaluated which included;

- Use of the process, forms and outcomes
- Higher compliance rate by staff in all departments
- Any required changes for improvement - there were no changes suggested

VMO's practice is reviewed during the credentialing process, where all applications for accreditation and re-accreditation must be supported with two current referees who are able to attest to the current practice the application is applying for.

Audit conducted in May 2019 for approval of accreditation at ACHA through the ACHA Medical Advisory Committee included the review of 1056 VMO's applications for both initial and re-accreditation, the results showed; 58 (5.5%) required further review, the outcomes were; (these results were published in the ACHA Doctor News Letter July 2019)

1. 33 VMO's were approved for accreditation after clarification of practice was sought

2. 10 VMO's scope of practice was altered prior to accreditation approval

3. 12 VMO's accreditation was not approved

4. 3 VMO's requested variation of practice was not approved

VMO's practice is also reviewed by peers through the ACHA Clinical Review Committee, where mortality and morbidity events are put forward for analysis. As a result of this thorough practice review, during 2016 to 2019;

* 3 VMO's accreditation rights have been terminated

* 267 VMO's practice has been reviewed by Clinical Advisors

* 109 VMO's have been required to respond to their practice outcomes

Shared learnings and recommendations are reported to the ACHA Medical Advisory Committee, which have all been supported and included in the ACHA Doctors Newsletters.

A number of audits have been conducted through the ACHA Medical Advisory Committee to review VMO's accredited scope of practice against actual procedures undertaken, these include;

* Bariatric Surgery

* Dental Surgery and Oral Maxillofacial Surgery

* Breast and ENT Surgery

* Robotic Surgery

* Gynaecology Surgery

Results of audits have been tabled at ACHA MAC, ACHA CRC and in the ACHA Doctors Newsletters

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

ACHA Health Performance Review and Development Process 4.14 defines the requirements for members of the workforce to review their performance. Performance appraisal completion is monitored across all three sites, with high compliance within the employed nursing and allied health staff. Assessors discussions with many clinical staff across the organisation confirmed that performance appraisals were performed annually. Assessor discussions with Critical Care Unit Medical Officers noted that they were yet to undertake performance appraisal this year. Performance development and review of the rotational medical officers from Flinders Medical Centre is performed by the Flinders Medical Centre. This recommendation is now closed.

Organisation: ACHA Health
Action 1.22: The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system

Recommendation NSQHSS Survey 0916.1.11.2 :
Ensure consistent compliance with the workforce performance review process on a timely basis.

Organisation Action:

Ensure consistent compliance with the workforce performance review process on a timely basis.

Actions

A review of the systems for tracking, a review of the frequency of audits, and the attainment of expected compliance across the health service is occurring

- Performance review of Visiting Medical Officers (VMO) sits within the ACHA Clinical Review Committee (CRC); this is an authorised peer review committee that holds statutory privilege. This committee reports to the ACHA Medical Advisory Committee (MAC).
- The credentialing of VMO's is governed by the Australian Commission on Safety and Quality in Healthcare (ACSQHC) National Standards. All VMO's are required to provide details of registration and referees within their clinical scope of practice prior to obtaining accreditation, which is governed by the ACHA Medical Advisory Committee
- VMO's are governed by the ACHA Medical Services Regulations
- Where VMO's do not meet the appropriate requirements for accreditation, they are de-activated and are unable to access the services of the hospital
- Accreditation audits are conducted on a quarterly and annual basis
- Audits where compliance outcomes are achieved are recorded on the Safety & Quality KPI report

Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans, and are re-audited to ensure compliance

Results are reported to the ACHA Executive and reported to the ACHA Board

Medical Peer Review;
In 2016 to 2019 (YTD), the Clinical Review Committee (CRC) reviewed a total of 1615 cases (2016: 559, 2017: 449, 2018; 431, 22019: 176);

- 85% of cases underwent level 1 review - cases reported to the committee which were considered to have been appropriately managed and no further action was required
- 8% level 2 review - cases where the review progressed to a review of the clinical record and the committee considered to have been appropriately managed and no further action was required
- 7% level 3 review - cases where following a review of the clinical record, the committee has sought further information from the treating clinician(s), clinical advisors, coroner etc and/or taken action, and/or made a recommendation
  Current credentialing audits for Visiting Medical Officers (VMO) results are 100% for each hospital, which includes scope of practice, registration and medical indemnity.

  All peer reviews conducted at the ACHA CRC are reported to the ACHA MAC, any that raise major concern are reported to the ACHA MAC Chair and ACHA CEO immediately.

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

ACHA Health Performance Review and Development Process 4.14 defines the requirements for members of the workforce to review their performance. Performance appraisal completion is monitored across all three sites, with high compliance within the employed nursing and allied health staff. Assessors discussions with many clinical staff across the organisation confirmed that performance appraisals were performed annually. Assessor discussions with Critical Care Unit Medical Officers noted that they were yet to undertake performance appraisal this year. Performance development and review of the rotational medical officers from Flinders Medical Centre is performed by the Flinders Medical Centre. This recommendation is now closed.

Standard 2

Organisation: ACHA Health
Action 2.4: The health service organisation ensures that its informed consent processes comply with legislation and best practice

Recommendation NSQHSS Survey 0916.1.18.2 :
1. Ensure that the consent forms used by VMOs meet the expectations of the health service, and also comply with governing legislation and standards.
2. Ensure that all consent forms are fully completed prior to the patient being transferred to the operating suite, where an emergency is not a factor.

Organisation Action:

1. Ensure that the consent forms used by VMOs meet the expectations of the health service, and also comply with governing legislation and standards.

Actions

Policy and Procedure are in place for informed consent;

- ACHA policy 2.17 Consent to Medical / Surgical Treatment
- ACHA has implemented a Consent Form that has been reviewed against the requirements of the National Standards
- VMO's are able to use their own consent forms. The ACHA policy has been reviewed and updated to include the appropriate components that VMO's must include in their own forms
- This has been tabled at the ACHA Medical Advisory Committee

2. Ensure that all consent forms are fully completed prior to the patient being transferred to the operating suite, where an emergency is not a factor.

Actions

Policy and Procedure are in place for team time out, ensuring the right patient and procedure will occur;

- ACHA policy 2.15 Correct Patient, Correct Procedure, Correct Site
- During this process the Consent Form is sited prior to entering the procedural room, and reviewed for completeness
- A Chain of Command policy and procedure has been implemented to assist when non-compliance occurs;
- ACHA policy 2.19 Chain of Command – Nursing Staff
- Audits tools are to incorporate VMO's Consent Forms for audit

Consent Forms audits are conducted on an annual basis

-

Audits where compliance outcomes are achieved are recorded on the Safety & Quality KPI report

-

Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans, and are re-audited to ensure compliance

-

Results are reported to the ACHA Executive and reported to the ACHA Board

Consent Policy 2.17 has been reviewed to include the use of a VMO own consent form. This was endorsed by the ACHA policy Committee in March 2017.
Non-compliances with the consent policy is reported to Riskman;

- From June 2018 to June 2019 - 40 non-compliances to the policy were reported to Riskman. Each event reported in relation to consent to medical treatment was investigated at the time, and corrective actions were put in place to ensure all patients had consented for the procedure that was undertaken.

  Audit tool has been reviewed and updated to include VMO own consent.
- Current results of the Consent To Medical Treatment audit for ACHA hospitals is 94%.

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes
Actions taken have met the requirements of this previous recommendation.

Organisation: ACHA Health
Action 2.10: The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge

Recommendation NSQHSS Survey 0916.3.19.2:
Ensure that consultation and evaluation of patient infection prevention and control information is undertaken consistently across the health service to ensure that it meets the needs of the targeted audience.

Organisation Action:

Ensure that consultation and evaluation of patient infection prevention and control information is undertaken consistently across the health service to ensure that it meets the needs of the targeted audience.

Actions

All Infection Control information for consumers across ACHA is standardised

- The information provided to patients is sourced from SA Health, ACSQHC, Hand Hygiene Australia, as well some internally developed information
- There is a robust document review process via the ACHA Policy Committee where all ACHA documents are reviewed on a 3 yearly basis and / or when required
- All ACHA documents are review by our Consumer Consultants and identified as 'Consumer Approved Publications' (CAP) – CAP's logo is noted on the publications as a sign of approval
- Consumer Representatives attended hospitals Safety and Quality meetings
- The 'It's OK to ASK' program commenced as an Infection Control based program and resource in response to consumer feedback
- Patient satisfaction surveys contain Infection Control related questions
- Infection Control Managers consult with patients who have known infections, provide Infection Control resources, which is documented in RL6 Solution – IT Infection Control Surveillance Program
- ACHA TV channel, which includes Infection Control information, reviewed and updated in 2019 with Consumer Consultant involvement
- Consumer Focus Groups review and discuss Infection Control information
- Compliments and Complaints Process is in place which includes the concerns raised regarding Infection Control issues
- Our Performance – Reviewed by external research company; included consumers and staff

Feedback received from discharged patients on; Overall, the quality and treatment of care received for FY2019 = ACHA - 84%, ASH - 83%, FPH - 84%, TMH - 85%

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

All patient information across ACHA Health is reviewed by the Consumer Representatives and the ACHA Health Infection Control Committee and the Infection Control Managers. This recommendation is now closed.

Organisation: ACHA Health
Action 2.14: The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce

Recommendation NSQHSS Survey 0916.2.6.2:
Consider other ways of engaging patients/carers to train the workforce other than feedback, complaints, and incidents.

Organisation Action:

Consider other ways of engaging patients/carers to train the workforce other than feedback, complaints, and incidents.

Actions

Consumers and Consumer Representatives are included in;

- Patient Journeys
- Visit inpatients
- Conduct patient surveys
- Speak at Hospital Orientation and present at various at study days
- Carer (ICU patient at Flinders Private Hospital) presented at the ICU study day
  - Involved in the development of the dedicated TV channel
  - Participate in presentations on each hospitals Facebook page
  - Involved in education videos to inform staff regarding patient centered care
- Consumers are represented at each hospitals Safety and Quality committees, and a Consumer Consultant is a member of the ACHA Executive meetings
  - Consumer Representatives attend ward handover sessions, and bedside handover takes place daily which includes the patient
  - ACHA Consumer Consultant presented at the 2017 Quality Managers Conference, attendees included; Quality Managers, Directors of Nursing, ACHA Clinical Risk Manager, General Manager, and Clinical Educators
  - Consumer Focus Groups are held in May 2017, which included education for Consumers on 'Ways to train the workforce'. This is now a regular event occurring twice yearly.
  - Consumers provide information directly to the hospitals of key issues to assist in informing and training of the workforce

- The corporate Patient Centred Care training program for the workforce, was developed directly from Consumer information and feedback
- The organsiation has two Aboriginal Advisors, to assist in educating the workforce on welcoming and embracing patients who identify as Aboriginal and Torres Strait Islander

Evidence;

1. Consumer Consultants attend hospital orientation days to speak with staff directly
2. Feedback results are tabled at ACHA Executive Committee and the ACHA Board Safety & Quality Report
3. Patient journeys across each hospital are scheduled, and was recently updated to include simulated journey (virtual). This was reviewed by Consumer Consultant - stating ' this is an excellent process, very similar to a patients actual journey - virtual reality, the person playing the part of the patient will need to be unknown to the staff to obtain full impact.
4. All feedback results and comments are provided to hospitals through the ACHA Executive Committee and the hospitals Safety & Quality meetings. This informs staff of positive & negatives experience identified by the consumers and patients.
5. A number of DVD's and Videos have been developed, which include; Bedside Handover and Patient Rounding, each which involve Consumers and staff. Scripts are written in collaboration with Consumers. Staff and students view the DVD and Videos at Hospital Orientation, Education Training Days and during In-services
6. Aboriginal Elder Advisor presented at a recent ACHA Executive meeting educating on 'how to welcome Aboriginal and Torres Strait Islander people into the hospitals, and how to assist the staff to do this'

Further DVDs and Videos continue to be developed, with the most recent one being edited, and planned to rollout in early August 2019.

Completion Due By: 22.07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

ACHA Health has invested considerable resources to better engage consumers and patients/carers in the development, presentation and delivery of training information for the workforce. The initiative to use multi-media messaging, which includes "experts by experience", consumers and staff presenting examples of clinical process and outcomes, is an intuitive tool with presentation targeting both new and existing staff of the health service. The messaging will be reviewed, expanded and update to align with changing clinical service delivery and to target the current learning needs of the workforce.

It was evident that ACHA Health Consumer Consultants are a valued resource and present examples of their experience and knowledge to newly recruited staff as part of the Orientation process. The consumer consultant collectively has a broad experience and knowledge base and sharing this is valued by the clinical and operational staff. Consumer membership of the Safety and Quality Committee is also an opportunity to present/report on consumer and patient views gained when sharing patient journeys in the wards and on invitation formally present to the Executive Committee.

This recommendation is closed.

Standard 3

Organisation: ACHA Health
Action 3.1: The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship

Recommendation NSQHSS Survey 0916.3.1.1:
Ensure that the required changes to the CSSD service of the Memorial Hospital are made as specified, and within the stated timeframes.

Organisation Action:

To ensure that the required changes to the CSSD service of The Memorial Hospital are made as specified and within the stated timeframes.

Actions

Construction is currently underway for the redevelopment of the Central Sterilising Service. This has occurred over 2 stages;

Building and refurbishment for stage 1 occurred in January 2017
Stage 1 included a restructure of the department and competency training of all staff;

- The adequate space for safe reception, accommodation and effective processing of re-usable devices
- Relevant and appropriate equipment has been purchased
- Adequate and effective flows from the dirty area, to the clean area, to the sterile area has occurred
- The risk of accidental use of unsterile stock/equipment has been eradicated
- The risk of cross contamination has been eradicated
- Optimal storage space for sterile and non-sterile stock has been provided

Effective compliance with governing legislation, standards and codes of practice has been reviewed and undertaken;

A full audit of the Central Sterilising Department has been undertaken by an external Sterilising Company and Architecture. This is completely in-line with the Australian Standards for Sterilising Departments - AS: 4187.
HICMR audit results against the standard have supported the gap analysis and action plans as per the requirements of Australian Commission on Safety and Quality Advisory - A 18/07.

HICMR audit was conducted at The Memorial Hospital on the 23 & 24 May 2018. CSSD achieved a compliance rate of 91%, which was an improvement of 11% from the 2016 audit. Recommendations made were to continue on with the implementation of the action plan for meeting the requirements of AS: 4187.

Stage 2 incorporates the completion of the construction works required for a full redevelopment of the CSSD. The Memorial Hospital is currently undergoing a major building redevelopment, which involves a full reconstruction of the CSSD.

Currently, staff competency training is 100% compliance. All staff have either completed formal training, or are currently enrolled in a formal training course. The department does have a small number of new employees, who are currently undertaking induction education, theses staff have all been enrolled into formal education, which will commence after the 3 month probationary period, this will include competency training and education for sterilising practices.

ACHA commenced a CSSD Working Party in October 2016. Membership includes CSSD Managers, Theatre Managers and Infection Control Coordinators from each ACHA hospital, and is chaired by the Director of Nursing from Flinders Private Hospital.

The Working party reports to the ACHA Patient Care Committee.

To date the working party has reviewed and developed;

1. Standardised competencies for ACHA CSSD staff
2. Organisation has organised a formal education program for staff to undertake - this is providing CSSD staff with Certificate 3: Sterilisation of Medical Devices
3. Reviewed and updated policies and procedures for CSSD
4. Currently working through the Action Plan for each hospital to fully comply with implementation of AS: 4187 (as per ACSQHC Advisory A18 / 07.

In June 2019, the external sterilisng company was re-approached to ensure The Memorial Hospital CSSD remains compliant during the building works, which continues to show compliance and with the required actions regarding ACSQHC Advisory 18/07.

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The building works currently underway in the CSSD at the Memorial Hospital have stringent infection control practices in place that have been risk assessed with accompanying risk management strategies to minimise and mitigate the risk of infection. This is constantly monitored, and daily discussion occurs with the contractors and identified problems resolved in a timely manner. This recommendation is now closed.

Organisation: ACHA Health
Action 3.1: The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship

Recommendation NSQHSS Survey 0916.3.15.2 :
Further monitoring of compliance with optimal cleaning regimes (eg between patient use) is recommended for those areas that still provide shared use of bathrooms/en suites.

Organisation Action:

Further monitoring of compliance with optimal cleaning regimes (e.g. between patients use) is recommended for those areas that still provide shared use of bathrooms/ensuites.

Actions

Rooms are cleaned daily, shared bathrooms and toilets are cleaned twice daily.

- There is a support services staff cleaning schedule and documentation to support this
- Shared items; i.e. Shower chairs are cleaned with detergent/bacterial wipes between patient use and at discharge
- Staff are educated on the cleaning and disinfection of shared patient items as required by the National Standard on Precautions at orientation and mandatory training days.
- A clinical staff cleaning schedule to support this has been developed
- Processes in place where patients are not placed in rooms with shared bathrooms.
- Staff are audited on compliance to Standard and Transmission based precautions
- Audit outcomes are reported on the hospitals Safety and Quality KPI report on a quarterly basis
- Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans
- Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcomes

Evidence of compliance is the burden of Multi-resistant Organisms (MRO) and low healthcare associated transmission.
This is reported to SA Health and nationally benchmarked with Healthscope.
Further evidence of infection risk is reduced by implementation of transmission based precautions as required.

HICMR audits conducted at Ashford Hospital in April 2019, Flinders Private Hospital in May 2019 and The Memorial Hospital in May 2018. HICMR advised that current cleaning practices for patients in shared bathroom toilet facilities, meets current Infection Control standards.

HICMR audit results for Facility Wide Risk Assessments for Infection Control are;

- Ashford Hospital - 95.8% (Audit conducted April 2019)
- Flinders private Hospital - 96.5% (Audit conducted May 2019)
- The Memorial Hospital - 98% (Audit conducted May 2018)

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes
There is a schedule for the cleaning of shared ensuites and these are cleaned twice daily, and showers cleaned immediately after use. Audits confirm compliance are supported through the surveillance program. This recommendation is now closed.

Organisation: ACHA Health

Action 3.1: The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship

Recommendation NSQHSS Survey 0916.3.18.1 :
1. Ensure all members of the workforce, working within the areas where cleaning and decontamination of reusable medical devices and instruments take place, have successfully achieved relevant, formally recognised, competency-based qualifications.
2. Ensure that the systems and processes used to maintain required documentation is consistent and effective, and in turn is able to provide evidence of successful completion on a timely basis.

Organisation Action:

1. Ensure all members of the workforce, working within the areas where cleaning and decontamination of reusable medical devices and instruments takes place have successfully achieved relevant, formally recognised, competency-based qualifications.

Actions

- A planned strategy and schedule is in place to conduct competency based training
- Analysis of mandatory competency training has been undertaken as part of a departmental reviews through the ACHA CSSD working party
- ACHA CSSD staff training is reported to the Safety and Quality KPI report on a quarterly basis
- CSSD staff are allocated the HICMR on-line training platform – ELMO; these education programs are automatically allocated to staff via individual email accounts by hospitals educators
- CSSD staff, who do not hold current certificates will undertake the Certificate 3 in Sterilisation Services. The course has been commenced with training on site since May 2017.

CSSD competencies are being met within a training schedule. Certificate 3 plus HICMR and in-house training are continuously conducted to achieve 100%.

In place;
- Endoscopy staff complete all 3 HICMR modules
- CSSD staff are required to complete the 3 CSSD HICMR modules and all Theatre Team Leaders, Coordinators are to complete the 4 HICMR modules

The company TIME has been engaged to conduct a Certificate 3 program which has been funded for all CSSD staff, ensuring all ACHA CSSD staff have a Cert 3 as a baseline education level.

New staff have on the job training, using HICMR resources, and at the 6 month stage of their employment complete the formal HICMR and Cert 3 course.
Some staff independently have Cert 4 in Sterilising.
All eLearning training records are stored electronically and hard copies available for staff files.
External training is able to be uploaded into eLearning.

Currently CSSD staff competency rate for ACHA is 99%, which continues improve: 2017 was 92% and 2018 was 98.6%.

- Ashford Hospital - 99%
- Flinders Private Hospital - 98%
- The Memorial Hospital - 100%

2. Ensure that the systems and processes used to maintain required documentation is consistent and effective, and in turn is able to provide evidence of successful completion on a timely basis.

Actions

- A planned strategy is required to ensure that a schedule is in place to conduct competency based training.
- Analysis of mandatory competency training has been undertaken as part of a departmental reviews.
- Mandatory training online platform is available to all staff – ELMO; appropriate education programs are automatically allocated to staff via individual email accounts by hospitals educators
- Mandatory education required by the NSQHSS, where compliance is achieved is recorded on the Safety & Quality KPI report
- Non or low compliance are noted on the hospital's Safety and Quality Action Plans
- Attendance records are maintained and accessible for review and auditing
- Education programs are evaluated using the standard evaluation tool template
- A planned strategy is being developed to ensure that records are able to be retrieved from current and prior systems on request

CSSD staff training and streamlining of competencies across each site is a standing agenda item for the CSSD Working Party, which meets monthly.

CSSD staff training is a required KPI which is reported quarterly on the Quality KPI Report. ACHA has committed to the HICMR competency program, including CSSD staff at each hospital.
Review of CSSD training and competency requirements is evaluated on a quarterly basis. An action plan is in place for new staff to the department, this includes; induction education, enrolment into the Cert 3 program, and commencement of competency training. The CSSD Managers manage each staff's education continously to ensure compliance rate remains as per the KPI.

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Training records sighted for each CSSD demonstrated completion or near completion of appropriate education, such as Certificate III or that provided by the manufacturer. This recommendation is now closed.

Organisation: ACHA Health
Action 3.8: The health service organisation has a hand hygiene program that: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative

Recommendation NSQHSS Survey 0916.3.5.3:
Further action be taken to maximise hand hygiene compliance rates for medical officers.

Organisation Action:

Further action is to be taken to maximise hand hygiene compliance rates for medical officers.

Actions

A policy and procedure is in place for the compliance and management of hand hygiene for the work force;

- ACHA policy 8.10 Hand Hygiene
- eLearning Program - Hand Hygiene and Aseptic Technique is available
- Installation of Purell GoJo Hand Sanitiser Gel, Foam and Conditioner
- Integrated Risk Register - Controls
- Auditing of compliance to 5 Moments - Aseptic Technique
- Brochures, Fact Sheets, Posters and Signage

Hand Hygiene Awareness Display - workforce, visitors and patients

-

Most recent initiative – 20% of all 5 Moments audits to be conducted on Visiting Medical Officers, and results table at ACHA Medical Advisory Committee.

-

Hospitals have undertaken external review by Hand Hygiene Australia. Program review of Hand Hygiene against the World Health Organisation (WHO) audit tool

-

Review and validation of program very positive, Hand Hygiene Australia (HHA) acknowledged compliance by VMO's is a world-wide challenge

-

Local VMO posters are in place which show VMO's involved in Hand Hygiene. These have been commended by external surveyors from Healthcare Infection Control Management Resource (HICMR)

-

ACHA conducts audits three times a year, and reports all outcomes to the Hand Hygiene Audit program

-

Results are published on ourPerformance – public reporting data

-

All information is tabled at the ACHA Medical Advisory Committee and noted in the ACHA Newsletter

-

VMO results are tabled and discussed at the ACHA Infection Prevention and Control Committee (sub-committee of the ACHA Medical Advisory Committee)
Overall compliance with Visiting Medical Officers has improved from 62% to 69.5%, an increase of 7.5% at ACHA hospitals from 2017 to 2019
Current compliance rates are;

- Hand Hygiene: Ashford - 89% (includes VMO's 68%), Flinders - 87.3% (includes VMO's 61.4%), Memorial - 89% (includes VMO's 79%) = ACHA 88.4% (includes VMO's 69.5%)

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes
The compliance with hand hygiene rates for medical officers is consistently improving at each audit and there are medical officers who actively promote the use of hand hygiene with their colleagues. This recommendation is now closed.

Organisation: ACHA Health
Action 3.9: The health service organisation has processes for aseptic technique that: a. Identify the procedures where aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique

Recommendation NSQHSS Survey 0916.3.10.1 :

Fully implement the training of the clinical workforce across the three sites.

Organisation Action:

Ensure that clinical workforce is trained in aseptic technique. Fully implement the training of the clinical workforce across the three sites.

Actions

A policy and procedure is in place for the compliance and management of aseptic technique for the clinical work force

ACHA policy 8.38 Aseptic technique

- Aseptic technique is mandatory for all employed clinical staff, including Staff Medical Officers
- High compliance rates are noted in each hospital; review and risk assessment of training has been conducted. A training plan is in place
- eLearning package has been developed and put onto the online platform – ELMO. This package has been adopted by Healthscope. The training package is based on Australian College of Infection Prevention and Control (ACIPC) resources
- Audits of competency are recorded and accessible for review
- Audit outcomes are reported on the hospitals Safety and Quality KPI report on a quarterly basis
- Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans
- Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcomes

A review of National Standard - 3.10 Aseptic Technique training, competency and auditing, which included VMO competency auditing.
Auditing of competency has been risk rated against casemix and ward or department type.
Aseptic technique has been added to each hospital Risk Registers, with controls in place.
ACIPC - audit and competency tools have been adopted, and approved by the ACHA Patient Care Committee
Training is scheduled and conducted based on audit of compliance of practice and clinical outcomes.
Audits are conducted as per each hospital audit schedule.

Current competency rate for Aseptic Technique, which includes VMO's at ACHA hospitals is;

- Aseptic Technique: Ashford - 94% (includes VMO's 100%), Flinders - 86% (includes VMO's 97%), Memorial - 92% (includes VMO's 100%) = ACHA 92% (this includes training of VMO's in high risk areas i.e. ICU, Theatre and Emergency Department)

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes
The training of the clinical workforce in aseptic technique continues with risk assessments conducted and staff completion in line with requirements. This recommendation is now closed.

Organisation: ACHA Health

Action 3.11: The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements – that: a. Respond to environmental risks b. Require cleaning and disinfection in line with recommended cleaning frequencies c. Include training in the appropriate use of specialised personal protective equipment for the workforce

Recommendation NSQHSS Survey 0916.3.15.1 :
Ensure appropriate, and adequate cleaning of baths, showers, toilets, and other shared items, between patients.

Organisation Action:

Ensure appropriate, and adequate cleaning of baths, showers, toilets, and other shared items, between patients.

Actions

Rooms are cleaned daily, shared bathrooms and toilets are cleaned twice daily

- There is a support services staff cleaning schedule to support this
- Shared items; i.e. Shower chairs are cleaned with detergent/bacterial wipes between patient use and at discharge
- Staff are educated on the cleaning and disinfection of shared patient items as required by the National Standard on Precautions at orientation and mandatory training days.
- A clinical staff cleaning schedule to support this has been developed
- Processes are in place where patients are not placed in rooms with shared bathrooms
- Staff are audited on compliance to Standard and Transmission Based Precautions
- Audit outcomes are reported on the hospitals Safety and Quality KPI report on a quarterly basis
- Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans
- Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcomes

Evidence of compliance is the burden of Multi-resistant Organisms (MRO) and low healthcare associated transmission.
This is reported to SA Health and nationally benchmarked with Healthscope.

Further evidence of infection risk is reduced by implementation of transmission based precautions as required.
HICMR audits conducted at Ashford Hospital in April 2019, Flinders Private Hospital in May 2019 and The Memorial Hospital in May 2018.HICMR advised that current cleaning practices for patients in shared bathroom toilet facilities, meets current Infection Control standards.
HICMR audit results for Facility Wide Risk Assessments for Infection Control are;

- Ashford Hospital - 95.8% (Audit conducted April 2019)
- Flinders private Hospital - 96.5% (Audit conducted May 2018)
- The Memorial Hospital - 98% (Audit conducted May 2018)
-

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

There is a cleaning schedule for the cleaning of shared bathroom facilities and audits and infection control rates confirm this is occurring. This recommendation is now closed.

Organisation: ACHA Health
Action 3.14: Where reusable equipment, instruments and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure

Recommendation NSQHSS Survey 0916.3.16.1:
Complete the required actions as derived from the recent AS4187 gap analysis.

Organisation Action:

Complete the required actions as derived from the recent Australian Standard for Reprocessing of Reusable Items - AS4187 gap analysis.

Actions

Discussion took place with the ACHA Executive team at the time of survey

-

A documented action plan has been submitted

-

The risk rating assessment has reduced the residual rating due to the commencement of planning and commitment to timeframes. It is essential that this commitment be fulfilled

-

ACHA has now incorporated a Central Sterilising Services Department (CSSD) working party, terms of reference include;

-

Review and implementation of the gap analysis for the recently updated AS 4187 standard, ensuring all actions are completed according to the required timeframes as set out by the ACSQHC

- Standardisation of competency training required for CSSD staff
- Standardisation of audit tools and timeframes
- Reporting of outcomes through the ACHA safety and quality framework
- Full HICMR review for each hospital included AS 4187;
- Ashford Hospital- April 2019
- Flinders Private Hospital - May 2019
- The Memorial Hospital – May 2018

Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcomes

Recent HICMR Audit results for CSSD;

- Ashford Hospital - 96.6% in April 2019 (an improvement of 3.6% from 2017)
- Flinders Private Hospital - 96.6% in May 2019 (an improvement of 3.6% from 2017)
- The Memorial Hospital - 91% in May 2018 (an improvement of 11% from 2016)

Currently, staff competency training is 99% compliance. All staff have either completed formal training, or are currently enrolled in a formal training course.

- CSSD Competencies; Ashford - 100%, Flinders - 98.4%, Memorial - 100% = ACHA = 99.3%
  ACHA commenced a CSSD Working Party in October 2016. Membership includes CSSD Managers, Theatre Managers and Infection Control Coordinators from each ACHA hospital. It is chaired by the Director of Nursing from Flinders Private Hospital.
  The Working party reports to the ACHA Patient Care Committee.

  To date the working party has reviewed and developed;

1. Standardised competencies for ACHA CSSD staff
2. Organised a formal education program for staff to enrol into
3. Reviewed and updated policies and procedures for CSSD
4. Currently working through the Action Plan for each hospital to fully comply with implementation of AS: 4187 as per ACSQHC Advisory A18 / 07.

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The AS/NZS 4187:2014 gap analysis and accompanying action plan was seen by the assessors with ongoing progress to date. This recommendation is now closed.

Standard 4

Organisation: ACHA Health
Action 4.14: The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines

Recommendation NSQHSS Survey 0916.4.10.1:
1. Ensure the safe and appropriate storage of all medications in line with governing legislation.
2. Ensure appropriate and timely monitoring systems are in place to achieve compliance.

Organisation Action:

1. *Ensure the safe and appropriate storage of all medications in line with governing legislation.*

Actions

A policy and procedure is in place for the compliance and management of medication storage;

- ACHA policy 8.89 Medication Safety Governance
- Review of Schedule 8 (S8) and Schedule 4 (S4) drug storage across each site has been conducted to ensure full compliance with legislation and policy
- Review of lockable Anaesthetic trolleys at each site has been conducted to ensure compliance with legislation and policy
- Audit tools have been developed and audits scheduled

2. *Ensure appropriate and timely monitoring systems are in place to achieve compliance.*

Actions

Review of Audit tool for storage of S8 & S4 drugs undertaken

- Audit outcomes are reported on the hospitals Safety and Quality KPI report
- Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans
- Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcome

Policy 8.56 Controlled Drugs - Storage and Administration has been reviewed and updated. Review of the audit tool was then conducted to be in-line with the policy. These were endorsed in April 2017.

Current audit results for medication storage;

- Ashford Hospital - 100%
- Flinders Private Hospital - 100%
- The Memorial Hospital - 100%

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The assessment team identified the need for improvement in the storage of medication and the monitoring of storage. The recommendation has been closed with a new one written.

Organisation: ACHA Health
Action 4.15: The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely

Recommendation NSQHSS Survey 0916.4.11.1:
1. The DDA registers be fully completed at the time of each entry.
2. The DDA register form part of the formal audit schedule, with the frequency of auditing to occur reflective of the risk assessment, and results of audits.

Organisation Action:

1. The Drugs of Dependence Authority (DDA) registers are to be fully completed at the time of each entry.

Actions

DDA register is to be completed at the time of each entry

- Auditing of the DDA registers for completion to occur on a shift by shift basis
- Accurate completion of the DDA register has been entered onto the hospitals risk registers with the commencement of a plan of action
- A policy's and procedure's is in place for the compliance and management of medications;
- ACHA policy 8.89 Medication Safety Governance
- ACHA policy 8.01 Medication Ordering and Administering
- Education to staff has been allocated on the on-line medication training program – Med+Safe

2. The DDA register is to form part of the formal audit schedule, with the frequency of auditing to occur reflective of the risk assessment, and results of audits.

Actions

Review of Audit tool for recording of S8 & S4 drugs administration has been undertaken

-

Audits have been scheduled on the audit schedule spreadsheet

-

Audit outcomes are reported on the hospitals Safety and Quality KPI report

-

Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans

-

Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcome

Policy 8.56 Controlled Drugs - Storage and Administration has been reviewed and updated. Review of the audit tool was then conducted to be in-line with the policy. These were endorsed in April 2017.

Current audit results for documentation of DDA's;

- Ashford Hospital - 100%
- Flinders Private Hospital - 99%
- The Memorial Hospital - 100%

Medication incidents, which includes near misses, has seen an improvement each year from FY2016 up to and including FY 2019, these include;

1. 2015 - 2016 = 0.27%
2. 2016 - 2017 = 0.22% (18.6% improvement)
3. 2017 - 2018 = 0.20% (9.1% improvement)
4. 2018 - 2019 = 0.17% (15% improvement)

ACHA has seen a total improvement of 37% from FY2016 to FY2019.

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Review of the Drug of Dependence Registers were observed to be compliant with policy and completed at time of entry and confirmed by monitoring. This recommendation is now closed.

Standard 5

Organisation: ACHA Health

Action 5.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care

Recommendation NSQHSS Survey 0916.10.3.1:

1. Review the audit monitoring process and schedule to meet the needs of each hospital site.
2. The frequency of audits/monitoring fully reflect the requirements of the NSQHSS, and that of the individual hospitals.

Organisation Action:

1. Review the audit monitoring process and schedule to meet the needs of each hospital site.

Actions

ACHA policies and procedures are in place for the prevention and management of patient falls;

- ACHA policy 8.04 Patient Falls – Prevention and Management of
- ACHA policy 8.04c Falls prevention- Grip Socks

- Audits have been developed to measure compliance with policies, and this includes observational, retrospective and documentation auditing
- Audit tools for falls prevention have been developed and placed on the audit schedule spreadsheet, these include;
  - Risk assessment and screening tool
  - Implementation of falls prevention devices i.e. grip socks
- Audit outcomes are reported on the hospitals Safety and Quality KPI report
- Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans
- Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcome

Audit tools are reviewed when changes to policy, legislation and guidelines occur.
Each ACHA hospital has an audit schedule that measures compliance to the National Standards and policies and work practices. This schedule is flexible dependent on audit results and site requirements.

2. The frequency of audits/monitoring fully reflects the requirements of the NSQHSS, and that of the individual hospitals.

Actions

- ACHA reviews its monitoring processes for all the actions under Standard 10 annually and ensures they are reflective of each hospital's requirements; i.e. compliance level and to meet the requirements of the NSQHSS
- Each ACHA hospital has an audit schedule that measures compliance to the National Standards and policies and work practices.
- This schedule is flexible dependent on audit results and site requirements

- Audit outcomes are reported on the hospitals Safety and Quality KPI report
- Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans
- Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcome

Current audits results for Falls Risk Assessment are;

- ACHA - 86.7%
- Ashford Hospital - 82%
- Flinders Private Hospital - 81%
- The Memorial Hospital - 97%

Further education is being conducted, and a further audit will be undertaken at Ashford and Flinders Private Hospitals during July 2019.

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The actions taken are appropriate and this recommendation is complete.

Organisation: ACHA Health

Action 5.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care

Recommendation NSQHSS Survey 0916.8.3.1:

1. Review the audit monitoring process and schedule to meet the needs of each hospital site.
2. The frequency of audits/monitoring reflect the requirements of the NSQHSS, and that of the individual hospitals.

Organisation Action:

1. Review the audit monitoring process and schedule to meet the needs of each hospital site.

Actions

- ACHA policy and procedure is in place for the prevention and management of pressure injuries;
- ACHA policy 8.05 Pressure Injury – Prevention, Identification and Management of

Audits have been developed to measure compliance with policies, and this includes observational, retrospective and documentation auditing

-

Audit tools for pressure injury have been developed and placed on the audit schedule spreadsheet, these include;

-

Risk assessment and screening tool

-

Implementation of pressure injury prevention devices

-

Audit outcomes are reported on the hospitals Safety and Quality KPI report

-

Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans

-

Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcome

-

Audit tools are reviewed when changes to policy or legislative and other changes occur.

2. The frequency of audits/monitoring reflects the requirements of the NSQHSS, and that of the individual hospitals.

Actions

ACHA reviews its monitoring processes for all the actions under National Standard 8 annually and ensures they are reflective of each hospital's requirements; i.e. compliance level and to meet the requirements of the NSQHSS

-

Each ACHA hospital has an audit schedule that measures compliance to the National Standards and policies and work practices.

-

This schedule is flexible dependent on audit results and site requirements

-

Audit outcomes are reported on the hospitals Safety and Quality KPI report

-

Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans

-

Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcome

A Wound Care nurse is available to review Pressure Injuries at each of the ACHA hospitals, which provides real time review and action for treatment.
Each ACHA hospital has an audit schedule that measures compliance to the National Standards and policies and work practices. This schedule is flexible dependent on audit results and site requirements. This includes scheduled audits for pressure injuries.

Current audit results for Pressure Injury Risk Assessment and Management;

- Ashford Hospital - 88%

- Flinders Private Hospital - 85%
- The Memorial Hospital - 97%

Pressure Injury (Stage 2 and Above) - Hospital Acquired has seen an improvement of 30%; from 0.03% in 2015 - 2016 to 0.02% in 2016 - 2017, which has stabilised in 2018 and 2019 remaining at 0.02%.

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

A review of the audit monitoring process for the prevention of pressure injuries has been undertaken and the frequency of monitoring activities at each hospital site meets the requirements of the NSQHSS. This recommendation is complete.

Organisation: ACHA Health

Action 5.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care

Recommendation NSQHSS Survey 0916.8.6.2 :

1. Evaluate and audit the new Pressure Injury Risk Assessment and Management tool for compliance with comprehensive skin assessments separate to the interventions to achieve relevant data and information for both.
2. Include more frequent targeted audits until compliance is at an acceptable level.

Organisation Action:

1. Evaluate and audit the new Pressure Injury Risk Assessment and Management TOOL for compliance of comprehensive skin assessment separate to the interventions to achieve relevant data and information for both.

Actions

ACHA policy and procedure is in place for the prevention and management of pressure injuries ;

-

ACHA policy 8.05 Pressure Injury – Prevention, Identification and Management of

-

Audits have been developed to measure compliance with policies, and this includes observational, retrospective and documentation auditing

-

Audit tools for pressure injury have been developed and placed on the audit schedule spreadsheet, these include;

-

Risk assessment and screening tool

-

Implementation of pressure injury prevention devices

-

Audit outcomes are reported on the hospitals Safety and Quality KPI report

- Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans
- Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcome

The Pressure Injury Risk Assessment Chart was reviewed and updated in July 2019, due to low compliance rates associated with documentation associated with wound dimensions. The audit also identified that a gap existed in the questions regarding wound type due to the recent changes in the staging of wounds.

The revised chart included the expert review of Wound Managers and will be rolled out during August 2019. Auditing will occur on the revised chart.

2. Include more frequent targeted audits until compliance is at an acceptable level.

Actions

ACHA policy and procedure is in place for the prevention and management of pressure injuries ;

- ACHA policy 8.05 Pressure Injury – Prevention, Identification and Management of
- Audits have been developed to measure compliance with policies, and this includes observational, retrospective and documentation auditing
- Audit tools for pressure injury have been developed and placed on the audit schedule spreadsheet, these include;
- Risk assessment and screening tool
- Implementation of pressure injury prevention devices
- Audit outcomes are reported on the hospitals Safety and Quality KPI report
- Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans
- Auditing is to continue until compliance is achieved and maintained
- Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcome

A Wound Care nurse is available to review Pressure Injuries at each of the ACHA hospitals, which provides real time review and action for treatment.
Each ACHA hospital has an audit schedule that measures compliance to the National Standards and policies and work practices. This schedule is flexible dependent on audit results and site requirements. This includes scheduled audits for pressure injuries.

Current audit results for Pressure Injury Risk Assessment and Management;

- Ashford Hospital - 88%
- Flinders Private Hospital - 85%
- The Memorial Hospital - 97%

Pressure Injury (Stage 2 and Above) - Hospital Acquired has seen an improvement of 30%; from 0.03% in 2015 - 2016 to 0.02% in 2016 - 2017, which has stabilised in 2018 and 2019 remaining at 0.02%.

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The Pressure Injury Risk Assessment and Management tool has been evaluated and demonstrates improved compliance. The actions taken are appropriate and this recommendation is complete.

Organisation: ACHA Health

Action 5.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care

Recommendation NSQHSS Survey 0916.8.8.3:

Develop an agreed tool /process for reviewing and auditing wound management plans for compliance and effectiveness.

Organisation Action:

Develop an agreed tool/process for reviewing and auditing wound management plans for compliance and effectiveness.

Actions

Revised Wound Management Plan has been implemented at each hospital

-

Audit tool has been developed and used to monitor compliance and effectiveness of revised chart

-

Audit outcomes are reported on the hospitals Safety and Quality KPI report

-

Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans

-

Auditing is to continue until compliance is achieved and maintained

-

Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcome

Wound Care Nurses were directly involved in the review and update of the Wound Management Plan

The audit tool for the revised Wound Management Plan (WMP) was completed and approved by the ACHA Patient Care Committee March 2017. Auditing was conducted in April 2017, which showed an improvement in compliance rate.

Recent audits have shown a low compliance rate to the recording of the wound dimensions, and a gap has been identified in the audit tool, which is directly due to the recent changes to wound / pressure injury staging. This has enforced a further review of the WMP, with expert involvement of the Wound Managers, the chart and audit tool were revised in July 2019. This was endorsed by the ACHA PCC, and the revise form will be rolled out in August 2019.

Education will be provided to clinical staff, and further audits will be conducted.

Current audit results for Pressure Injury Risk Assessment and Management;

- Ashford Hospital - 88%
- Flinders Private Hospital - 85%
- The Memorial Hospital - 97%

Pressure Injury (Stage 2 and Above) - Hospital Acquired has seen an improvement of 30%; from 0.03% in 2015 - 2016 to 0.02% in 2016 - 2017, which has stabilised in 2018 and 2019 remaining at 0.02%.

Completion Due By: 05/09/2018

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The Wound Management Plan at each hospital site has been reviewed with input from the Wound Care Nurse and endorsement by the ACHA Patient Care Committee. The actions taken are appropriate and this recommendation is complete.

Standard 6

Organisation: ACHA Health

Action 6.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes

Recommendation NSQHSS Survey 0916.5.1.2:

1. Update the current patient identification policy to provide further clarity on the optimal identification of public patients receiving care at Flinders Private Hospital.
2. Ensure the processes are in line with the requirements of the Australian Commission on Safety and Quality in Health Care.

Organisation Action:

1. Update the current patient identification policy to provide further clarity on the optimal identification of public patients receiving care at Flinders Private Hospital.

Actions

A policy and procedure is in place for patient identification;

- ACHA policy 2.08 Patient Identification
- ACHA Policy 2.08 Patient Identification has been reviewed and amended to include the process around identification and labelling of public patients on transfer of care into Flinders Private Hospital.
- Content on the identification process for private patients on admission from Flinders Medical Centre Emergency Department to Flinders Private Hospital has been included
- Policy and procedure update has been tabled at the ACHA Policy Committee, and forwarded to the ACHA Executive Committee for endorsement. This is then reported to the ACHA Board

ACHA Policy 2.08 - Patient Identification amended to include the process around identification and labelling of public patients on transfer of care into Flinders Private Hospital (FPH). This included content on the identification process for private patients on admission from Flinders Medical Centre (FMC - public hospital) Emergency Department to FPH.

This policy update was endorsement through ACHA Policy Committee on 3 April 2017. ACHA Executive Committee ratified the policy on 21 April 2017.

2. Ensure the processes are is in line with the requirements of the Australian Commission on Safety and Quality in HealthCare.

Actions

ACHA Policy 2.08 Patient Identification has been reviewed and amended to include the process around identification and labelling of public patients on transfer of care into Flinders Private Hospital.

- Review has included the requirements on the ACSQHC National Standards on Patient Identification
- Content on the identification process for private patients on admission from Flinders Medical Centre Emergency Department to Flinders Private Hospital has been included
- Policy and procedure update has been tabled at the ACHA Policy Committee, and forwarded to the ACHA Executive Committee for endorsement. This is then reported to the ACHA Board
- Audit on patient identification has been placed on the audit schedule spreadsheet
- Audit outcomes are reported on the hospitals Safety and Quality KPI report
- Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans

Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcome

The process for identification of public and private patients on transfer is now outlined in the ACHA Policy 2.08 Patient Identification.

Flinders Private Hospital audit against FMC/FPH ID bands is currently 95%

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Actions taken have met the intent of the recommendation relating to action 5.1.2.

Standard 7

Organisation: ACHA Health
Action 7.8: The health service organisation participates in haemovigilance activities, in accordance with the national framework

Recommendation NSQHSS Survey 0916.7.3.3:
Review the health service against the requirements of this action to determine gaps and weaknesses, and develop and implement formal reflective activities accordingly.

Organisation Action:

Review the health service against the requirements of this action to determine gaps and weaknesses; and develop, implement, formal reflective activities accordingly.

Actions

BloodMove auditing, conducted by SA Health, occurs every 2 years. Development of Blood Prescription form - ACHA 069 implemented in 2016

- Massive Blood transfusion form developed and implemented in 2016
- Participation has occurred in new BloodSTAR program which specifically monitors haemovigilance
- Quarterly SA Pathology and Flinders Private Hospital liaison meetings have been scheduled to discuss pathology and blood issues
- Audit on haemovigilance has been placed on the audit schedule spreadsheet
- Audit outcomes are reported on the hospitals Safety and Quality KPI report
- Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans

Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcome
An audit tool has been developed to monitor compliance to new Blood Prescription Form. Education occurred with all clinical staff.

Bloodmove audits conducted by SA Health in May 2019 each hospital obtained a satisfactory pass.

Completion Due By: 22/07/2019

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes
Haemovigilance activities are now adequate. This recommendation is now closed.

Organisation: ACHA Health
Action 7.10: The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage

Recommendation NSQHSS Survey 0916.7.8.1:
Develop and implement a formal and consistent approach to monitoring blood and blood product wastage.

Organisation Action:

Develop and implement a formal and consistent approach to monitoring blood and blood product wastage.

Actions

BloodMove auditing, conducted by SA Health, occurs every 2 years. Development of Blood Prescription form ACHA 069 implemented in 2016

- Massive Blood transfusion form developed and implemented in 2016
- Participation has occurred in new BloodSTAR program which specifically monitors haemovigilence
- Quarterly SA Pathology and Flinders Private Hospital liaison meetings have been scheduled to discuss pathology and blood issues
- Longstanding problems with external pathology providers unable to supply meaningful blood wastage information have resulted in an in-house audit tool being developed to monitor this
- Audit on haemovigilence has been placed on the audit schedule spreadsheet
- Audit outcomes are reported on the hospitals Safety and Quality KPI report
- Non or low compliance audit outcomes are noted on the hospital's Safety and Quality Action Plans

Results are reported to the ACHA Executive and reported to the ACHA Board. Department managers inform the staff of the outcome

Current audit results show for internal blood wastage for ACHA hospitals is 0%, which is the same for last period.
BloodMove audit conducted by SA Health in May 2019, showed each hospital received a satisfactory pass.

Completion Due By: 05/09/2018

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Blood and blood product wastage reporting is now consistent and formal. This more appropriate approach has resulted in nil wastage in the last three months and formal agreements between the three ACHA hospitals and South Australia's Blood Move program to re-direct unused blood products to other sites in a timely manner. This recommendation is now closed.