The Australian Council on Healthcare Standards

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

Organisation-Wide Survey

Central Adelaide Local Health Network

Adelaide, SA

Organisation Code: 315894

Survey Date: 19 - 23 February 2018

Advanced Completion: 30 - 31 May 2018

ACHS Accreditation Status: ACCREDITED

Disclaimer:

The information contained in this report is based on the evidence provided by the participating organisation at the time of the accreditation survey and information that the organisation supplied through the reporting and editing process. Accreditation issued by ACHS/ACHSI does not guarantee the ongoing safety, quality or acceptability of an organisation or its services or programs, or that legislative and funding requirements are being met, or will be met.

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Table of Contents

Executive Summary………………………………………………………………….. 1

Organisation-Wide Survey Summary……………………………………………… 5

Survey Report

National Safety and Quality Health Service Standards………………………. 21
Mental Health In-Depth Review (IDR) – NSQHSS Survey Report………….. 81
National Standards for Mental Health Services (NSMHS)
(Unmapped Criteria)……………………………………………………….. 133

Recommendations from Previous Survey

National Safety and Quality Health Service Standards………………………. 162
Mental Health In-Depth Review (IDR) – NSQHSS Survey Report………….. 183

Advanced Completion (AC) 90 Review

National Safety and Quality Health Service Standards………………………. 204
Mental Health In-Depth Review (IDR) – NSQHSS Survey Report………….. 227
National Standards for Mental Health Services (NSMHS)
(Unmapped Criteria)……………………………………………………….. 242

Central Adelaide Local Health Network

EXECUTIVE SUMMARY

Executive Summary

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Outcome Summary: Central Adelaide Local Health Network – Accreditation Assessment

The **Central Adelaide Local Health Network (CALHN**) underwent accreditation assessment on 19-23 February 2018 to the **National Safety and Quality Health Service Standards (NSQHSS**) which have been a federally mandated requirement for all Australian hospital and associated healthcare facilities since January 2013.

The NSQHS Standards currently comprise 256 Actions contained in 10 Standards, covering key recognised standards and criteria in Governance for Safety and Quality, Partnering with Consumers and Carers, Infection Control, Medication Safety, Patient Identification and Procedure Matching, Clinical Handover, Blood and Blood Products, Preventing and Managing Pressure Injuries, Clinical Deterioration and Preventing Falls and Harm from Falls. Core Actions are required to be met for NSQHSS accreditation to be awarded.

Australian hospitals and health services have been voluntarily assessing their performance against healthcare standards since the 1970s; recognising the need to maintain a high-quality focus, ensure risk mitigation strategies are in place and, embed a culture of continuous improvement in a highly complex environment. The process of healthcare quality program accreditation is not a compliance audit, neither does it guarantee that error will never occur. It is an evidence-based systemic review, by trained healthcare professional peers, of not only the 'done' but the 'doing'. It encapsulates regular review of key nationally recognised components of healthcare services, with a quality focus on identified clinical areas as well as essential clinical and corporate governance.

The Central Adelaide LHN has chosen to undergo rigorous extensive review, noting the environment of significant change in healthcare delivery in South Australia and, the issues associated with structural elements including the opening of a major new facility. Accordingly, the NSQHS accreditation assessment was programmed to review all acute service facilities, including the new Royal Adelaide Hospital, Prison Health Services, as well as review of Mental Health services, which not only required evaluation against the NSQHS Standards but also the National Standards for Mental Health Services.

Outcomes

At survey, CALHN in three concurrent assessments, was assessed by independent survey teams as follows:

	Total Actions (Core and Developmental)	Core Actions Met	Core Actions Not Met
CALHN NSQHSS excluding Mental Health	256	202	7
CALHN Mental Health NSQHSS	256	202	7
CALHN Mental Health NSMHS	155	147	8

Core Actions are Actions within the Standards and Criteria that are required to be Met in order for accreditation to be awarded. Developmental actions are not required to be met in order to be awarded accreditation.

Across CALHN (including Mental Health) survey processes there were fourteen (14) Core Not Met action ratings over nine (9) NSQHSS actions.

Executive Summary

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Advanced Completion

Recognising the nature of individual and multi-site healthcare service delivery, the mechanism of **Advanced Completion** (AC), developed years ago by the ACHS and adopted by the ACSQHC, allows remediation of areas of identified focus to be addressed within a strictly set period of 90 days. The strength of the AC process within the accreditation assessment process, while not always welcomed, is that while not undermining the evidence-based achievements in the greater portion of original assessment, it allows necessary focus on remediation within a set period and ultimately strengthens patient safety and quality processes by formal assessment and proactive action in required areas; a key driver for strengthening healthcare service and quality action and validating regular review as a recognised key component of quality and safety. This is recognised not only in healthcare but also other areas with a recognised potential for risk including aviation and other industries. The focus is not on management of an assessment event, but on embedding best practice so that assessment is part of embedded quality and safety culture.

CALHN has undergone the assessment process transparently and with a noted willingness in pursuit of best practice and outcomes for its constituency of patients, carers and the clinicians who provide service.

On review (AC90), all core actions required for accreditation have now been assessed as Satisfactorily Met at the point of review.

It should be noted that healthcare quality accreditation is not a single event but an ongoing process with regular reviews undertaken by external assessors, and more importantly by the staff that work within the organisation so as to ensure the pursuit of best practice for optimal patent safety and quality outcomes is inherent in the *way they do business*.

The ACHS is acutely aware of the challenges and environment in which staff have endeavoured to address the requirements of accreditation, continued to deliver services to the people of South Australia and settle into a new facility (in the case of the nRAH). The CALHN is commended on its response at survey and subsequent action taken to date; the Central Adelaide LHN after substantial review is accordingly accredited as required by federal and state jurisdictions to the National Safety and Quality Health Service (NSQHS) Standards for three years, and also recognised as meeting all criteria of the National Standards for Mental Health Services (NSMHS).

Advanced Completion (AC) 90 Review - Overview comments for the three assessment components reviewed

1) CALHN (excluding MH) **NSQHSS - AC90 Review 30-31 May 2018**

The AC90 review was conducted by two surveyors from the previous survey teams.

The primary aim of the AC90 Review was to ensure that the NSQHS Standards **Not Met** Core Actions had been addressed within the 90-day period for CALHN and for the CALHN Mental Health Service. Also, concurrently assessed at AC were the Not Met Criteria of the National Standards for Mental Health Services (NSMHS) which were not mapped to the NSQHS Standards.

Note: *This AC90 Review Report relates to CALHN excluding Mental Health, which is subject to separate AC90 documentation. Assessment report components should be reviewed in conjunction. Final outcomes are included in the overall report.*

The surveyors found that extensive work had been undertaken and supported by the CALHN Executive in consultation and collaboration with clinicians, health professionals and consumers. The new structures, systems and policies that have been introduced were closely examined and the survey team were assured that CALHN have the relevant systems in place that not only **address the seven Core Not Met Actions** but will continue to provide good standards of patient care.

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

The CALHN Executive demonstrated recognition and commitment to ensuring that quality and safety standards will continue to be assessed and that the organisation will continuously improve the quality of patient care that CALHN is providing.

2) CALHN MH In-Depth Review NSQHSS - AC90 Review 30-31 May 2018

The Central Adelaide Local Health Network (CALHN) Mental Health Service (MHS) have actioned all the Not Met seven (7) Core Actions with strong evidence available to the survey team of the processes now in place by the MHS.

The primary aim of the AC90 Review was to ensure that the NSQHS Standards Not Met Core Actions had been addressed within the 90-day period for CALHN and for CALHN Mental Health. Also, concurrently assessed at AC were the Not Met Criteria of the National Standards for Mental Health Services (NSMHS) which were not mapped to the NSQHS Standards.

Note: *This AC90 Review Report relates to CALHN Mental Health. Assessment report components should be reviewed in conjunction. Final outcomes are included in the overall report.*

The **seven Core Actions 1.2.2, 1.5.2, 4.2.1, 4.6.1, 4.12.3, 4.12.4 and 6.3.3 have all now been Satisfactorily Met.**

3) CALHN MH In-Depth Review NSMHS - AC90 Review 30-31 May 2018

As noted in the Executive Summary for the **Central Adelaide Local Health Network (CALHN)** NSQHS Standards & NSMHS survey of 19-23 February 2018; in the CALHN Mental Health Services concurrent assessment to the **National Standards for Mental Health Services (NSMHS),** eight (8) NSMHS criteria were identified as Not Met.

In the ten National Standards for Mental Health Services (NSMHS) there are a total of 155 Criteria; however, when assessed concurrently with the National Safety & Quality Health Service (NSQHS) Standards accreditation survey, 87 of the NSMHS criteria (56% of the total 155) are mapped to the NSQHS Standards, and 68 NSMHS Criteria (44%) are Unmapped to the NSQHS Standards.

For the award of Certificate of Recognition, all NSMHS Criteria are required to be assessed as Met.

Accordingly, NSMHS Criteria 2.2, 4.5, 5.4, 5.6, 7.2, 7.11, 10.6.1 and 10.6.8 were scheduled to be reviewed at the CALHN NSQHSS AC90 Review.

The eight criteria rated as Not Met represent approximately 5% of the total 155 NSMHS Criteria

The eight NSMHS Criteria rated as Not Met at the Central Adelaide Local Health Network (CALHN) survey in February 2018 were re-surveyed in May 2018 by two surveyors from the February 2018 survey teams.

Considerable work had been undertaken within the 90 days to address the eight NSMHS Not Met criteria.

All the eight recommendations had, with support from the CALHN Executive, senior staff, stakeholders, health professionals and consumers, been addressed.

The relevant systems were tested to ensure that the CALHN Mental Health Service (MHS) continues to address the aims of the NMHS in ensuring these standards of quality and safety are met.

Central Adelaide Local Health Network

ORGANISATION-WIDE SURVEY

Organisation-Wide Survey Summary

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

SUMMARY

Background

Central Adelaide Local Health Network (CALHN) is a tertiary provider of health services to the people of Adelaide and South Australia. CALHN also manages some of the State-Wide Services including Clinical Support Services and Prison Health Services which were included in this survey scope.

The Central Adelaide Local Health Network (CALHN) Organisation-Wide Survey (OWS) against the National Safety and Quality Health Service Standards (NSQHSS) was undertaken between the 19th and 23rd February 2018.

CALHN were keen to ensure a 'deep dive' – strengthening the quality of the process' while noting the challenges of the recent (September 2017) opening of the new Royal Adelaide Hospital and acknowledging that this review would incorporate substantial Mental Health Services. As such additional surveyors were allocated to review the CALHN Mental Health Services against both the NSQHSS and National Standards for Mental Health Services (NSMHS). The CALHN survey therefore comprised concurrent assessments by two survey teams:

- CALHN including Prisons Health and Primary Care
- CALHN Mental Health

The combined survey process required fifteen (15) surveyors for a period of five (5) days and included on-site visits to facilities throughout the Network.

Additionally, while four (4) Prisons had been visited in the March 2017 CALHN onsite survey to Standards 1 to 3 (Adelaide Women's Prison, Adelaide Pre- Release Centre, Mobilong and Yatala Prison), the Australian Council on Healthcare Standards (ACHS) had never been to Port Augusta or Port Lincoln Prison Health Services as part of CALHN contracts.

For this reason and, noting that Port Augusta Prison is the largest Regional Prison, an additional surveyor was included to enable an onsite visit to Port Augusta Prison Health and Port Lincoln Prison Health.

Summary

The Central Adelaide Local Health Network (CALHN) demonstrated good work in a range of areas and initiatives, systems and processes, as noted in the Survey Report content. It is well recognised that success in many areas of safety and quality are dependent on good and sustained leadership.

There have been improvements made to the governance structures and processes since the last survey however changes continue to be made and variability is still apparent across services.

The areas for improvement identified during this survey are in the areas of governance, consumer participation, medication management, medical handover, blood management and the deteriorating patient.

These are detailed further in the Executive Summary and the Full Report.

'MAIN SURVEY' OVERVIEW

The surveyors met with staff and patients when they visited the Royal Adelaide Hospital (RAH), The Queen Elizabeth Hospital (TQEH), Hampstead Rehabilitation Hospital (HRH), St Margaret's and the Pregnancy Advisory Centre (PAC). Primary care services and six sites of the SA Prison Health Service were also visited.

The RAH is being managed within a private-public partnership. Celsus is the corporate entity which operates and services the building and Celsus subcontracts to Spotless for a range of services such as cleaning, food services and security. DXC technologies provides information and communication technology. The contract with Celsus is managed by SA Health. CALHN provides the health services within the RAH. The relationship is complex and does require good communication and effective governance. The CALHN Facilities Operation Team is monitoring performance on a daily basis and a structured governance framework is in place.

In addition, there are clinical support services that are managed by CALHN and provided on a Statewide basis. These are: Medical Imaging, Pathology, Pharmacy, and SA Breast Screen is to join in the near future. Biomedical Engineering is also a State-wide service but is independent of CALHN and reports directly to the SA Health Department.

Even though these services are provided State-wide the management of the services falls under the responsibility of CALHN in that the Executive Manager of State-wide services formally reports to the Chief Executive of CALHN. However, there is a frequent and important relationship with the central Health Department.

There have been improvements made to the governance structures and processes since the last survey however changes continue to be made and variability is still apparent across services.

The survey team noted a relatively new executive team in place including permanent medical leadership appointments which will facilitate effective and sustained leadership.

At survey the majority of the NSQHS Standards Actions were assessed as Satisfactorily Met (SM).

Summary Ratings:

- Seventeen (17) Developmental actions were rated Not Met
- Seven Core Actions (1.5.2, 1.6.1, 2.6.1, 4.2.1, 4.12.3, 4.12.4 and 6.3.3) were identified as Not Met.

The Core Not Met actions will be reassessed at AC90 Review.

NB. Met with Merit ratings *require that, in addition to achieving the actions required, measures of good quality and a higher level of achievement are evident. This would mean a culture of safety, evaluation and improvement is evident throughout the organisation in relation to the action or standard under review (ACSQHC, 2012)*

CALHN MHD did receive a Met with Merit in Standard 2.

Mental Health In-depth Review - SURVEY OVERVIEW

The Central Adelaide Local Health Network (CALHN) Mental Health Directorate (MHD) is governed by clinical policies and guidelines to establish best practice approaches across SA Health MHD and, assist and support MHS clinicians in determining the appropriate health care for MHD consumers.

The clinical policy directives are mandatory requirements that are implemented across SA Health as operational practice whether short term or permanent and must be complied with no scope to deviate from the specifications within the clinical policy directives.

A clinical guideline however has flexible requirements and implementation and may be developmental or staged according to the MHD.

At the time of survey, the MHD were operating within a difficult environment at the RAH in a number of areas and caring for consumers/patients in a less than therapeutic environment. The duress system has not worked fully since the RAH opened. Until the duress system is fully operational a security presence will remain to manage any potential risk to both patients and staff in designated areas.

The move to the new RAH had in place a robust set of logistical, operational and strategic plans but it was recognised that unforeseen problems could occur. A Rapid Incident Review and Response Function was in place across the RAH (over the period of the move) using a “real time” system of analysing incidents enabling prompt action and allowing information from the Executive to be shared with the MHD in a timely fashion.

Many positive initiatives for 2018 are planned or are in place. These include the Patient Sexual Safety Project, the proposed Connecting with People Program (focused on capacity development in the general community) and Interventions for Suicide Management. There is a Short Stay Unit (SSU) in the RAH and a short stay unit at The Queen Elizabeth Hospital to manage the transition between the Emergency Departments and bed availability will soon be operational.

New workforce models include;

- ‘Chaperones’ in the MHD Inpatient Units to assist patients with activities of daily living and,
- the introduction of a MHD Infection Prevention and Control Link nurse has commenced.
-

A Strategic Mental Health Quality Improvement Indicator report provides Safety and Quality data including: New Treatment Orders, Restraint and Seclusion, ECT Treatments Challenging Behaviours, Self-Harm and Morbidity.

Summary Ratings:

At survey the majority of the NSQHS Standards Actions were assessed as Satisfactorily Met (SM).

- 23 actions in Standard 7 were rated non-applicable.
- Action 2.2.2 was awarded a Met with Merit rating.
- Eight Developmental actions were rated Not Met.
- Seven Core Actions (1.2.2, 1.5.2, 4.2.1, 4.6.1, 4.12.3, 4.12.4 and 6.3.3) were identified as Not Met.

The Core NM actions will be reassessed at AC90 Review.

Further detail for both the Mental Health In-Depth Review and CALHN Organisation-Wide Survey Not Met Core Actions are provided pages 10 – 19.

NOT METS:

- Core NSQHSS actions must be met in order to be awarded accreditation.
- Developmental actions are not required to be met in order to be awarded accreditation.

  Across CALHN (including Mental Health) survey processes there were fourteen (14) Core Not Met action ratings over nine (9) NSQHSS actions.

The following is presented in two parts. Part 1 – CALHN Not Met Summary and Part 2 – Mental Health In-Depth Review Not Met Summary

PART 1 - CALHN Not Met Summary

The CALHN NSQHSS survey (not including Mental Health Services) achieved a total of twenty-four (24) Not Mets (Core and Developmental) across all Action areas.

Detailed below are the seven (7) Core Not Mets for CALHN OWS ('*Main Survey*')

Actions Rated Not Met		Action required
1.5.2 ***Actions are taken to minimise risks to patient safety and quality of care***	**Core**	**Surveyor Comment:** The risk management systems and processes have evolved over the last year and at an organisation wide level and directorate level the systems appear to work effectively for those risks that are identified and accepted; although review of the register shows some updates are overdue. Accountability and responsibility for risk management is not at the unit level and the surveyors found engagement and knowledge at that level was variable. Some frustration was voiced at not having more control over risk whilst others were content with the directorate structure. The surveyors concern was that some risks are not being identified or if they are then not accepted but, still remain a risk at a unit level. Assessments are carried out by the quality, safety and risk team. The assessments are very detailed and time consuming and can often not be accepted as a risk at a directorate level. Other processes are then found to solve the perceived problem e.g. calling it a 'quality improvement' and putting it on the quality register. The risk however may not be resolved or escalated. There is not a clear understanding of what is a risk and what is an issue as both terms are used in the activation of the nRAH. A risk profiling exercise was due to start at the time of survey. This has not been done for some time and was a recommendation from a SA Health internal audit last year. This is targeting the directorate level. **Surveyor's Recommendation:** 1. The organisation expedite the risk profiling exercise, ensuring coverage of key points identified at survey in particular: i. Overdue updates ii. Strengthening engagement and knowledge by staff at unit level iii. Ensuring escalation of appropriate risks to relevant executives 2. Risks identified in Mental Health Service ligature audit be actioned.

		3. Develop a framework which supports local decision making regarding risk. 4. Identify and adapt an education program to develop capability at unit level.
1.6.1 ***An organisation wide quality management system is used and regularly monitored***	**Core**	**Surveyor Comment:** The report on the 'Review of the Safety and Quality Systems, Leadership and Functions report' was finalised in December 2016 and a comprehensive action plan was developed to address the issues identified in the review. There has been progress in addressing actions and developing a framework to support clinical governance and develop a culture of safety and improvement in the organisation however, the last year has also been a time of significant change in the organisation with the move to the new hospital, service restructures and new senior leadership becoming established in their roles. This has impacted on the organisation's ability to move forward on a number of initiatives including the implementation of the new clinical governance framework. The impact of change may continue as the services in the new hospital were about to move across to a new electronic record) and services continue to adjust to working within the new building. The move towards a safety and improvement culture requires change in the supporting structure. The quality and safety team will benefit from planned training to increase capability. *(Additional Note: ACHS has been advised that following the survey a new government was appointed and the implementation of the electronic record has been suspended pending a formal review.)* "Our commitment to quality" a statement to support delivery of safe and effective care was sent to all staff in September 2017. This sets out expectations in terms of safe quality service provision and clinical governance and was endorsed by the leaders of the organisation. It does not appear to be widely understood and whilst the structure for safety and quality remains in place at a directorate level the participation of staff across the organisation in quality activities is variable. The directorates are large and complex and the ward or unit level are not always engaged. Mortality and Morbidity Committee meetings are improving however there is variability across clinical services. These meetings plus Mortality Review and the Incident Review Panel are having protection lifted and this will provide greater transparency. The planned structure will clarify reporting lines and accountabilities. There is not a clear definition of quality that staff relate too neither is there yet a quality plan. There were examples of clinical engagement noted by the survey team however this is still very variable. The quality and safety unit staff do much of the documentation, reporting and monitoring review of the quality register and the recommendations register show there are difficulties in meeting reporting requirements. Audits are undertaken although there is variability in follow up and repeat audits to address non-compliance are not always undertaken. **Surveyor's Recommendation:** 1. Communicate a shared definition of quality and clinical governance across all levels of the organisation. 2. Implement the draft clinical governance framework. 3. Develop an organisation wide quality plan and reporting framework for all levels of the organisation.

2.6.1 ***Clinical leaders, senior managers and the workforce access training on patient centred care and the engagement of individuals in their care***	**Core**	**Surveyor Comment:** There are SA Health guiding resources to lead this practice including the: Framework for Active Partnership with Consumers and the Community; Partnering with Carers Policy Directive; and the Guide for Engaging with Consumers and the Community. There is also a training program available on Partnering with Consumers and Community but little evidence of pickup of this training or of how the organisation is implementing the SA Health strategies. There was an example of local training in patient centred care being given to clinical leaders, senior managers and the workforce at Hampstead Rehabilitation Hospital and discussion that this training might be rolled out at TQEH in 2018 but no firm plans at this time. There was no other evidence on a CALHN approach for clinical leaders, senior managers and the workforce being supported to facilitate consumer engagement and maintain ongoing partnerships with them. It is not evident therefore that the developed SA Health approach to patient centred care is being implemented across CALHN as the examples of such practice were only observed in parts of the organisation. **Surveyor's Recommendation:** Develop a strategy for an organisation-wide approach to orientation and training for clinical leaders, senior managers and the workforce in patient and family centred care.
4.2.1 ***The medication management system is regularly assessed.***	**Core**	**Surveyor Comment:** A regular comprehensive review of medication management using a recognised tool is an essential component of risk management. The organisation last undertook such a review in 2013 – five years ago. Much has changed in this time which may well have had an effect on the medication management system. It is recognised that specific assessments have taken place over this period but these, in the main, have been focused assessments resulting from a reported incident or recognised problem. The intention of this criterion is to ensure that assessments are carried out in order to detect potential service shortcomings and correct them before an incident occurs. These reviews are time-consuming but are necessary. Furthermore, in a time of change such structures, assessments are probably even more important. Though the National Standards did not stipulate how frequently such an assessment should take place it is generally accepted that a review every three years is appropriate. **Surveyor's Recommendation:** Carry out a comprehensive review of the medication management system using a recognised 'assessment tool'.
4.12.3 ***A current comprehensive list of medicines is provided to the receiving clinician during clinical handover***	**Core**	**Surveyor Comment:** The clinical pharmacists in each service unit ensure wherever possible, that patients, on discharge are given a comprehensive and up-to-date listing of their medications. This list also records changes in the medication that may have occurred while in hospital. Upon request, additional copies can be printed for subsequent health care providers. The patient's list can be made available to the patient's receiving clinician – but only on request from the clinician. Thus, this particular criterion is not met as there was no evidence to show that this important information is made available. Satisfactory compliance with this criterion is closely related to improvement in the completion of discharge summaries.

		Surveyor's Recommendation: Provide evidence to demonstrate that a comprehensive list of medicines is provided on discharge to the receiving clinician.
4.12.4 ***Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover***	**Core**	**Surveyor Comment:** This recommendation is a rider to the previous recommendation. As part of the plan to address 4.12.3 it is recommended that robust monitoring processes are established to ensure sustainability. **Surveyor's Recommendation:** Ensure that action is taken to increase the proportion of receiving clinicians that are provided with a current, comprehensive list of medicines at discharge.
6.3.3 ***Action is taken to increase the effectiveness of clinical handover***	**Core**	**Surveyor Comment:** Surveyors noted that, whilst variable across sites and clinical disciplines, audits indicate that there are frequent occasions where there are delays in medical discharge summaries being completed and provided to appropriate health care providers. Interns and General Practitioner (GP) Liaison provided feedback consistent with the audit results. The most recent (January 2018) RAH audit results provided to Surveyors reveal an overall positive result in relation to timeliness where a medical discharge summary has been generated for the separation. The most recent TQEH audit data provided to Surveyors however shows inconsistency and at times poor compliance with medical discharge summary completion timeliness. This recommendation relates to ensuring consistency across sites and clinical disciplines in meeting medical discharge summary completion timelines in accordance with CALHN OWIs. **Surveyor's Recommendation:** Ensure that completion of medical discharge summaries complies with CALHN policies, especially the timeliness of completion and provision to appropriate health care providers.

PART 2 - In-Depth Review Mental Health Services Core Not Mets

The CALHN Mental Health services in-depth review (IDR) NSQHSS survey received a total of fifteen (15) Not Met ratings across all Action Areas.

Seven (7) of the Not Mets were **Core Actions (1.2.2, 1.5.2, 4.2.1, 4.6.1, 4.12.3, 4.12.4 and 6.3.3)** and eight were Developmental Actions.

Actions Rated Not Met	Core	Action required
1.2.2 ***Action is taken to improve the safety and quality of patient care***	**Core**	**<u>Surveyor Comment:</u>** The MH survey team observed a patient who was in what constitutes seclusion at the RAH. This was defined by confinement in the authorised hospital by the locked door of one of the two seclusion rooms constituting a physical barrier preventing the patient from leaving. Discussion was held with the MH clinician and evidence was not able to be provided that the criteria applied was in accordance with an oral or written seclusion order but rather to manage the patient until a bed could be found. Two security guards were outside each of the two seclusion rooms. The second room also had a patient in it, but the door was ajar also with a second security guard sitting inside. **<u>Surveyor's Recommendation:</u>** Ensure that the safety of any patient placed in the seclusion rooms of CALHN is maintained at all times.
1.5.2 ***Actions are taken to minimise risks to patient safety and quality of care***	**Core**	**<u>Surveyor Comment:</u>** The MHD has undertaken ligature audits but were unable to provide evidence to demonstrate which recommendations from these audits had been completed. The MHD were also unable to provide satisfactory evidence that the seven-day follow-up of all MH discharged in-patients occurs, although some areas verbally described to the survey team that it does occur. **<u>Surveyor's Recommendation:</u>** 1. Ensure that action is taken to minimise the risks to patient safety and quality of care by ensuring that the Ligature Audit recommendations are actioned, completed and documented with a report sent to all relevant areas of the completion of the recommendations in a timely manner. 2. Ensure that a system for the capture and documentation of all 7-day patient follow-up post discharge is captured and evidence of the mechanisms put in place if a patient is unable to be contacted.
4.2.1 ***The medication management system is regularly assessed***	**Core**	**<u>Surveyor Comment:</u>** The surveyors noted that the Medication Safety Self-Assessments® (MSSAs) have not been reviewed or repeated since the last survey in 2013. The usual frequency of completion would be every three years or so. The service has identified that it has not yet reviewed completion of all the action items from the previous MSSA. The MHS has informally identified significant gaps in medication safety systems within the community mental health teams. The audits that have been conducted across MH regarding the management of the medication safety systems do not provide sufficient coverage to allow confidence that the MHS has systems in place to ensure the medication management system is safe.

		The MHS must complete an MSSA with associated action plans of the whole of the MHS including community sites as soon as possible. **<u>Surveyor's Recommendation:</u>** The MHS must complete an MSSA with associated action plans of the whole of the MHS including community sites as soon as possible.
4.6.1 ***A best possible medication history is documented for each patient***	**Core**	**<u>Surveyor Comment:</u>** Evidence was provided by Central Adelaide Local Health Network (CALHN) Mental Health Service (MHS) that community completion of medication history within the Community Based Information System (CBIS) reviewed every 180 days was very low and had been low for some time. Within the narrative of the community notes it was unclear where one could routinely find the best possible medication history. **<u>Surveyor's Recommendation:</u>** Ensure that a best possible medication history is documented for each patient within the community file. CALHN MHS must implement a system to maintain medication documentation rates on an ongoing basis.
4.12.3 ***A current comprehensive list of medicines is provided to the receiving clinician during clinical handover***	**Core**	**<u>Surveyor Comment:</u>** The surveyors noted that the discharge summary completion rate within 48 hours lies at 34%. The discharge summary is the main communication tool for medication management to primary care and secondary tier community mental health service providers. **<u>Surveyor's Recommendation:</u>** The MHS ensure that clinical service providers such as GPs and private practitioners, are routinely provided with a comprehensive medication list on transfer from Inpatient care. The surveyors recommend that this be achieved by improving the timely discharge summary completion rate close to target and ensuring that this discharge summary is provided in a timely fashion to relevant clinical services external to the public mental health service. This is also a recommendation in Action 6.3.3.
4.12.4 ***Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover***	**Core**	**<u>Surveyor Comment:</u>** The MHS is aware of the low rates of discharge summary completion and the implications for primary and secondary care providers outside of the public mental health service. However, systematic action has not been taken to address the issue. **<u>Surveyor's Recommendation:</u>** The MHS ensure that a system is put in place to ensure GPs and private practitioners receive a discharge summary within a timely period.
6.3.3 ***Action is taken to increase the effectiveness of clinical***	**Core**	**<u>Surveyor Comment:</u>** Discharge summary completion rates are low across the service and have been for some time. This is particularly an issue for clinical handover of a comprehensive clinical summary to GPs and private clinical providers as Community Based Information System (CBIS) allows for handover within the public mental health system of the available clinical material.

handover		**Surveyor's Recommendation:** Action be taken to improve the discharge summary completion rate for patients whose care is being taken on wholly, or in part, by primary care or private health providers. That the service ensures that the completed discharge summary is provided to the appropriate health providers in a timely manner.

The CALHN Mental Health services concurrent assessment to the **National Standards for Mental Health Services (NSMHS)** received eight (8) Not Met Criteria.

For the award of Certificate of Recognition, all NSMHS Criteria must be assessed as Met.

NSMHS Criteria Rated Not Met	Action required
2.2 ***The MHS reduces and where possible eliminates the use of restraint and seclusion within all MHS settings.***	**Surveyor Comments:** The Seclusion rooms in the Emergency Departments of the Royal Adelaide and Queen Elizabeth Hospitals are being used on occasions to sleep patients due to the unavailability of a MHD bed. **Surveyor's Recommendation:** Ensure that the safety of any patient placed in the seclusion rooms of CALHN is maintained at all times. This recommendation is cross referenced to NSQHSS Recommendation - Action 1.2.2
4.5 ***Staff are trained to access information and resources to provide services that are appropriate to the diverse needs of its consumers***	**Surveyor Comments:** Cultural awareness training had low attendance rates and was available for Mental Health staff until the end of 2016. No training has been available in 2017 with Aboriginal Culture learning courses to be offered in 2018. **Surveyor's Recommendation:** Cultural awareness training be made available for all mental health services staff in 2018 and the attendance monitored and reported on, to ensure the MHS workforce are provided with appropriate knowledge and understanding of the diverse needs of the consumers in their care.
5.4 ***The MHS evaluates strategies, implementation plans, sustainability of partnerships and individual activities in consultation with their partners. Regular progress reports on***	**Surveyor Comments:** No evidence was available to demonstrate that the MHS had strategies in place to ensure there is consistent approach in ensuring appropriate progress reports are provided to consumers, carers other service providers and relevant stakeholders. **Surveyor's Recommendation:** The MHS provide evidence of regular consultation and documented progress reporting to ensure the sustainability of all partnerships.

achievements are provided to consumers, carers, other service providers and relevant stakeholders.	
5.6 ***The MHS ensures that their workforce is adequately trained in the principles of mental health promotion and prevention and their applicability to the specialised mental health service context with appropriate support provided to implement mental health promotion and prevention activities.***	**Surveyor Comments:** The MHS ensure staff are provided with Mental Health promotion and prevention training and education to demonstrate that promotion and prevention activities are an important component of the direction CALHN MHS for all staff. **Surveyor's Recommendation:** The MHS to include on the staff education calendar training in Mental Health Promotion and Prevention principles.
7.2 ***The MHS implements and maintains ongoing engagement with carers as partners in the delivery of care as soon as possible in all episodes of care.***	**Surveyor Comments:** Carers identified that they do not feel engaged in the delivery of care for the consumer - this is further evidenced in the care plan. In conversation with the survey team it was noted that not all consumers were aware that they could have carer involvement and a number stated they did have a family member actively supporting them. **Surveyor's Recommendation:** The CALHN MHD actively review the involvement of carers in consumer treatment and document in consumer care plans the engagement and level of carer involvement for the consumer.
7.11 ***The MHS actively encourages routine identification of carers in the development of relapse prevention plans.***	**Surveyor Comments:** It has been identified that carers are not actively engaged in the development of consumer relapse prevention plans. **Surveyor's Recommendation:** Ensure there is a mechanism for carer input and feedback to support consumers in the development of their relapse prevention plans.

10.6.1 ***The MHS ensures that on exiting the service the consumer has access to services that promote recovery and aim to minimise psychiatric disability and prevent relapse.***	**Surveyor Comments:** Prior to a consumer/patient exiting the service the treating clinical teams liaise with the consumer's General Practitioner, existing supports and the Non-Government Sector (NGO) to provide ongoing support to prevent relapse and to manage their disability. Case reviews are documented in CBIS detailing the exit plan and the relevant contacts. **Surveyor's Recommendation:** Ensure all information is sent to the General Practitioner (GP) or designated support service/s within the designated timelines as per policy and documented.
10.6.8 ***The MHS, in conjunction with the treating clinician, has a procedure for appropriate follow-up of all consumers within 7 days after discharge from inpatient care wherever possible, and has a follow-up procedure for those consumers who do not keep the planned follow-up arrangements.***	**Surveyor Comments:** The first audit conducted of Transfer of Care from CALHN MHD inpatient services without adequate follow-up from some MHD wards/units demonstrated further improvement is required. Patients leaving hospital after an admission for an episode of mental illness have heightened vulnerability and without adequate follow-up may relapse or require re-admission. **Surveyor's Recommendations:** 1. Ensure consumers receive a telephone call and clinical assessment within seven days of discharge and this is documented in CBIS seven-day PDFU section. 2. Ensure unsuccessful attempts are escalated to the ward/ area/ unit Nurse Unit Manager and the Medical Head of Unit and ensure a continuing focus on those areas that did not meet the target rate of 60%.

ADVANCED COMPLETION REQUIREMENT

As CALHN were rated as Not Met with recommendations in Core actions the Australian Commission on Safety and Quality in Health Care (ACSQHC) requires that the organisation has a remediation period (90 days) in which to address those Core actions that were rated Not Met. These actions are the subject of an **Advanced Completion (AC90) review, scheduled for 30-31 May 2018.**

SUMMARY RECOMMENDATIONS (Core) – subject to the AC Review

1.5.2
1.6.1
2.6.1
4.2.1
4.12.3
4.12.4
6.3.3

Mental Health In-Depth Review

1.2.2
1.5.2
4.2.1
4.6.1
4.12.3
4.12.4
6.3.3.

Specific performance comments and recommendations related to each Standard are provided over the following pages.

The Australian Council on Healthcare Standards

Central Adelaide Local Health Network

Survey Reports

- CALHN NSQHSS Survey Report
- CALHN Mental Health In-Depth Review (IDR) NSQHSS Survey Report
- CALHN NSMHS (Unmapped Criteria) Report

Central Adelaide Local Health Network

NSQHSS SURVEY REPORT

NSQHSS Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

SURVEY OVERVIEW

Central Adelaide Local Health Network (CALHN) is a tertiary provider of health services to the people of Adelaide and South Australia. CALHN also manages some of the State-Wide Services including Clinical Support Services, Primary Care and Prison Health Services which were included in this survey scope.

Assessment was against the National Safety and Quality Health Service Standards. A separate in-depth survey of the Mental Health Services was undertaken at the same time as this assessment. The reports from external reviews were provided to the surveyors.

The surveyors met with staff and patients when they visited the Royal Adelaide Hospital (RAH), The Queen Elizabeth Hospital (TQEH) Hampstead Rehabilitation Hospital (HRH), St Margaret's and the Pregnancy Advisory Centre (PAC). Primary care services and six sites of the SA Prison Health Service were also visited.

The organisation has gone through significant change under the SA Health Transforming Health agenda.

The relatively new executive team is now in place with permanent medical leadership appointments. The clinical services moved into the new RAH in September 2017.

The new RAH is being managed within a private-public partnership. Celsus is the corporate entity which operates and services the building and Celsus subcontracts to Spotless for a range of services such as cleaning, food services and security. DXE technologies provides information and communication technology. The contract with Celsus is managed by SA Health. CALHN provides the health services within the building. The relationship is complex and does require good communication and effective governance. The CALHN Facilities Operation Team is monitoring performance on a daily basis and a structured governance framework is in place.

There are three clinical support services that are managed by CALHN and provided on a State-wide basis. These are: Medical Imaging, Pathology, Pharmacy, and SA Breast Screen is to join in the near future. In addition, Biomedical Engineering is also a State-wide service but is independent of CALHN and reports directly to the SA Health Department.

Even though these services are provided State-wide the management of the services falls under the responsibility of CALHN in that the Executive Manager of State-wide services formally reports to the Chief Executive of CALHN. However, there is a frequent and important relationship with the central Health Department.

There have been improvements made to the governance structures and processes since the last survey however changes continue to be made and variability is still apparent across services.

There are areas for improvement identified at this survey in governance, consumer participation, medication management, medical handover, blood management and the deteriorating patient.

At survey the majority of the NSQHS Standards Actions were assessed as Satisfactorily Met (SM).

A number of Developmental Actions were rated Not Met, and seven Core Actions (1.5.2, 1.6.1, 2.6.1, 4.2.1, 4.12.3, 4.12.4 and 6.3.3 were identified as Not Met; the Core NM actions will be reassessed at AC90 Review.

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

Surveyor Summary

Governance and quality improvement systems

CALHN has been managing significant challenges for a number of years and the organisation has not been helped by the many leadership changes. The current executive, although relatively new, are providing the stable leadership that has been needed for some time. Staff speak positively of the new direction and the supportive environment.

Changes continue to be made to service delivery and facilities. There were many delays to the move to the new hospital which was difficult for staff morale however the move went well and staff are pleased to finally get into the new building. The building provides a pleasant environment for patients, families and staff with single rooms with ensuites for patients and many internal gardens. There are however some, not totally unexpected, impacts from the design and space issues which require workarounds currently and may require some building alterations at some point. There is a high awareness of the issues in the emergency department. And staff are managing although care needs to be taken that workarounds do not become accepted practice. This is particularly so in the triage area of the emergency department where maintaining confidentiality of information is a challenge in the very small triage and waiting area.

A working group with consumers has been formed to address the signage and other information provision issues throughout the building. Volunteers are staffing the foyer and they offer their assistance to patients and families.

The survey team noted a different approach being taken with the planning of the new QEH where a comprehensive clinician and consumer engagement process is beginning to inform the design of the facility.

The relationship with the Private Public Partnership partners is going through a settling in period. The Enterprise Patient Administration System (EPAS) is in place at TQEH and HRH but is yet to be rolled out in full to RAH.

(Additional Note: ACHS has been advised that following the survey a new government was appointed and the implementation of the electronic record has been suspended pending a formal review.)

CALHN also manages State-wide Clinical Support Services. This reporting relationship adds a degree of complexity to the management of the services and from a governance perspective is somewhat confusing. LHNs must have absolute clarity regarding governance of these services. Though these services are not actually in the hospital management structures they, nevertheless, relate closely to the hospital in which they work; this being particularly so for the pharmacy service. However, there is an advantage in providing services in this manner; the big advantage being realised particularly by the peripheral health services where staff can be provided at relatively short notice to fill gaps. Also, there is a significant advantage in being able to standardise practices in these clinical activities across the whole of the State. The disadvantage observed by the surveyors is that there is an additional level of bureaucracy which has the potential to slow down decision-making and the introduction of change. CALHN advises that it is continuing to work through this issue with other LHN's, and that governance of SCSS may change further with the advent of the new state Government in March 2018.

It is suggested that clarity be sought about the responsibilities and accountabilities in regard to clinical governance.

There have, in the last two years been a significant number of external and internal reviews which have resulted in numerous recommendations. Many are duplicated or cover a similar theme which results in time consuming effort with minimal progress.

It is within this context that the actions from the Clinical Governance review in 2016 are being implemented. However, given the findings of that review, it is important that the changes required to create a culture of safety and improvement along with clinician and consumer engagement are made.

The actions arising from the review were also subject to a recommendation at the last survey.

The governance structures and systems continue to slowly evolve. The new clinical governance framework is developed but not yet implemented.

At an executive level the monitoring of quality and risk is regular and structured and the survey team noted the improvements in the past year however across CALHN quality processes are variable. Quality and safety committee meetings are convened at directorate level whilst standards committees provide governance over the requirements of those standards. It was noted that not all committees were active and the emphasis appears to be on meeting the requirements of accreditation rather than ongoing improvement.

CALHN is developing a plan for building capability in quality & safety especially for its quality, safety and risk coordinators.

The quality and safety systems are supported by both SA Health and local policies and procedure documents. Those developed by CALHN are controlled and available electronically on eCentral as are guidelines and other documents such as patient information. The organisation is encouraged to continue the task of refining the number and amalgamating similar documents from different services.

Performance indicators are set and monitored by SA Health and the CALHN governing council, although surveyors noted that the Governing Council has no formal Governance role. Benchmarking occurs. While the organisation collects data, there are ongoing difficulties with accessing timely and accurate information required to measure compliance and enable service improvements. The problems are known and effort is being made to improve this at a state and local level.

It was noted that the new hospital has nothing on the walls, as per policy, however that means limited data or information for patients is being displayed, Journey boards have been used in the old hospital and are in place in other hospitals. This is currently under discussion with the PPP.

All staff are advised of their quality and safety responsibilities and locums and agency staff are managed and monitored.

Orientation and training is provided to all staff. The Learning Management System (LMS) is still not able to provide accurate data but workarounds are in place. Mandatory training has not been a priority for some areas during the move and this is evident in the compliance rates.

The SA Health risk management policy is followed by the organisation. Since the last survey an executive risk management committee is monitoring the risk register which is organisation-wide and at a directorate level. Risks are understood and managed well at the at executive level. There is also a Risk and Audit committee for CALHN that is advisory to the CEO and reports up to the SA Health Risk and Audit committee. As well as risks arising from the directorates there is the risk and issues register used for the nRAH project and this will soon be handed over from the project for management by CALHN. There is not yet a clear understanding of what is a risk and what is an issue. A new risk register was also under development to identify shared risks between CALHN and the Private partners at the RAH.

A new risk consultant has been appointed to CALHN.

The risk treatment and control chart is detailed and shows that there are still ineffective controls in some areas of the business. Whilst these appear to be monitored it was noted that risks that have been addressed (the installation of a generator at St Margaret's for example) have not been closed off or updated to reflect current status.

Overall there has been improvement in many areas however there is still not consistency in the implementation and monitoring of quality and safety systems and processes. Developmental Actions 1.4.2 and Core Actions 1.5.2 and 1.6.1 are rated as Not Met; the core actions rated NM are subject to reassessment at AC90 Review.

Clinical practice

A wide range of clinical guidelines, pathways and care models are utilised across the service. Work is undertaken across CALHN to implement evidence-based models of care promulgated by the SA Health Transforming Health streams of care. A number of clinical areas report to registries, for example Stroke and Intensive Care. There is evidence of auditing and benchmarking of clinical outcomes utilising ACHS clinical indicators, registry indicators, Health Round Table data and other databases. Reports are presented to Clinical Directorate and Executive Quality and Safety Committee meetings. One example of a significant program of clinical work to enhance safety and quality of care for cancer patients has been the Chemotherapy Prescribing project.

The clinical care provided by the nursing staff in the prisons visited was observed to be of a good standard, considering the environment and limitations of a prison.

The Fundamentals of Nursing Care framework is in place. A range of screening tools are used to identify at-risk patients, including risk of falls, pressure injury, malnutrition and cognitive impairment. Compliance with screening tools is audited through clinical documentation audits and results are discussed at Unit meetings as well as presented to the Safety and Quality Committee. Risks are also discussed at the multidisciplinary huddles, during intentional rounding and at bedside handover.

SA Prisons Health Service has recognised the need to manage a number of high risk health issues across the organisation. Projects that are currently being progressed include the management of diabetes with a goal to move to a self-management model of care. A Blood Borne Virus Prevention Plan is being progressed and is addressing the issues of Hepatitis C and Hepatitis B. Following consultation with aboriginal prisoners a Model of Care for Aboriginal Prisoners Health and Wellbeing has been developed and is being implemented.

There are systems in place to identify patients who are at risk of deterioration and to escalate care and this will be addressed in more detail under Standard 9.

Patient clinical records are generally available at the point of care, as an electronic record at TQEH and in hard copy at RAH.

(Additional Note: ACHS has been advised that following the survey a new government was appointed and the implementation of the electronic record has been suspended pending a formal review.)

Currently hard copy records are stored off site and brought to RAH when required for patient care. The hard copy records are ordered via a web portal process. Most records are ordered days in advance (e.g. for scheduled outpatient appointments, but there is capacity to have a 1-hour delivery where required. Clinicians are trained in use of the clinical record, particularly with respect to the implementation of EPAS at RAH. Clinical documentation audits are used to measure the accuracy of documentation and to audit clinical care. Full implementation of the electronic record should further enable auditing and analysis of clinical outcomes. A daily duplicate record report is undertaken and this KPI is benchmarked monthly by SA Health. A coding review has been undertaken and a number of recommendations have been implemented, including recruitment of an increased number of coding audit staff.

It is suggested that the prisons at Port Augusta and Port Lincoln develop a protocol regarding the frequency of written clinical entries for those prisoners who may not be current active health clinic patients but had been in the past.

Performance and skills management

CALHN has policies (aligned with SA Health Policy Directives) and systems in place for credentialling and defining the scope of practice for medical staff, nursing staff and allied health staff, all overseen by the relevant Committees, with the allied health and nursing committee being combined.

For nursing and allied health staff, the combined committee's role is to credential and define the scope of practice of Nurse Practitioners and nursing and allied health practitioners with extended scope of practice. The SAPHS is encouraged to review the clinical quality improvements that could result if selected senior nurses in the prison health clinics were supported to expand their scope of practice to include suturing and plastering. If this type of intervention could be done by a nurse it would decrease the delay in treatment caused by waiting for transport to an emergency department. An alternative, or adjunct to the expanded scope of practice, would be to consider the creation of Rural and Remote nurse practitioner position(s) within SAPHS.

Registrars have their scope of practice determined by the Heads of Units and are only able to undertake procedures for which they are approved. Each procedure list has a defined member of the senior medical staff overseeing it. CALHN could consider further formalising this system so that specific procedures are documented for each registrar.

A state-wide database is used to document and monitor of credentials and scope of practice and this can be accessed by relevant staff, including theatre staff to ensure that a surgeon is operating within his/her scope of practice.

The Committee for New Clinical Procedures, Services and Other Interventions reviews applications for new interventions and technologies and scope practice is updated where required.

Scope of practice for senior medical staff is defined at various levels, depending on the speciality. There have been instances where a member of the senior medical staff has been appointed directly via the Directorates and this has meant that credentialling has occurred after appointment, which is not compliant with best practice and accepted standards. The service has just implemented a new process whereby the e-recruitment system for medical appointments triggers a report to the credentialling officers when a decision for an offer of appointment is made and this will include the details of the individual, the position and the hiring manager which will give the credentialling officers the ability to start credentialling. In addition, a weekly report of all medical appointment requisition approvals will be provided to the EDMS allowing oversight of medical recruitment at the senior leadership level. This process will require evaluation.

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

Junior staff are well supervised and supported by senior staff.

A system is in place to review and record performance and development needs of staff. The PR&D template has recently been reviewed to make it more user friendly. There are some issues with recording of PR&Ds in the HR system and completion rates appear to be lower at an organisation-wide level than would be ideal. However, the organisation-wide rate has been increasing steadily over recent months, from 40% in early June 2017 to the current rate of 62%. The team also saw evidence of much higher completion rates at local unit and ward level throughout the service and believes that there is evidence that CAHLN is working consistently to meet these Actions.

A range of quality and safety education and training activities are available to staff. These are available on-line and also in other modalities such as the Nursing Leadership Group and a Learning for Change Program developed in conjunction with Adelaide University.

A staff survey was undertaken in late 2017 to ascertain staff understanding of quality and safety systems and an Action Plan is currently being developed to identify further improvement activities.

Incident and complaints management

Staff demonstrated knowledge of the Safety Learning System and medical staff have increased their use of the system. Incidents and complaints are reported, investigated and outcomes monitored. It was noted however that actions on the recommendations register are not always being addressed in a timely manner. The Incident Review Panel (IRP) monitors all serious events including coroner's cases etc.

Training is provided and support is provided to those clinicians involved in open disclosure.

Information on incidents and complaints is reported through the organisation to the Governing Council and also to SA Health. The surveyors noted that recent incidents that has received publicity such as the power outage were reported and managed appropriately.

The surveyor who visited the Port Augusta Prison was impressed by the much improved collaborative approach by the DCS Emergency Response Group (ERG) and Primary Health nursing staff to behavioural or aggression incidents. There appears to be a much better understanding by the ERG in assisting nursing staff in managing acute psychiatric incidents.

Patient rights and engagement

The organisation has a charter of patient rights that is consistent with the current national charter of healthcare rights. It is available to patients and their carers through leaflets contained within the Welcome Pack which is distributed by the CALHN Friends (Volunteers). Leaflets are also displayed in ward areas and on screens (particularly at the RAH which is limited in how much signage can be placed on walls). Patients and carers are asked if they have any questions at admission, during intentional rounds and bedside handover, but there does not appear to be specific questioning about patient understanding of the Charter. The survey team encourages the service to continue to work with their private partners about how to improve signage at the RAH.

There are multiple examples of patients and carers being involved in care planning. As already described, patients are involved in decisions at admission, during intentional rounds and also handover. Many NUMs also undertake a round of all patients in their wards and this provides further opportunity for patients and carers to be involved.

The general consent form is comprehensive and there is space for doctors to describe the risks and complications they have discussed with patients and their carers as well as space to describe the type of patient information provided. There is a comprehensive suite of patient information leaflets, some developed by the relevant specialist colleges and others developed at CALHN with consumer input.

Interpreters are available if required and both the Charter and many patient information leaflets are available in other languages but there is room for improvement in this area. While the Charter brochures are provided to patients and they are asked if they have any general queries about the Welcome Pack, they are not specifically asked if they have any specific questions about the charter. As such, Developmental Action 1.17.3 is Not Met.

Completion of consent is formally audited as part of the audit schedule but there is also auditing of consent during completion of the surgical safety checklist and patient identification audits.

There is an effective system in place to document Advance Care Directives (ACDs) and treatment limiting orders following implementation of the Advance Care Planning and 7 Steps Pathway project some years ago. Surveyors noted such documentation in clinical records and there is also an annual audit of these documents. The mortality review process also includes review of ACDs and treatment limiting orders.

Patient feedback is provided through clinician-patient interactions, through receipt of compliments and complaints and through the various consumer engagement groups. In addition, the SA Health supported SACESS provides useful data for the service and the opportunity to take further action to improve.

Governance and quality improvement systems

Ratings

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

Action 1.4.2 Developmental
Annual mandatory training programs to meet the requirements of these Standards

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

Surveyor Comment:

Compliance with mandatory training requirements is still an issue for CALHN. Getting accurate information has been a problem and still is although now the use of CHRIS21 should enable better reporting. Review of current data however shows variable compliance across professional groups and services. It was noted that workarounds are in place in most wards. Nursing could provide evidence of compliance which was generally of a high level.

Surveyor's Recommendation:

Ensure that the annual mandatory training programs meet the requirements of these standards.

Risk Level: Moderate

Risk Comments:

Non-compliance with policy is a risk to the organisation and could impact on patient care.

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

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

Surveyor Comment:

The risk management systems and processes have evolved over the last year and at an organisation wide level and directorate level the systems appear to work effectively for those risks that are identified and accepted; although review of the register shows some updates are overdue. Accountability and responsibility for risk management is not at the unit level and the surveyors found engagement and knowledge at that level was variable. Some frustration was voiced at not having more control over risk whilst others were content with the directorate structure. The surveyors concern was that some risks are not being identified or if they are then not accepted but still remain a risk at a unit level.

Assessments are carried out by the quality, safety and risk team. The assessments are very detailed and time consuming and can often than not be accepted as a risk at a directorate level.

Other processes are then found to solve the perceived problem e.g. calling it a quality improvement and putting it on the quality register. The risk however may not be resolved or escalated. There is not a clear understanding of what is a risk and what is an issue as both terms are used in the activation of the new RAH.

A risk profiling exercise was due to start at the time of survey. This has not been done for some time and was a recommendation from a SA Health internal audit last year. This is targeting the directorate level.

Surveyor's Recommendation:

1. The organisation expedite the risk profiling exercise, ensuring coverage of key points identified at survey in particular:

    i Overdue updates
    ii Strengthening engagement and knowledge by staff at unit level
    iii Ensuring escalation of appropriate risks to relevant executive

2. Risks identified in Mental Health Service ligature audit be actioned.
3. Develop a framework which supports local decision making regarding risk.
4. Identify and adapt an education program to develop capability at unit level.

Risk Level: Moderate

Risk Comments:

Not identifying and managing risk could impact on patient safety.

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

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

Surveyor Comment:

The report on the 'Review of the Safety and Quality Systems, Leadership and Functions report' was finalised in Dec 2016 and a comprehensive action plan was developed to address the issues identified in the review. There has been progress in addressing actions and developing a framework to support clinical governance and develop a culture of safety and improvement in the organisation however, the last year has also been a time of significant change in the organisation with the move to the new hospital, service restructures and new senior leadership becoming established in their roles. This has impacted on the organisation's ability to move forward on a number of initiatives including the implementation of the new clinical governance framework. The impact of change is going to continue as the services in the new hospital are about to move across to a new electronic record and services continue to adjust to working within the new building. The move towards a safety and improvement culture requires change in the supporting structure. The quality and safety team will benefit from planned training to increase capability.

"Our commitment to quality" a statement to support delivery of safe and effective care was sent to all staff in September 2017. This sets out expectations in terms of safe quality service provision and clinical governance and was endorsed by the leaders of the organisation. It does not appear to be widely understood and whilst the structure for safety and quality remains in place at a directorate level the participation of staff across the organisation in quality activities is variable. The directorates are large and complex and the ward or unit level are not always engaged. Mortality and morbidity committee meetings are improving however there is variability across clinical services. These meetings plus Mortality Review and the Incident Review Panel are having protection lifted and this will provide greater transparency.

The planned structure will clarify reporting lines and accountabilities.

There is not a clear definition of quality that staff relate too neither is there yet a quality plan.

There were examples of clinical engagement noted by the survey team however this is still very variable.

The quality and safety unit staff do much of the documentation, reporting and monitoring review of the quality register and recommendations register show there are difficulties in meeting reporting requirements. Audits are undertaken although there is variability in follow up and repeat audits to address non-compliance are not always undertaken.

Surveyor's Recommendation:

1. Communicate a shared definition of quality and clinical governance across all levels of the organisation.
2. Implement the draft clinical governance framework.
3. Develop an organisation wide quality plan and reporting framework for all levels of the organisation.

Risk Level: Low

NSQHSS Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Clinical practice

Ratings

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

Performance and skills management

Ratings

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

Incident and complaints management

Ratings

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

NSQHSS Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Patient rights and engagement

Ratings

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

Action 1.17.3 Developmental
Systems are in place to support patients who are at risk of not understanding their healthcare rights

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

Surveyor Comment:

While the charter brochures are provided to patients and they are asked if they have any general queries about the Welcome Pack, they are not specifically asked if they have any questions about the charter.

Surveyor's Recommendation:

Provide evidence to demonstrate that systems are in place to support patients who are at risk of not understanding their healthcare rights.

Risk Level: Low

STANDARD SUMMARY 2: PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

CALHN has strengthened its structures for involvement of consumers and the community in the clinical and organisational governance of the organisation and there has been strong support for these by senior organisational executives. These structures provide the foundation for a well-connected system for CALHN with its Consumer Advisory Council and its representative membership from across the various CALHN services and special interest groups. The linkage between the Consumer Advisory Council and the CALHN Governing Council has also been improved with the Chair of the Consumer Advisory Council being a member of the Governing Council. The 2017 appointment of a Consumer Manager is also acknowledged as an enabler for the organisation.

In the capital development of the new RAH there has been a very significant inclusion of a culturally appropriate space for Aboriginal people within its design. There is also strong work undertaken in Aboriginal and Migrant Health Services through the Intermediate Care and the SA Prison Health Service. There is however recognition that the consumer, carer and community participation in CALHN needs to be more inclusive of all communities served, especially in relation to vulnerable groups.

In early 2018, CALHN supported wide participation of its consumers, carers and volunteers in the organisation's strategic planning workshop and participants have expressed an expectation that their involvements were valued by CALHN and that is will continue.

CALHN has recognised the need to strengthen its consumer partnership in service planning and has entered into an agreement with the Health Consumers Alliance of South Australia in developing the CALHN Consumer and Carer Engagement Strategy that will be implemented in 2018-19.

The Developmental Actions 2.1.2, 2.2.2, 2.5.1, 2.6.2, 2.8.1 and 2.8.2 are rated NM; Core Action 2.6.1 rated NM will be reassessed at AC90.

Consumer partnership in designing care

It is noted there is excellent involvement of patients and carers at Hampstead and across rehabilitation services that could be a model for the whole of CALHN. There was also a summary of all 2017 consumer feedback that was collated by the Consumer Experience Advisors and this was reviewed by the organisation's Quality and Governance Committee that led to the recognition of improvement opportunities.

Through the various consumer fora including the Consumer Advisory Council, there has been considerable feedback from consumers and volunteers on issues arising following the relocation to the new RAH in late 2017. These issues have particularly involved way finding and signage and the CALHN executive has worked closely with consumers and volunteers in responding to these issues. Similarly, there was strong consumer and carer involvement in bed management at Hampstead that has also been successful. It is noted there are consumers on respective directorate quality committees such as Allied Health and others.

CALHN has made a strong commitment to the training of consumers and carers and is hoped this training will continue to develop as the involvement of consumers and carers more systematically expands across the organisation. For instance, some consumers and carers have expressed an interest in participating in recruitment selection and although such involvement has happened in some services it is felt this could be broadened if consumers and carers were offered appropriate training in selection processes.

There is a well-developed system across CALHN for patient and carer input into patient information publications prepared by the organisation. The patient information does not proceed to approval unless the patient and/or carer input has been made and there has been a high level of agreement that the quality of publications is appropriate.

Partnerships in designing care will be strengthened through the development of the CALHN Consumer and Carer Engagement Strategy.

Consumer partnership in service measurement and evaluation

There are some excellent examples of consumer engagement in the design and redesign of services. For instance, the End-of-Life Working Party comprised a very diverse group of practitioners and consumers and there was significant input by consumers into key aspects of this group's model development. Similarly, the Model of Care for Aboriginal Prisoner Health in SA has been recognised by external partners as a critical development in working with people in a custodial setting. This model utilised a co-design approach with strong input from inmates and staff and has fundamentally redefined health service delivery for this group.

It is noted that CALHN can improve its organisation-wide approach to patient-centred care however strong work in this domain has commenced within rehabilitation services and is planned to be rolled out across TQEH in 2018. This work is based on the Patient and Family Centred Care, Clinical Best Practice Model from the Registered Nurses' Association of Ontario.

There is other evidence of strong patient-centred care at clinical levels across the organisation but there is no organisational strategy driving it and as such is dependent on local site or service based initiatives.

The Consumer Advisory Council and its representative services are seeking consumers to tell their stories to clinical staff. Expressions of interest have been called for and training is being considered to support consumers and carers to use their experiences of care to train the clinical workforce. These fora also regularly review and evaluate safety and quality information with their membership but these practices could be more systematically practiced across the organisation.

There has been a very systematic process undertaken at Intermediate Care Services to share safety and quality information with consumers. This has been done by feeding back results from waiting room audits through displays in the waiting rooms of the respective services that has led to ongoing dialogue with consumers. This approach was used by the O'Brien Street Practice to show its consumer engagement as part of its accreditation with AGPAL. There is also active sharing of quality and safety information at the various parts of the governance system in which consumers participate.

Consumer partnership in service planning

Ratings

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

Action 2.1.2 Developmental
Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback

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

Surveyor Comment:

It is noted there is not sufficient diversity amongst the consumers and carers engaged with CALHN to reflect the communities' diversity. The development of the CALHN Consumer and Care Engagement Strategy could include this critical element of wider inclusiveness of consumers and carers.

Surveyor's Recommendation:

Ensure the ongoing development of the CALHN consumer and carer strategies include the diverse communities served.

Risk Level: Low

Action 2.2.2 Developmental
Consumers and/or carers are actively involved in decision making about safety and quality

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

Surveyor Comment:

There are good examples of consumers and carers being involved in decision making about safety and quality across a range of service settings and types however this is not consistently practiced across CALHN. For instance, there are safety and quality meetings with consumer members and others without along with some planning processes that have been strengthened by consumer involvement such as the End-of-Life Working Party. There is a strong emphasis on patient-centred care within the stroke services but no established shared work with consumers; although this has been considered for future development. All practice could be strengthened through the development of the CALHN Consumer and Carer Engagement Strategy.

Surveyor's Recommendation:

Further systematise the processes for a whole of CALHN approach to involving consumers and carers in decision making about safety and quality.

Risk Level: Low

Consumer partnership in designing care

Ratings

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

Action 2.5.1 Developmental
Consumers and/or carers participate in the design and redesign of health services

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

Surveyor Comment:

There are clear examples of consumers and carers participating in the design and redesign of health services and also in the delivery of care to meet patient needs and preferences however this is not consistent across all services. There has been strong engagement with consumers in designing care in the Intermediate Care Services and the Rehabilitation Services. There was much commentary that many significant opportunities for involvement of consumers and carers were missed during the development of the new RAH. Subsequently there has been involvement with consumers and collaborative work with RAH executives to rectify identified issues. A more systematic approach to consumer involvement could be worked towards through the CALHN Consumer and Carer Engagement Strategy development.

Surveyor's Recommendation:

Identify and implement the strategy for engagement of consumers and carers in design and redesign opportunities.

Risk Level: Low

Action 2.6.1 Core
Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care

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

Surveyor Comment:

There are SA Health guiding resources to lead this practice including the: Framework for Active Partnership with Consumers and the Community; Partnering with Carers Policy Directive; and the Guide for Engaging with Consumers and the Community.

There is also a training program available on Partnering with Consumers and Community but little evidence of pickup of this training or of how the organisation is implementing the SA Health strategies.

There was an example of local training in patient-centred care being given to clinical leaders, senior managers and the workforce at Hampstead Rehabilitation Hospital and discussion that this training might be rolled out at TQEH in 2018 but no firm plans at this time.

There was no other evidence on a CALHN approach for clinical leaders, senior managers and the workforce being supported to facilitate consumer engagement and maintain ongoing partnerships with them.

It is not evident therefore that the developed SA Health approach to patient-centred care is being implemented across CALHN as the examples of such practice were only observed in parts of the organisation.

Surveyor's Recommendation:

Develop a strategy for an organisation-wide approach to orientation and training for clinical leaders, senior managers and the workforce in patient and family centred care.

Risk Level: Moderate

Risk Comments:

Lack of training could impact on patient care.

Action 2.6.2 Developmental
Consumers and/or carers are involved in training the clinical workforce

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

Surveyor Comment:

There are plans underway to more systematically include consumers and carers in the training of the clinical workforce as this has been identified as a gap by CALHN. The issue is being progressed by the CALHN Consumer Advisory Council and an expression of interest process has been developed for consumers and carers to come forward with possible stories that could be incorporated into training of the clinical workforce. There were some examples of consumers being used to share experiences with other patients or families such examples were isolated.

This strategy of including consumers and carers in training the clinical workforce could be supported to be more consistent as part of the CALHN Consumer and Carer Engagement Strategy.

Surveyor's Recommendation:

Implement the current plans for consumer and carer training of the clinical workforce and include its systematic delivery across CALHN.

Risk Level: Low

Consumer partnership in service measurement and evaluation

Ratings

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

Action 2.8.1 Developmental
Consumers and/or carers participate in the analysis of organisational safety and quality performance

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

Surveyor Comment:

There are examples of how CALHN involves its consumers and carers in the analysis of safety and quality performance information and data and in the development of action plans but these are not demonstrated across the organisation. For instance, Hampstead, Allied Health and Intermediate Care Services were seen as having good practice.

There is not consistent practice across CALHN.

Surveyor's Recommendation:

Identify and implement a mechanism to engage consumers and carers in the analysis of the health service's safety and quality performance.

Risk Level: Moderate

Risk Comments:

This could affect patient safety.

Action 2.8.2 Developmental
Consumers and/or carers participate in the planning and implementation of quality improvements

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

Surveyor Comment:

There are examples of consumer and carer partnership in service measurement and evaluation however this is not consistent across CALHN. An excellent example of how this occurred with the SAPHS Consumer Initiated Escalation of Care strategy through which consumers and staff were able to plan and evaluate this strategy. It is likely as the Consumer Advisory Council continues to establish itself this will influence the practice across all locality and service committees. This issue could also be strengthened through the development of the CALHN Consumer and Carer Engagement Strategy.

Surveyor's Recommendation:

Further identify and implement a mechanism to engage consumers and carers in the planning and implementation of quality improvements.

Risk Level: Moderate

Risk Comments:

This could affect patient safety.

STANDARD SUMMARY 3: PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

CALHN has Infection Prevention and Control systems and processes including reporting mechanisms to appropriate bodies. The CAHLN Prevent and Control Standard 3 Committee (referred to as the Std 3 Committee) report to CAHLN Executive Quality and Governance Committee and have oversight of the TQEH and RAH IPC (Infection Prevention & Control) Committees. These later groups where established to ensure engagement of local key stakeholders. The smaller sites are part of one or the other of these groups to ensure coverage and engagement across the network.

The Standard 3 Committee has developed a strategic plan and have undertaken site risk assessments. A comprehensive suite of reports is collated and tabled at a variety of IPC meetings. This has resulted in the development of a core group of KPIs that the Standard 3 Committee monitors. A Risk Register has been developed and is regularly monitored by the Standard 3 Committee and the CALHN Executive Quality and Governance Committee.

Policies and Procedures are regularly updated and staff can fine these on e-Central. The effectiveness of the Policies, Procedures and Organisation-Wide Instructions (OWIs) are assessed through the auditing processes undertaken by the Link Nurses. If a problem or issue is identified it is addressed at the time of audit.

Surveillance monitoring is a priority of the team and a comprehensive set of KPIs are reported monthly to the Committee and to Executive. Where an issue is identified a SLS is written and a multidisciplinary team approach is taken to investigate and resolve. The surveyors saw examples of such investigations. Where appropriate the issues are escalated to not only CAHLN Executive and SA Government but also the TGA.

There has been a significant body of work undertaken by the IPC team under the Single Service Multiple Site (SSMS) model to standard practices across all sites. There have been some challenges in adjusting to the new PPP model at RAH particularly around obtaining timely audits results on areas not covered by the health service for example airflow and water quality audits but these are being resolved.

CALHN has a well-developed Infection Control Link Nurse Program (ICLN). There are currently 35 Link Nurses who provide evidence and reports to the local groups and have training on a regular basis. In addition, each clinical area has one clinician who has the portfolio of IPC. Mental Health have recently appointed a Link Nurse who is currently undertaking training in this area.

There has been a number of Quality Improvement activities implemented which include the JUMP’N and bare below elbows project; giving patients hand wipes; designing and trialling new covers for linen trolleys; bathing patients in ICU with chlorhexidine impregnated cloths and application of intranasal antibiotic ointment, all have seen good results.

The organisation is encouraged to review the current surveillance screening and KPIs’ to ensure they continue to meet the organisations’ needs and provide future direction.

Infection prevention and control strategies

CALHN is guided by Hand Hygiene Australia’s (HHA) policy and guidelines for workforce compliance which is assessed through regular auditing. Hand Hygiene (HH) compliance with the 5 moments is and has been above the National Benchmark but is below the SA Health target of 85%. There are still pockets and groups where compliance is not to the accepted level.

It is suggested that to engage and improve medical staff in HH compliance it is beneficial to have some medical staff trained as HH auditors which has in other facilities found to improve their compliance rate.

The staff health program is proactive in regard to immunisation status of staff at a pre-employment level and a plan is in place to encompass current staff. Substantial work has been done on the workforce immunisation program to ensure all new staff complete the recommended vaccinations as per SA Health policy prior to employment as part of the recruitment process. A database captures staff status and assists with reviewing current staff for their immunisation status.

CALHN is committed to the protection of staff from occupational exposure and comply with the SA policy for Occupational Health & Safety. For any blood and body fluid exposures there is an exposure packs on the wards that contains a list of processes and forms that covers counselling and follow-up. These are monitored and managed appropriately. Staff are trained and competency assessed for effective personal protective equipment (PPE) usage including Fit Testing of N95/P2 masks if working in a high-risk area. The introduction of the new needless system is a proactive approach to reducing risks for staff.

Developing and implementing systems for the use and management of invasive devices and aseptic technique is undertaken across CAHLN. There is an eLearning package for clinicians in regard to aseptic technique and is a mandatory training program to be undertaken every five years. Areas have been risk rated in regard to requirements around Aseptic Non-Touch Technique (ANTT) with good compliance for training. An action plan has been developed based on the risk to ensure relevant staff are aware and progressing the requirement to undertaken competencies in this field. The next step will be the evaluation of the process but the challenge will be to ensure compliance across all disciplines as well as the sustainability of the process.

The importance of hand hygiene and sound practices in ANTT cannot be underestimated. The reported S*taphylococcus aureus* (*S. aureus*) bacteraemia (SAB) bloodstream infection rates for 2017 are an area for concern. This has resulted in CAHLN developing an action plan and the issue has been escalated with a report to CALHN Executive that includes remedial actions required. It is suggested that this area will be important to prioritise and action as soon as practicable.

Managing patients with infections or colonisations

There are robust systems in place to enable identification and containment of those patients with or are at risk of changing their status to have an infection or colonisation of one. The Standard Precautions and Transmission-Based Precautions in place are consistent with current national guidelines. Auditing of precautions demonstrate high levels of compliance. Patients presenting with or at risk of acquiring infections are promptly screened and receive necessary placement, management and treatment. Alerts are visible in the medical record and in EPAS. The infectious status is also identified at clinical handover.

Personal protective equipment (PPE) is available at all sites to assist staff to effectively comply with standard and transmission-based precautions when caring for at-risk patients. New admissions who are flagged as at risk have an alert provided to the infection control nurses. The IPC NUMs conduct daily rounds to ensure placement requirements are appropriate and the ward has been notified, from pathology, of newly identified at-risk patients. The appropriate isolation of at-risk patients has been facilitated by the profile of the bed base with RAH having all single rooms for patients and other sites having a smaller number of single rooms. Once the organisation has further progressed the concept of a SSMS model this will also assist in the capacity to manage patients with infections and colonisations. 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.

At the RAH, although there is some signage, it was noted there was a lack of signage and HH stations at the entrance to wards and outpatient areas. It is suggested that the HH placement, including current HH gels, and signage be reviewed and strategies implemented to improve access.

Antimicrobial stewardship

Antimicrobial stewardship (AMS) has a long history at CAHLN, with the program being established in the 1980s at the old RAH facility. This program is well known to have a strong multidisciplinary team approach and is well integrated across CAHLN. The program is managed by the AMS Committee which reports to the Drugs and Therapeutics Committee.

AMS is well supported by policies, good governance, appropriate committees and pathways. The clinical workforce has easy access to therapeutic guidelines and clinical pharmacists are available and provide support to prescribers. Prescribers have access to the restricted antimicrobial drug list, including when an infectious disease physician is to be consulted. Access to Infectious Disease Physicians is readily available across CAHLN.

There is a number of mechanisms in place to control the use of antimicrobials. These include: a restricted antimicrobial prescribing process in place with the requirement for an ID Physician to sign off designated high-risk antimicrobials; ongoing monitoring, with antiobiograms for RAH and TQEH undertaken annually by SA Pathology, to inform the prescribing process.

Surveillance mechanisms are sound and there was evidence to the surveyors of the auditing and monitoring processes that have resulted in the identification of issues and need for changes to practice.

Examples of such include: the recent Vancomycin audit which resulted in changes to the guidelines and practices; daily review of meropenem dispensing; daily monitoring of any restricted antimicrobials removed from ADCs; monitoring of MRSA, VRE and Clostridium difficile acquisition, and the anaesthetic database which tracks patients receiving prophylactic antibiotics.

The recent National Antimicrobial Prescribing Survey (NAPS) 2017 results highlighted some issues and gaps with appropriateness of surgical prophylaxis. This has been discussed with the Surgical Division and together an action plan has been developed. Strategies to improve compliance include education and awareness raising activities. This will continue to be monitored.

Cleaning, disinfection and sterilisation

The multiple clinical service environments at CAHLN are managed through a number of internal and external contract arrangements. These cover cleaning, portage, linen and waste services. Auditing processes are in place to monitor the compliance with the standards and contract arrangements which are set by the Department of Health and Aging - SA Health and based on the Cleaning Standards for Healthcare Facilities 2014.

The new Central Sterilising Services Department (CSSD) at the RAH is well designed and built with the future in mind and creates opportunities for the future of sterilising services in CAHLN. On the other hand, the aging infrastructure at TQEH sterilising services create some risks for the organisation. The two CAHLN CSSD have undertaken an audit for compliance with the new AS/NZ 4187 (2014) standards and the Advisory requirements for Action 3.16.1. Where a criterion/action was not met, this has informed the gap analysis and an implementation plan has been developed with actions required, milestones and timeframes. The survey team sighted this plan and confirmed that progress towards implementation is progressing.

There are policies and OWIs in place in regard to the reprocessing of reusable medical equipment and are available in the CSSD reprocessing areas to ensure activities are performed in accordance with AS/NZS 4187:2014.

Staff have completed the required education for cleaning, disinfection and sterilisation, such as Certificate III in CSSD. The staff in the Endoscopy suites comply with the GENCA education program for endoscopes with updates organised regularly.

At RAH CSSD there is a new computerised tracking system T-Doc for the managing the traceability of all Reusable Medical Devices (RMD) and monitoring their working life which is able to trace individual instruments back to the patient. At TQEH there is a manual tracking system for managing the traceability of reusable instruments and devices (to a tray level or single items). The devices are traced to the patient and the identification system adheres to the infection control standards and the Safety and Quality Commission guides.

There is some closed shelving still in use for the storage of sterile stock across CAHLN but there is a plan for replacement of these containers particularly in the RAH Theatres. It is suggested that formal reporting and auditing of the cleaning of the new shelving at RAH be undertaken to give assurances of the integrity of clinical supplies due to the environment.

Communicating with patients and carers

It is important to ensure consumers are provided with information on infection prevention and control and then for this information to be evaluated by consumers as to it effectiveness or usefulness. Information is available to patients across CAHLN via the SA Health Patient Safety Report; My-Hospital website; Unit Safety boards at all sites except RAH (due to restrictions on building); patient information sheets for specific areas; engagement on promotional days/surveys i.e. International Infection Prevention Week (IIPW), HH day; Infographic display for outbreaks to inform the public and staff.

Information is also available to patients at RAH on new the patient information channel (on continuous loop).

It is suggested that a review at RAH of the number of HH stations in public areas and at the entrance to wards be undertaken to facilitate engagement of the community/consumers with hand hygiene compliance. It is also suggested that HH compliance and acquired infection rates be more visible to the public across all sites.

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

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

Action 3.10.1 Core
The clinical workforce is trained in aseptic technique

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

Surveyor Comment:

CAHLN has undertaken a risk analysis of aseptic competencies required. They have embedded aseptic technique principles into the training procedures that require use of aseptic technique. In addition, an overarching training package has been implemented on aseptic techniques. Despite the strategies being implemented there is a higher rate of SAB infections than expected so this needs to be actively managed. There is not clear evidence of total compliance with all relevant staff. This meets the transitional requirements of the action.

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

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

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

Surveyor Comment:

The organisation has undertaken a gap analysis of compliance with AS/NZ 4187 (2014) and has developed an action plan to address gaps. This includes with projected milestone, timelines, deliverables and accountabilities. It is suggested that an annual comprehensive gap analysis be undertaken and reflected in the organisation's action plan.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD SUMMARY 4: MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

The medication management processes across CALHN are complex and varied. For example, The Queen Elizabeth Hospital is using an electronic prescribing system (EPAS) and a manual supply and dispensing system. On the other hand, the Royal Adelaide Hospital has a highly automated supply system but are still using manual paper-based prescribing. The Mental Health Service and Prison Health Service are essentially “manual”. Furthermore, significant changes are planned for the Royal Adelaide Hospital should EPAS be introduced.

(Additional Note: ACHS has been advised that following the survey a new government was appointed and the implementation of the electronic record has been suspended pending a formal review.)

The CALHN pharmacy service and medication management system is one of the components of the State-wide services. Thus, a number of the policies governing the service are centrally mandated and governed. Nevertheless, CALHN, and the individual hospitals within the local health network, at a functional level, are more or less independent.

A Medication Governance Framework for CALHN has been prepared and was reviewed by the surveyors in its draft form. It is a well-written document and appears to deal with all aspects of medication management. It is now important that this framework is escalated through the various management committees, is signed off and adopted.

Unfortunately, there has been no formal assessment of the medication management system since 2013.

Even though there is a lack of a formal service-wide assessment there is ample evidence that there have been individual, focused assessments on various aspects of the medication management systems and as a result of these assessments changes to practices have occurred. As an example, there have been increased, robust requirements placed around the prescribing and administration of chemotherapy agents.

Pharmacists, medical officers and nursing staff are all required, on appointment, to undergo orientation into medication management. Nurses have regular competency requirements and pharmacists are required to demonstrate continuing professional development for their regular annual registration. There are specific competencies for those clinical staff working in high-risk areas such as chemotherapy units. Furthermore, there are rigid requirements for all staff in these high-risk areas to follow strict protocols which, in the main, result in double checking of all prescribing and administration of chemotherapeutic agents.

As mentioned in the overview there have been significant changes in the hospitals that make up the CALHN over the past three or four years. This has required significant up-skilling of all clinical staff earning to use electronic prescribing and to use the ward dispensing systems now in place at the Royal Adelaide Hospital. It is also noted that in both the iPharmacy system and in EPAS there are mechanisms to recognise fraudulent prescribing thus increasing the integrity of the process and making it especially difficult for illegal use of medications.

A number of incident reports were reviewed, one of which resulted in an RCA, and noted that the process followed accepted standards and the recommendations arising from the reports have been implemented in a timely fashion. It is noted that all staff have mandatory training in the SLS incident reporting system and viewed data which suggests that the system is being used well and appropriately.

Core Action 4.2.1 is rated NM and is subject to review at AC90.

Documentation of patient information

It is standard practice for all patients, on admission, or as soon thereafter as possible, to have a full medication history taken by one of the clinical pharmacists. The pharmacy service keeps these data as a KPI. Presently the KPI records completed histories within 24 hours.

Though every patient has a recorded medication history the percent that has this done within the 24 hours could be improved.

There are clinical pharmacists and all wards who continually monitor prescribing and dispensing. Pharmacist used the purple pen so that when they make an entry or correction on a medication chart it is clear that this has been made by the pharmacist.

Recording of adverse drug reactions is monitored with a good response rate. It is noted that EPAS remind users to consider adverse reactions before making any changes to the and electronic medication chart. At the RAH the medication charts are kept in a slot immediately outside the patient's room and accompany the doctors on rounds. With the potential move to full EPAS the current medication lists will be available on the bedside computers.

Medication management processes

All computers in clinical areas throughout the hospitals have access to SALUS – the South Australian online library system. This includes access to MIMS, Up-To-Date and other reputable sources of information. The critical care areas also have access to specific information sources relevant to their service.

Regular audits support ongoing monitoring of cool storage facilities in all hospitals. There is evidence to show compliance with the storage requirements. Recently, the Royal Adelaide Hospital experienced a power outage for some 20 minutes. A check of the recordings for all refrigerators shows that they did not go outside the strict temperature parameters. The main pharmacy in the Royal Adelaide Hospital has a large number of bulky packing cases in main thoroughfare areas. Apparently, these have been left over from the move from the old hospital. It is strongly suggested that alternative location for these should be found. Pharmacists also should be reminded of the importance to ensure that no medications, even in their original packing, are stored on the floor.

The automated dispensing systems (Pyxis) now in use at the Royal Adelaide Hospital adds an additional level of security for the storage and distribution of high-risk medications. However, in addition to these physical barriers all those who access the high-risk medication areas must do so by fingerprint recognition. Finally, routine regular checking of schedule 8 drugs occurs at shift changes.

Clearly, the increased security and safety of these Pyxis systems are significant and the introduction of the system into the Queen Elizabeth Hospital would be desirable.

Continuity of medication management

The surveyors observed frequent examples of a comprehensive list of medications being available at in-house clinical handovers. At the RAH this was largely achieved through reference to the medication charts located immediately outside patients' rooms. At TQEH the medication chart is accessible via EPAS on mobile computers.

Unfortunately, the transfer of a comprehensive medication list to community clinicians is not well-managed – this reflects the relatively poor performance with completion of patient discharge summaries in a timely fashion. However, there will be recommendation under this standard aimed at addressing the provision of detailed medication information – at least as an interim arrangement until the completion of discharge summaries is significantly improved.

Though there is no formal process for advising community clinicians of patients' discharge medications general practitioners may ask for a list of these medications to be provided. It is further noted that wherever possible, patients on discharge are given a comprehensive and up-to-date listing of their current medications. This list also records changes in the medication that may have occurred while in hospital. It was suggested that this list should, at the top, have a statement in bold type, recommending that the patient takes this list when next they have to visit the general practitioner. This is seen as a stopgap measure but will go some way to address this shortcoming.

The Core Actions 4.12.3 and 4.12.4 are rated NM, to be reassessed at AC90 Review.

Communicating with patients and carers

There are clinical pharmacists attached to all wards/clinical units. There is evidence that these pharmacists frequently interact with patients; initially obtaining a comprehensive medication history followed by frequent interaction during the inpatient stay so as to help explain changes in medication prescribed by the medical staff and discussing the need for closely following the dosage instructions and to be aware of unwanted side-effects.

Pharmacists enter this information that has been discussed in the patient's medical record – where there is still a paper record the pharmacist use a purple pen so that their interventions are clearly apparent to the medical staff.

There are a number of formal medication management plans which are a component of a total condition management plan. Examples were asthma management plans; diabetes management plans and rheumatoid arthritis plans. In addition to these specific plans the pharmacists have access to a range of pamphlets dealing with a range of medications – these are handed to patients to help them understand what to expect from this particular treatment.

Governance and systems for medication safety

Ratings

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

Action 4.2.1 Core
The medication management system is regularly assessed

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

Surveyor Comment:

A regular comprehensive review of medication management using a recognised tool is an essential component of risk management. The organisation last undertook such a review in 2013 – five years ago.

Much has changed in this time which may well have had an effect on the medication management system.

It is recognised that specific assessments have taken place over this period but these, in the main, have been focused assessments resulting from a reported incident or recognised problem. The intention of this criterion is to ensure that assessments are carried out in order to detect potential service shortcomings and correct them before an incident occurs.

These reviews are time-consuming but are necessary. Furthermore, in a time of change such structures, assessments are probably even more important. Though the National Standards did not stipulate how frequently such an assessment should take place it is generally accepted that a review every three years is appropriate.

Surveyor's Recommendation:

Carry out a comprehensive review of the medication management system using a recognised 'assessment tool'.

Risk Level: Moderate

Risk Comments:

Without regular assessment, there could be gaps in the system that could impact on patient safety.

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

Continuity of medication management

Ratings

Action	Organisation	Surveyor
4.12.1	SM	SM
4.12.2	SM	SM
4.12.3	SM	NM
4.12.4	SM	NM

Action 4.12.3 Core
A current comprehensive list of medicines is provided to the receiving clinician during clinical handover

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

Surveyor Comment:

The clinical pharmacists in each service unit ensure wherever possible, that patients on discharge are given a comprehensive and up-to-date listing of their medications. This list also records changes in the medication that may have occurred while in hospital. Upon request, additional copies can be printed for subsequent health care providers.

The patient's list can be made available to the patient's receiving clinician – but only on request from the clinician. Thus, this particular criterion is not met as there was no evidence to show that this important information is made available. Satisfactory compliance with this criterion is closely related to improvement in the completion of discharge summaries.

Surveyor's Recommendation:

Provide evidence to demonstrate that a comprehensive list of medicines is provided on discharge to the receiving clinician.

Risk Level: Moderate

Risk Comments:

Non-compliance with this action could result in patient harm.

Action 4.12.4 Core
Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover

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

Surveyor Comment:

This recommendation is a rider to the previous recommendation. As part of the plan to address 4.12.3 it is recommended that robust monitoring processes are established to ensure sustainability.

Surveyor's Recommendation:

Ensure that action is taken to increase the proportion of receiving clinicians that are provided with a current, comprehensive list of medicines at discharge.

Risk Level: Low

NSQHSS Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Communicating with patients and carers

Ratings

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

STANDARD SUMMARY 5: PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

Policies, procedures and protocols that are designed to ensure the correct identification of a patient at any point of time during admission or course of treatment and apply to inpatient and outpatient settings are utilised. The three approved identifiers, include: MRN, name and date of birth and are used at the time of admission, when care is delivered, at the time of clinical handover and patient transfer or discharge. Compliance is variable at the time of clinical handover and individual units are addressing this issue. Incidents are reported in the incident management system. In depth analysis of incidents during 2017 has been undertaken and interventions have occurred were required. The patient identification band meets national specifications. Where patient identification bands are not utilised alternatives include photographs. Prisons manage identification of prisoners very well. All prisoners must present their Department Correctional Services (DCS) identification card which includes a photograph to the nurse before services, treatments or medication is administered. Radiology utilises an orderly transport slip to check patient identifications at the ward level and in the radiology department.

Processes to transfer care

The patient identification system is part of the clinical handover, transfer and discharge processes. Observation of the clinical handover and medication administration demonstrated use of the approved identifiers.

Processes to match patients and their care

South Australian Surgical Team Safety Checklist Policy provides direction for the management of procedure matching in the operating theatres and the technical suites and there is regular monitoring of compliance. The Patient Identification and Procedure Matching Committee has commenced a review of the matching and checking processes for non-operative procedures. Radiology has specific policies to ensure procedure matching occurs using the time out concept. There is regular auditing of compliance.

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

STANDARD SUMMARY 6: CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

The Clinical Handover Standard Committee provides governance oversight to clinical handover at CALHN. The Committee provides reports to the Executive Quality and Governance Committee. CALHN acknowledged that there have been challenges in engaging medical staff in clinical handover initiatives. The Committee has recently undergone membership changes and a new Chairperson has been appointed. It is anticipated that the new Chairperson will facilitate increased medical engagement.

CALHN has several clinical handover related OWIs available on eCentral. The OWIs are consistent with the SA Health Clinical Handover Policy Directive. Surveyors noted that the OWIs provide clear guidance in relation to clinical handover expectations and processes for staff to follow in a variety of inpatient and non-inpatient clinical handover situations. ISBAR is the overarching CALHN clinical handover format, which surveyors observed is appropriately adapted for use in different clinical areas.

Online learning on clinical handover is available to CALHN staff. Whilst staff members are encouraged to undertake the learning module, it is not mandatory. Interns commented that clinical handover is not well covered in their general orientation; rather they are advised of the expectations of their directorates/clinical specialities at the commencement of their rotations.

From a review of Clinical Handover Standard Committee minutes and other documentation provided, surveyors noted several examples of clinical handover quality improvement activities that have been undertaken by CALHN. These include at the Hampstead Rehabilitation Centre and in non-inpatient areas such as the SA Prison Health Service and the CALHN Intermediate Care Services. Surveyors also noted the comprehensive 2017 Allied Health Clinical Handover Action Plan.

Clinical handover processes

The surveyors observed several CALHN clinical handover events, including nursing bedside handovers and Emergency Department and Intensive Care Unit clinical handovers.

The multidisciplinary Emergency Department and Intensive Care Unit clinical handovers were noted to be thorough and well-constructed using ISBAR principles. Clinicians commented that feedback regarding their experiences with clinical handover is sought, supporting the evolution of clinical handover processes to maximise their effectiveness.

The surveyors observed that nursing bedside handovers have some inconsistency in the way they are conducted, most notably in relation to active patient identification. These surveyor observations are consistent with findings in CALHN annual clinical handover audits. The clinical handover audits indicate that whilst several bedside handover parameters are showing positive trends and are at reasonably high compliance levels, patient identification remains an area needing further attention. CALHN is encouraged to continue the focus on ensuring active patient identification is consistently undertaken at bedside nursing handover, as described the “Handover: Nursing Shift to Shift - Bedside” OWI. The clinical handover portfolio nurses may be a valuable resource to support this undertaking. Surveyors also suggest that it may be useful to implement bedside handover audits more frequently than the current annual audits to ensure that improvements occur and are maintained. Surveyors noted that the current annual audit tool does not include feedback from patients/carers regarding their experiences with clinical handover.

The surveyors noted that brief daily or twice daily multidisciplinary huddles have been widely introduced across inpatient clinical areas. The Intermediate Care Service also routinely uses multidisciplinary huddles. Surveyors received very positive feedback from many clinicians regarding the effectiveness of the brief multidisciplinary huddles, particularly as a communication tool. CALHN is acknowledged for this valuable initiative.

As noted above, Interns are advised of the expectations of their directorates/clinical specialities with regards to medical discharge summaries at the commencement of their rotations. Surveyors received feedback that Interns receive varying and sometimes conflicting advice from consultants and registrars regarding discharge summaries. Some registrars and consultants emphasise the importance of medical discharge summaries and others reportedly show less concern and interest. Whilst CALHN OWIs state “The discharge summary is a concise summary of the patient’s episode of care in hospital”, in some units a high level of detail is expected to fulfil additional audit and research imperatives. In addition, Interns reported that often on commencement of a new rotation there are large numbers of discharge summaries to be completed on patients cared for by the previous Interns. Surveyors suggest that CALHN develop a more consistent organisational wide approach to requirements surrounding medical discharge summary content and that these requirements, along with general expectations regarding medical discharge summaries, be outlined to medical staff as part of their organisational orientation.

The surveyors noted that, although variable across sites, there are significant delays in medical discharge summaries in some clinical disciplines being completed and provided to appropriate health care providers. A recommendation has therefore been made in action 6.3.3 in relation to the timely completion of medical discharge summaries.

Currently medical discharge summaries are being produced either in EPAS or OACIS software depending on the site. Surveyors were advised that discharge summaries are generally faxed to general practitioners due to lack of encryption and problems in interfacing with clinical software used by general practitioners.

The surveyors noted that CALHN identified a risk associated with delays in transcription and distribution of discharge/treatment update letters from outpatient clinics to general practitioners. Surveyors further noted that an improvement project was instituted to address this matter and that ongoing improvements have resulted.

Whilst local processes for clinical handover are reviewed in collaboration with clinical staff, surveyors could not find evidence that there is also collaboration with patients and carers. A recommendation in developmental action 6.3.2 has been made in regards to this matter. Surveyors noted that the terms of reference of the Clinical Handover Standard Committee include a consumer representative in its membership. Currently however no consumer representative has been appointed to the Committee.

The Clinical Handover Standard Committee monitors and reviews incidents related to clinical handover. No SACS one incidents were noted in the documentation provided.

Developmental Action 6.3.2 is Not Met; Core Action 6.3.3 is rated NM and subject to review at AC90.

Patient and carer involvement in clinical handover

The CALHN OWI regarding nursing shift to shift clinical handover clearly indicates that the handover is to be undertaken at the bedside with patient/carer involvement. Surveyors noted that in the 2017 audit it was reported that clinical handover was conducted quietly and directly next to the patient 94% of the time, an encouraging result.

The question “was the patient and/or carer actively included in bedside handover?” is also included in the annual nursing bedside clinical handover audit.

A positive response was received in 73% of cases in 2015 and in 85% of cases in 2017. Although further improvement is still desirable, there is a clear positive trend.

NSQHSS Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Action 6.3.2 Developmental
Local processes for clinical handover are reviewed in collaboration with clinicians, patients and carers

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

Surveyor Comment:

Whilst feedback from clinical staff is used to inform local clinical handover processes, mechanisms to also collaborate with patients and carers regarding clinical handover processes are not in place.

Surveyor's Recommendation:

Ensure that local processes for clinical handover are reviewed in collaboration with patients and carer as well as clinical staff.

Risk Level: Low

Action 6.3.3 Core
Action is taken to increase the effectiveness of clinical handover

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

Surveyor Comment:

The surveyors noted that, whilst variable across sites and clinical disciplines, audits indicate that there are frequent occasions where there are delays in medical discharge summaries being completed and provided to appropriate health care providers. Interns and General Practitioner Liaison provided feedback consistent with the audit results. The most recent (January 2018) RAH audit results provided to surveyors reveal an overall positive result in relation to timeliness where a medical discharge summary has been generated for the separation. The most recent TQEH audit data provided to surveyors however shows inconsistency and at times poor compliance with medical discharge summary completion timeliness. This recommendation relates to ensuring consistency across sites and clinical disciplines in meeting medical discharge summary completion timelines in accordance with CALHN OWIs.

Surveyor's Recommendation:

Ensure that completion of medical discharge summaries complies with CALHN policies, especially the timeliness of completion and provision to appropriate health care providers.

Risk Level: Moderate

Risk Comments:

Not providing information to GPs could impact on safe care for the patient.

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

STANDARD SUMMARY 7: BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

CALHN has a well-established committee structure to support the governance of blood and blood product usage. There are Blood Management Committees at the Royal Adelaide Hospital and The Queen Elizabeth Hospital which report to the CALHN Blood Management Committee. Regular reports in turn are provided to the CALHN Executive Safety and Quality Committee. The Blood Management Committees have clear terms of reference and have multidisciplinary membership. CALHN works in close partnership with SA Pathology and both organisations have high levels of expertise. There are also links to the SA Blood Management Council.

OWIs are evidence based and are informed by agencies such as the National Blood Authority (NBA) and the Australian and New Zealand Society of Blood Transfusion (ANZSBT). The OWIs are available on eCentral.

BloodSafe Transfusion Nurse Consultants facilitate a comprehensive audit program covering the broad range of blood and blood product management processes. The BloodSafe Transfusion Nurse Consultants also play key roles in staff education and training, in quality improvement activities and in haemovigilance reporting. The BloodSafe Nurse Consultants are supported by ward Blood Link Nurses. Audit results, quality improvement activities and identified risks are monitored through the blood management committee structure.

CALHN has a strong blood management training program for its staff. There are also a variety of tools to guide clinical staff, including “flippin blood”, reference guides and checklists. Surveyors noted the excellent “transfusion orientation pack” which is issued to junior doctors at orientation. The pack provides practical guidance for medical staff and includes “blood prescribing cards” on a lanyard which contain concise information and prompts.

Several quality improvement activities were undertaken during 2017. Examples include the introduction of Emergency Department haemorrhage starter packs and changes to EPAS request forms to facilitate improved transfusion history. Considerable work related to the use of pneumatic tube system also occurred. A current CALHN focus, in cooperation with SA Pathology, relates to minimising risks associated with “Wrong Blood in Tube”.

Documenting patient information

CALHN and SA Pathology pay close attention to ensuring that there is high quality documentation related to blood and blood products, including transfusion history. Electronic order forms in EPAS and standardised blood product request forms both require the inclusion of blood transfusion history. Information regarding patient blood transfusion history is also held in OACIS.

Various aspects of blood and blood product documentation form part of the CALHN ongoing audit program.

SA Pathology has zero tolerance to any non-conformance with blood product ordering requirements, including inadequate documentation or incorrect labelling of blood specimen tubes.

A detailed clinical management and reporting process involving both CALHN and SA Pathology is in place in the event of a transfusion reaction.

CALHN reported that there have been two blood product related SAC 1 incidents in last five years. Both were thoroughly investigated and relevant actions taken. Surveyors noted that neither incident occurred within the previous two years.

Managing blood and blood product safety

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 via co-located SA Pathology which dispenses blood via the pneumatic tube system (red blood cells) and porterage. A risk management approach is taken in this regard, amply demonstrated by the quality activities aimed at mitigating identified risks, which are regularly reviewed. Relevant staff undertake e-learning on blood/blood product management, including porters employed by the organisation’s public/private partnership (PPP) partner. All blood is stored centrally and allocated on a just-in-time basis reducing the risks associated with delayed administration at the bedside. Prescribing accuracy is strictly controlled and blood is not dispensed unless request forms are correctly completed.

The multidisciplinary Patient Blood Management Committee monitors quality control relating to receipt, storage, collection and transport of blood and blood products through incident reports and quality activities. Many incidents and activities have involved the pneumatic tube system which was implicated in delayed collection of/incorrectly re-directed blood units and specimens in the early months following the move to the new site.

The Committee has seen improvement in this regard over time with more initiatives still underway to further streamline blood delivery to the correct destination.

Blood wastage has reduced significantly in recent years with prior red cell wastage of 15% now at 0.7 – 1%. There are multiple reasons for this which include state initiatives such as the timely reallocation of unused blood from smaller services across the state via the Blood Management Project; a range of blood sparing strategies at RAH; the introduction of ROTEM devices in the Technical Suites; and the education of clinicians regarding appropriate ordering of blood/blood products (e.g. the introduction of a single unit policy). Cell salvage has been targeted this year as one of the Committee’s quality initiatives to further reduce waste.

Communicating with patients and carers

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 on specific blood transfusion forms. Medical patients (who are most likely to receive blood via elective process) provide informed consent in this manner. Audits demonstrate steadily improving compliance with the process.

Elective surgical patients however currently sign a general procedural consent form which now contains a tick box which when ticked by the surgeon gaining consent indicates consent for use of blood/blood products. The organisation was unable to provide evidence that such patients are provided with sufficient information at the time of signing the consent form to give informed consent and recommendations have been made under Developmental Actions 7.10.1 and 7.11.1 in this regard.

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
7.9.1	SM	SM
7.9.2	SM	SM
7.10.1	SM	NM

7.11.1	SM	NM

Action 7.10.1 Developmental
Information on blood and blood products is provided to patients and their carers in a format that is understood and meaningful

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

Surveyor Comment:

Information about blood and blood products is available and provided to patients in the Medical Services as a part of the informed consent process. A formal specific blood consent process is evident.

There is however no evidence that the Surgical Service provides patients with sufficient information to make an informed decision regarding transfusion. Instead Surgical Services uses a general surgical consent form which contains a check box indicating consent for blood/ blood products.

Surveyor's Recommendation:

Provide evidence that information on blood and blood products is provided to relevant surgical patients and their carers, and that it is in a format that is understood and meaningful.

Risk Level: Low

Action 7.11.1 Developmental
Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation

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

Surveyor Comment:

Although medical patients give informed consent via the use of a specific blood/blood product transfusion consent form which contains relevant information, patients in the Surgical Service consent via a general surgical consent form which contains a tick box indicating consent for blood and blood products. There is no obvious mechanism to guarantee signage of this consent form is informed through the provision of verbal information or appropriate written information to support decision making.

Surveyor's Recommendation:

Ensure that informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the relevant health service policy in regard to surgical patients.

Risk Level: Low

STANDARD SUMMARY 8: PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

There are a number of OWIs which guide clinical practice in the prevention and management of pressure injuries. These are available online through eCentral and provide detail on pressure injury prevention and management, wound assessment and management and equipment/support surfaces for pressure relief.

The Standard 8 Skin Integrity and Pressure Management Committee is charged with reviewing Standard 8 and undertaking a gap analysis against the Standard and determining future actions required to address these gaps. Overall responsibility for quality and safety governance lies within the Executive Quality and Governance Committee. It is noted that continuing work is being undertaken to improve the clinical governance structure within CALHN.

There is an audit schedule for Standard 8 with an annual pressure injury prevalence survey noted as the main tool for gathering information on the effectiveness of the program. Other evaluation tools are used including the NSQHS documentation audit and patient surveys. Audits may be completed across the whole of CALHN or in specific clinical areas, such as the Intraoperative Pressure Audit. There is evidence that results of the audits have been acted on. For example, following on from the NSQHS audit, it was a requirement that areas with non-compliant criteria undergo a self-re-audit two months post baseline following actions taken to address non-compliant areas. Evidence that action had been taken was provided, for example, by the Medical Directorate, where wards with non-compliant criteria at initial audit scored above the 91% benchmark at the follow up audit. Examples of improvements were provided to the survey team.

Incidents are reported through the Safety Learning System (SLS) and there are good processes in place to manage these incidents. The Executive are notified of any serious incidents immediately. Detailed reports on incidents resulting in pressure injury and reported in the SLS are provided to the Executive Safety and Governance Committee on a monthly basis with an annual report summarising all incidents reported for the previous year. On investigating pressure injury incidents, it was found that staff were incorrectly staging the pressure injury and reporting them as serious incidents. This has led to further education provided to staff on how to classify pressure injuries.

Training is available to staff on pressure injury prevention and management, although this is not mandatory. A network of Skin Wound Assessment Team (SWAT) nurses has been established who have completed more advanced training and who are resource staff for clinical areas on pressure injury prevention and management.

There are dedicated staff with specialist skills in pressure injury prevention and wound management who are available to assist in complex cases or in high need areas, such as Vascular Services and the Spinal Unit.

Preventing pressure injuries

According to the Organisation-Wide Instruction on Preventing and Managing Pressure Injuries (OWI-02941), the Braden Scale is to be completed on presentation of all patients within eight hours, the level of risk determining further actions required, such as the frequency of reassessment and the need for a pressure injury management plan. A skin assessment and pain assessment is also to be completed on presentation. The MUST or MST malnutrition screening tool is also required with a referral to the Dietetics Service required for relevant patients. Audit results have shown a decrease in the number of referrals to a dietician, a result that requires further examination.

As mentioned above, audits are conducted on compliance with the relevant OWI and action is taken to improve compliance.

A number of improvements have been implemented in response to the evaluation process. Of note, a recent initiative has been the introduction of pressure relieving dressings used on the sacrum and heel in response to findings that the most common area for pressure injuries to occur within the Health Service were the sacrum and heel.

A number of medical records were reviewed by the survey team across a range of services and it was found that most of these services consistently assessed patients for pressure injury risk using the Braden, completed a malnutrition screen where required, did daily skin inspections and documented a pressure injury management plan.

An alert is raised in the medical record if the patient is at risk of pressure injury.

Equipment is available for use for patients at risk of or having a pressure injury. There is a central equipment pool and online ordering of equipment from relevant companies is now available. An annual audit of mattresses is undertaken with the last audit resulting in 35 new mattresses being acquired. There is a Clinical Protocol available to staff on the selection of devices and equipment to reduce skin pressure. Staff have training on how to use equipment with findings from the mattress audit showing that staff were not clear on the reasons for ordering a pressure relieving mattress.

Some services consider all patients to be at risk of a pressure injury such as in Vascular Services, Intensive Care and the Spinal Unit and respond accordingly, setting up pressure injury prevention plans on admission. Other areas, for example, radiotherapy is more focused on skin integrity due to a very low risk of a patient acquiring a pressure injury in that environment but a high risk of having a skin reaction requiring wound management.

Other strategies in place to prevent pressure injury include hourly rounding, early mobilisation, foot care for high-risk patients and appropriate seating, to name a few.

The Pressure Injury Prevalence Survey conducted in 2016 showed a decrease in the prevalence of pressure injuries from the preceding year. This may indicate that the pressure injury prevention program is having some affect.

Managing pressure injuries

An Organisation-Wide Instruction (OWI:03453) guides the clinical practice for the assessment and management of wounds and includes wound assessment, wound referral pathways for the different facilities within CALHN, and a wound management dressing guide. Basic training is available on Pressure Injury Prevention and Management for clinicians involved in the day-to-day care of patients, with more advanced training available for nursing staff wishing to have more advanced competencies in wound management and to become part of the Skin Wound Assessment Team. This has resulted in a network of SWAT nurses across CALHN providing areas with more support in wound management. Other clinical resources are available who have specialist wound management knowledge and who provide a consultation service to services within CALHN to manage complex wounds. Allied Health members are also part of the specialist team with Occupational Therapy providing a consultation service on seating requirements and Podiatrists providing foot care.

Communicating with patients and carers

There is a Consumer Factsheet on Preventing Pressure Injuries available through SA Health which is used in CALHN. Many clinicians spoke about providing specific education to relevant patients on pressure injury prevention and management, including an interpreter where necessary and involving carers as appropriate.

Questions included in the pressure injury point prevalence audit conducted in 2016, show that over 70% of patients surveyed were aware of their pressure injury risk and aware of how to prevent pressure injuries. Patients spoken to during the survey week confirmed this finding and spoke of their own active involvement in care planning.

NSQHSS Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

NSQHSS Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

The Resuscitation and Deteriorating Patient Committee (RDPC) has responsibility for oversighting the systems that supports the recognition and management of deteriorating patients. This mature Committee (which has been in place since the inception of the National Standards) in turn reports quarterly to the Executive Quality and Governance Committee. A mechanism exists outside of this framework to expedite reporting should the need arise. The Committee is clinician led, multidisciplinary, active and passionate, reflected in the Terms of Reference, and meeting minutes which are quite detailed and informative. The Mental Health team is represented and participates in the Committee's activities.

Management of resuscitation and the deteriorating patient is governed and informed by a comprehensive series of policies and work instructions (OWIs) which guide clinicians in recognising and responding to clinical deterioration. Guidance for example is provided regarding early warning and response system tools, correct use of observation charts, rapid response systems and escalation of care.

The Committee is well supported with accurate data via a MERS database which provides details of all MET Calls and Codes Blue events across CALHN. The Committee's monitoring function includes a comprehensive suite of audits which range from documentation in the Recognition of Deterioration and Response Chart (the RDR Chart) to patient outcomes. Deaths and cardiac arrests are reviewed to identify failures of the recognition and response system. The Committee reviews audit results and clinical incidents, as well as action plans arising from such activities. It is responsible for identification of risks related to clinical deterioration which are on risk registers at Directorate level.

Audit information on outcomes and the recognition and response system is fed back to clinicians via all clinical communication forums in a timely manner, with emphasis on where improvements can be made in future. Two-way communication is encouraged and examples were provided of active engagement.

Recognising clinical deterioration and escalating care

Track and trigger mechanisms are in place to record observations which alert staff to deterioration and guide response. The Recognition of Deterioration and Response Chart (the RDR) is comprehensively used across CALHN electronically via EPAS at TQEH and on paper elsewhere, including the RAH.

(Additional Note: ACHS has been advised that following the survey a new government was appointed and the implementation of the electronic record has been suspended pending a formal review.)

The RDR includes the design elements required by this Standard. Correct use of each chart, is appropriately monitored via audit and results show pleasingly high levels of compliance with comprehensive documentation of observations. This was borne out by surveyors who visited multiple wards and departments and noted this to be the case. Appropriate escalation of care is less well embedded in organisational culture as attested by audit but is improving following intensive intervention and re-audit. It is gratifying to see that staff are performing increasingly effectively in escalating care according to policy.

Examples were provided of effective use of the modification process. For example, in the Respiratory Ward at the RAH, respiration parameters are frequently modified to accommodate the altered respiratory rates of many of its patients. In other wards temporary modifications were noted with timeframes for the modification routinely included.

Mechanisms are in place to escalate care and call for emergency assistance including documented flow charts; the use of nurse call systems and emergency buzzers depending on the site. Use of escalation processes, including process failures, are well monitored via audit, action plan and re-audit as required.

Responding to clinical deterioration

Clear policy and work instructions relating to escalation contain criteria for triggering a call for emergency assistance. At very small sites, including community centres, this may simply be the use of the ‘000’ system to call for an ambulance. At the larger sites sophisticated systems ensure specialised and timely care through MET teams and Code Blue teams. The process at TQEH for inpatient management of clinical deterioration has recently been amended to a two-tier response; previously a Code Blue was called for all instances of deterioration necessitating a full team of expert clinicians to attend what may have been a relatively minor event. A two person MET team has now been introduced. All clinical staff at this site were aware of the change, how to discriminate between the new MET call and a Code Blue call according to the parameters of the RDR chart, and how to contact each team.

Evidence was provided at the time of the survey of relatively low rates of compliance with Basic Life Support (BLS) training as per the Learning Management system at 74%. It is recommended under Action 9.6.1 that the organisation addresses this deficit, particularly regarding medical staff where the most recent rate is recorded as 31%. Training reports are provided to ward/departmental managers, who have a responsibility to ensure that their staff members undertake mandatory and requisite training. An excellent example of innovation in regard to BLS training was provided by Prison Health who have invited prisoners to become proficient in BLS.

Many clinicians in high-risk areas or with key escalation of care responsibilities are trained in Advanced Life Support (ALS) and there are always adequately trained personnel on duty in acute hospitals. Procedures related for the checking and monitoring of resuscitation equipment are well embedded throughout the organisation and all equipment is standardised. Compliance is audited and surveyors observed that appropriate checking processes were being rigorously followed by staff.

Communicating with patients and carers

Patient, family and carer participation in recognition and response of deterioration is a work in progress. A range of policies, work instructions and tools have been developed but sign off leading to implementation has been slow to progress. Recommendations have been re-issued in Developmental Actions 9.7.1; 9.9.1; 9.9.2; 9.9.3 and 9.9.4 to support achievement of effective patient, family and carer engagement.

CALHN has done a lot of work regarding Advance Care Directives (ACD) and now has a detailed policy, a work instruction and a system to record their presence in the patient history via hard copy in the medical record (and identified on patient handover documents) and electronic alerts where EPAS is operational. The organisation is also working with the community to encourage more widespread use of ACDs and the number being presented to the organisation is slowly increasing.

NSQHSS Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Action 9.6.1 Core
The clinical workforce is trained and proficient in basic life support

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

Surveyor Comment:

While accurate data was difficult to find regarding staff numbers who are trained in BLS, sufficient was available to suggest that there is inconsistency across wards and departments, with some wards as low as 50%.

The most recent data for nursing rates of BLS was 74% medical BLS showed 31% of medical officers had met requirements although a plan was in place to increase rates and 'BLS Blitzes' were widely advertised throughout the organisation. The action is therefore met under transitional arrangements for 2018.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

Action 9.7.1 Developmental
Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include:
• the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient’s condition, to the clinical workforce
• local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration

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

Surveyor Comment:

A comprehensive initiative relating to participation of patients, families and carers has been prepared but commencement of the roll out has not yet begun.

Surveyor's Recommendation:

Introduce the initiative to ensure that information is provided to patients, family and carers - in a format that is understood and meaningful - on the importance of communicating indications of deterioration, and local systems through which they can raise their concerns.

Risk Level: Low

Action 9.9.1 Developmental
Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response

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

Surveyor Comment:

A comprehensive initiative relating to patient, family and carer involvement in initiating a care response has been developed but has not yet been implemented.

Surveyor's Recommendation:

Implement the initiative and provide evidence to demonstrate that mechanisms are in place for a patient, family member or carer to initiate an escalation of care response.

Risk Level: Low

Action 9.9.2 Developmental
Information about the system for family escalation of care is provided to patients, families and carers

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

Surveyor Comment:

A comprehensive initiative inclusive of family escalation of care information has been developed but has not yet commenced implementation.

Surveyor's Recommendation:

Implement the initiative to ensure patients, families and carers receive information about the system for family escalation of care.

Risk Level: Low

Action 9.9.3 Developmental
The performance and effectiveness of the system for family escalation of care is periodically reviewed

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

Surveyor Comment:

A comprehensive initiative relating to patient, family and carer involvement in escalating care has been developed but not yet implemented. Consequently, the performance of the system cannot yet be reviewed.

Surveyor's Recommendation:

Ensure that the initiative regarding patient, family and carer involvement in escalating care contains performance measures to monitor its effectiveness when the initiative is implemented.

Risk Level: Low

Action 9.9.4 Developmental
Action is taken to improve the system performance for family escalation of care

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

Surveyor Comment:

Because implementation of the initiative to involve patients, families and carers in escalation of care has not yet commenced, no action has been undertaken to improve its performance.

Surveyor's Recommendation:

Once implemented, take action to improve the system relating to family escalation of care.

Risk Level: Low

STANDARD SUMMARY 10: PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

CALHN uses the SA Health policies in relation to falls screening, prevention and management which are consistent with best practice. It is suggested that CALHN update the Safe Use of Bedrails OWI to include instructions for the new beds at the RAH which have significantly different bedrails to those previously used in the organisation. Annual audits are conducted across CALHN to monitor compliance with the policies and results are reported by Service. Services or individual units where the results are less than benchmark are required to develop an action plan to improve compliance.

The Falls Prevention Clinical Standing Committee (FPC) is a multidisciplinary committee with representation from all sites and includes a consumer. The FPC has the delegated authority to determine CALHN's clinical governance for falls prevention and injury management. The FPC reports to the highest level of governance; the Executive Quality and Governance Committee through a twice-yearly report.

Falls reporting occurs through the Safety Learning System (SLS). Incident review occurs consistently across CALHN when a fall occurs and is reported back through the SLS. Falls data from SLS is presented to the FPC monthly, trended over time by occupied bed day and separates total falls and falls with harm as well as acute, rehabilitation and post-acute falls rates.

The FPC has developed an OWI consistent with the SA Health policy which instructs staff on training, screening, assessment, use of bedrails, equipment and post falls management. Across CALHN there was evidence of quality projects underway to improve falls rates. The organisation identified a risk around the move to the new RAH with all single rooms, however the implementation of intentional hourly rounding has resulted in overall falls rates decreasing.

The FPC has identified risks regarding falls however it was determined that the risks would be consolidated with the emerging challenging behaviours risk. Across CALHN falls are identified by the front-line staff as the largest clinical risk. There have been various spikes in falls with harm. It is suggested the organisation reviews the risk register and considers including falls as an organisational risk.

Staff across CALHN have access to equipment and devices to reduce harm from falls. In all areas staff were able to articulate and demonstrate how they utilise this equipment for patients. The new beds at the RAH have built in sensor capacity which has assisted staff manage frequent fallers.

Screening and assessing risks of falls and harm from falling

CALHN uses the SA Health falls screening and falls assessment tools. Screening should occur within two hours of admission and the subsequent risk assessment completed within eight hours of admission. Across the organisation it was evident that these tools are used for the majority of patients. Audits are conducted twice per year to monitor compliance and reported to the FPC by Service. Services or Units where compliance is below the 90% benchmark are required to produce an action plan to identify opportunities for improvement. The action plan is registered in the quality database for monitoring.

Preventing falls and harm from falling

Across CALHN the multi-factorial SA Health Risk Review tool constitutes the prevention and falls care plan to prevent patient falls and harm from falls. The falls care plan is documented and implemented within 48 hours of admission in an inpatient or ambulatory care setting, 48 hours in aged care and one-two weeks in the community. The plan should be reviewed once every 24 hours in the acute setting, daily for three days then weekly in sub-acute settings, when there is a change in condition, when a fall occurs and prior to discharge. The twice-yearly audit program also monitors compliance with the falls care plan and reports results to the FPC. Action plans are developed to address compliance below 90%.

Innovative quality improvement projects aimed at reducing falls were evident through The Stepping Forward Program at Hampstead, the AmbIGeM research in Geriatrics at the Queen Elizabeth Hospital and the inclusion of pharmacy and medication review post falls. The organisation is encouraged to continue the work commenced regarding the impact of cognitive impairment on falls and the implementation of post falls huddles. The survey team encourages CALHN to evaluate these programs for the next OWS.

The SA Health Risk Review tool includes referral to community services on discharge. The My Falls Prevention Team work in the community to follow up patients at risk of falling on discharge. The team has updated the Falls Directory for ward staff to ensure they are aware of options for patients on discharge.

Communicating with patients and carers

Information on falls prevention strategies is available for patients and carers in relevant community languages. However, the organisation has not undertaken an assessment to ensure the information is meaningful and understood. As a result, a recommendation will be made in this regard in Developmental Action 10.9.1.

Across CALHN patients and carers are partners in developing falls prevention plans. Recording of patient involvement is included on the risk plan and compliance audited via the audit program. Great examples of this in practice were seen at Hampstead Hospital and in neurosurgery at the RAH where the services are innovative and adaptable based on the needs of their patient group.

Governance and systems for the prevention of falls

Ratings

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

Screening and assessing risks of falls and harm from falling

Ratings

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

Preventing falls and harm from falling

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	NM
10.10.1	SM	SM

Action 10.9.1 Developmental
Patient information on falls risks and prevention strategies is provided to patients and their carers in a format that is understood and meaningful

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

Surveyor Comment:

There is information available for patients and carers about falls risks and falls prevention strategies which is available in relevant languages. However, the organisation has not undertaken an assessment to ensure the information is meaningful and understood.

Surveyor's Recommendation:

Ensure that patient information on falls risk and prevention strategies is provided to patients and carers, and it is meaningful and understood.

Risk Level: Low

Central Adelaide Local Health Network

MENTAL HEALTH IN-DEPTH REVIEW (IDR)
NSQHSS Survey Report

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

SURVEY OVERVIEW

The Central Adelaide Local Health Network (CALHN) Mental Health Directorate (MHD) is governed by clinical policies and guidelines to establish best practice approaches across SA Health MHD and assist and support MHS clinicians in determining the appropriate health care for MHD consumers.

The clinical policy directives are mandatory requirements that are implemented across SA Health as operational practice whether short term or permanent and must be complied with no scope to deviate from the specifications within the clinical policy directives.

A clinical guideline however has flexible requirements and implementation and may be developmental or staged according to the MHD. The Clinical State-wide networks have been replaced by Transforming Health Clinical Advisory groups of which the Mental Health Clinical Network is one.

At the time of survey the MHD were operating within a difficult environment in a number of areas and caring for consumers/patients in a less than therapeutic environment. This was due to the breakdown of the duress system caused by a wiring fault resulting in the duress system not accurately relaying the location when staff are calling for assistance. Until the duress system is fully operational a security presence will remain to manage any potential risk to both patients and staff in designated areas.

The move to the Royal Adelaide Hospital (RAH) had in place a robust set of logistical, operational and strategic plans but unforeseen problems were recognised as having the possibility of occurring. A Rapid Incident Review and Response Function was in place during the period of the move using a "real time" system of analysing incidents enabling prompt action and allowing information from the Executive to be shared with the MHD in a timely fashion.

Many positive initiatives for 2018 are planned or are in place these include the patient Sexual Safety project, the proposed Connecting with People Program focused on capacity development in the general community and Interventions for Suicide Management. The development of Short Stay Units (SSU) in both the RAH and The Queen Elizabeth Hospital (TQEH) to manage the transition between the Emergency Departments and bed availability will soon be operational.

A new level of staff in the MHD Inpatient Units named the "Chaperones" has commenced to assist patients with activities of daily living and the introduction of an Infection Prevention and Control Link nurse is soon to commence.

A Strategic Mental Health Quality Improvement Indicator report provides Safety and Quality data including: New Treatment Orders, Restraint and Seclusion, ECT Treatments Challenging Behaviours, Self Harm and Morbidity.

At survey the majority of the NSQHS Standards Actions were assessed as Satisfactorily Met (SM). Twenty-three (23) Actions in Standard 7 were rated Not Applicable. Action 2.2.2 was awarded an MM rating. Eight Developmental Actions were rated Not Met, and seven Core Actions (1.2.2, 1.5.2, 4.2.1, 4.6.1, 4.12.3, 4.12.4 and 6.3.3) were identified as Not Met; the Core NM actions will be reassessed at AC90 Review.

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

Surveyor Summary

Governance and quality improvement systems

The CALHN MHD has in place a comprehensive Annual Audit Schedule 2017-2018 with a number of related audits identified against both the NSQHS and NSMHS criteria. Included are the ECT Consumer Satisfaction audits per ECT Suite, MHD Triage, Nursing Shift Handover and the Sexual Safety audit.

A seven day Post Discharge Follow Up audit (this was the first audit conducted on seven day follow-up in the CALHN MHD) and with some wards/units not meeting the state target rate of 60%; this is subject to a current recommendation.

The MHD workforce are aware of their delegated safety and quality roles and responsibilities with orientation education and training providing staff with the skills and information required to fulfil their roles. Annual mandatory training programs are conducted with the evidence available in the Mandatory Training and Performance Review and Development Compliance report demonstrating current compliance at 91% - February 2018.

Performance Review and Development demonstrated an overall result of all disciplines of 95%.

Clinical practice

The use of outcome measurements, especially consumer measurements is variable across different parts of the CALHN MHD. Procedures are available which include the requirements for the use of various tools and measurements and care planning, including input from consumers and carers.

For example, in evidence available to the survey team, data from audits for August 2017 showed care plans on CBIS for Intermediate Care was at 25%. In acute inpatient areas, four of six areas were below 50%, with one at 65% and another at 85%.

Consumer measurements, such as the K10 in Older Adult Metal Health Services varied between 23 to 60% across four services. No audit compliance data was evidenced of the use of K10 measures for adult inpatient services. However, it was evidenced in Intermediate and Community Services.

In interviews with staff, surveyors asked about the utility of consumer and other clinical measures. The advice given was that while the measures may be collected, they were not used for clinical decision making.

It is suggested that the organisation consider improving the utilisation of outcome measures in clinical care.

Performance and skills management

Medical staff have developed a prevocational training program to attract HMOs into psychiatry training and to provide GP vocational trainees with a solid experience of psychiatry. The mental health service conforms with the CALHN wide credentialling and scope of practice procedures.

There have been instances where a member of the senior medical staff has been appointed directly via the Directorates and this has meant that credentialling has occurred after appointment, which is not compliant with best practice and accepted standards. The service has just implemented a new process whereby the e-recruitment system for medical appointments triggers a report to the credentialling officers when a decision for an offer of appointment is made and this will include the details of the individual, the position and the hiring manager which will give the credentialling officers the ability to start credentialling. In addition, a weekly report of all medical appointment requisition approvals will be provided to the EDMS allowing oversight of medical recruitment at the senior leadership level. This process will require evaluation.

An audit of ECT credentialling and specific scope of practice was undertaken and led to the recognition of some deficits that required action to ensure that psychiatrists credentialling for ECT specifies sites appropriately. Within ECT suites a register of credentialled ECT Psychiatrists is maintained. Audits of credentialling compliance have included Allied Health and Self-regulated health practitioners. The medical credentialling committee reports regularly on credentialling completion rates for senior medical staff. Scope of practice Organisation-Wide Instructions (OWIs) support a structured approach in ensuring the clinical workforce has the skills required to provide clinical services and to review credentialling and scope of practice when new services are being introduced. Mental Health PRD completion rates are relatively good compared to CALHN. Supervision expectations are set out within the models of care and business rules. There are two credentialled nurse practitioners and one nurse practitioner candidate in MH. Scope of practice in MH for allied health has been reviewed according to changes in MH service system needs. It is hoped that the service will have the first credentialled Aboriginal nurse practitioner working within the Aboriginal community in MH in the country. Medical staff supervision is entrenched and consistent for all juniors and SIMGEs. Allied health and nursing professional development takes into account changing needs of the service components.

Incident and complaints management

MHD has access to the Safety Learning System (SLS), an integrated multi-module web-based system and contributes to with this system which is across all the Local Health Networks. All incidents or near misses which have or may impact on patient care and safety are reported with the system identifying areas for improvement. Trends are monitored and where necessary individual incidents, actions taken and outcomes are examined and reviewed through relevant CALHN committees. All complaints are well managed and feedback is reported to the MHD staff following analysis of reported complaints with review of all MHD complaints occurring at the highest level of governance.

Patient rights and engagement

The MHD displays a charter of patient rights consistent with the national charter and information is provided and explained to patients who are at risk of not understanding their rights or have diminished capacity. Patient records and confidential information is available at the point of care for all patients receiving treatment and care in the MHD with systems in place to restrict inappropriate access without compromising access by clinicians.

Governance and quality improvement systems

Ratings

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

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

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

Surveyor Comment:

The MH survey team observed a patient who was in what constitutes seclusion at the RAH. This was defined by confinement in the authorised hospital by the locked door of one of the two seclusion rooms constitutes a physical barrier preventing the patient from leaving. Discussion was held with the MH clinician and evidence was not able to be provided that the criteria applied was in accordance with an oral or written seclusion order but rather to manage the patient until a bed could be found. Two security guards were outside each of the two seclusion rooms. The second room also had a patient in it, but the door was ajar also with a second security guard sitting inside.

Surveyor's Recommendation:

Ensure that action is taken to improve the safety and quality of patient care by adhering to the Mental Health Act of South Australia in the correct use of Seclusion in CALHN Emergency Departments.

Risk Level: High

Risk Comments:

The seclusion of a person under the Mental Health Act in an Authorised Hospital from which a person is unable to leave without the oral written seclusion order or physiological observations in place constitutes a high risk.

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

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

Surveyor Comment:

The MHD has undertaken ligature audits but were unable to provide evidence to demonstrate which recommendations from these audits had been completed. The MHD were also unable to provide satisfactory evidence that the seven-day follow-up of all MH discharged in-patients occurs, although some areas verbally described to the survey team that it does occur.

Surveyor's Recommendation:

Ensure that action is taken to minimise the risks to patient safety and quality of care by ensuring that the Ligature Audit recommendations are actioned, completed and documented with a report sent to all relevant areas of the completion of the recommendations in a timely manner. Ensure that a system for the capture and documentation of all seven-day patient follow-up post discharge is captured and evidence of the mechanisms put in place if a patient is unable to be contacted.

Risk Level: High

Risk Comments:

The completion of Ligature Audit recommendations across the Directorate and the system and documentation of the seven-day follow up of all discharged patients requires close monitoring and documentation as both areas constitute a high-risk if not completed.

Clinical practice

Ratings

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

Performance and skills management

Ratings

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

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

Action	Organisation	Surveyor
1.17.1	SM	SM
1.17.2	SM	SM
1.17.3	SM	SM
1.18.1	SM	SM
1.18.2	SM	SM
1.18.3	SM	SM
1.18.4	SM	SM

NSQHSS MH IDR

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

1.19.1	SM	SM
1.19.2	SM	SM
1.20.1	SM	SM

STANDARD SUMMARY 2: PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

Governance systems are in place within the CALHN MHD that supports consumer and carer participation and engagement. The CALHN MHD Consumer and Carer Advisory Group (CCAG) also has mental health consumer representation at the wider CALHN Consumer Advocacy Committee (CAC). Further the coordinator of the Lived Experience Workforce Program sits on the CALHN MHD Executive. This further reflects a commitment by CALHN MHD to support the consumer perspective and consumer involvement within it governance structure.

Consumer representation was evident at key meetings within CALHN - inclusive of the Quality and Governance meeting and the Western and Eastern Sector Management meetings. The Framework for Active Partnership with Consumer and the Community is also reflective of the organisation's intent in partnering with consumers. Documentation sighted noted that this document is due for review in 2016. It is suggested by the survey team that CALHN MHD source as to whether this framework has been reviewed and in line with current contemporary practice with regards to consumer partnerships and involvement. A further suggestion with regards to the CCAG is for CALHN MHD to look towards supporting this consumer and carer group and work towards reinforcing to the group the significance of their contribution to the CALHN MHD.

There has been a body of work undertaken by CALHN MHD with regards to the diversity of the population in particular the Aboriginal Torres Strait Islander (ATSI) community - with documented attempts to engage with this community. Additionally recognition by the CCAG to seek CALD and ATSI consumer representatives has been identified as a gap within the CCAG structure and advice received to the survey team that plans are in place to support this action. It is suggested that this action be further pursued to ensure these consumer and carer groups have a voice at the table. Some further work could also be undertaken to hear the consumer voice of the hearing impaired and the LGBTI community. It is clearly documented in the Terms of Reference of the CALHN MHD Quality and Governance Committee and the CALHN CCAG that the expectation and responsibilities of its members inclusive of consumer representatives participate in the decision making and strategic operations of CALHN MHD. In order to fulfil this role consumer and carer representative attend orientation. The Lived Experience Workforce (Peer Specialists) employed by CALHN MHD attend regular Professional Development days and are also participants in State - Wide Professional Development Days. The Co-ordinator of the Lived Experience Workforce Program is further supported to attend Leadership Training. The initiative of reviewing all information available to consumers that was undertaken by CALHN MHD was consumer and carer led. The Information Workgroup further implemented resources at the service sites in the form of fact sheets and a booklet Welcome to Service. These factsheets and resources were developed with consumers and by consumers and are now readily available for consumers. It is suggested that these are reviewed as to their currency at a date /year determined by CCAG and or other consumer representatives.
Action 2.2.2 has been rated Met with Merit (MM).

Consumer partnership in designing care

A number of examples were evident to the survey team on the involvement of consumer and carer participation in and redesign of care. This was both at a CALHN level with the Co-ordinator of the Lived Experience Workforce Program providing consultation on the newly built RAH. Within CALHN MHD projects such as the Model of Care and the Physical Health project have seen consumer influence and consumer perspective I their design. Further to this and an extension of the implementation of the physical health project sees the peer specialists supporting consumers at the Physical Health stations located in the CALHN MHD Community Mental Health centres.

The Acting Lived Experience Coordinator also provide consumer consultation on the design of the new mental health short stay unit at The Queen Elizabeth Hospital (TQEH). At a more local level consumer input and feedback guides the development of activity and programs with service site setting for example at Elpida. Consumer participation by CALHN MHD consumers has led to the Coordinator Lived Experience Workforce Program co-authoring published journal articles.

Recovery philosophy and the ethos of patient-centred care underpins education delivered to clinicians at both a CALHN MHD level and at a local service site level. The Learning Centre is available to all staff of CALHN MHD inclusive of the peer specialists and carer consultants. In-services are also a feature of educational learning for staff and these are occurring on a regular basis. In both a CALHN MHD and a local level - peer specialist deliver a wide training CALHN MHD staff. This engagement of training to CALHN MHD clinicians by the peer specialist is noted a strength of CALHN MHD. It is suggested that this practice continue to occur within CALHN MHD with ongoing review and evaluations of the training delivered by peer specialists.

Consumer partnership in service measurement and evaluation

Consumer and carer involvement and participation in service measurement and evaluations occurs within different points in CALHN MHD. Consumers and carer representatives have the opportunity to review data whilst on designated committees. The YES survey feedback data, whilst still in its infancy has been presented to the CCAG in an easy to understand format and opportunity exists for discussion to occur based on this reports and future reports. The CALH MHD Consumer Advisor is a member of the CCAG and presents reports to this group. It is suggested that reports of feedback is present and displayed to consumers of the service at service sites. How this is presented could be developed in partnership with consumer groups.

The Physical Health project, Values in Action, Consumer Carer Forums and the Consumer and Carer Audit Pilot are examples of consumer involvement in the development and implementation of quality initiatives within CALHN MHD. Consumer Feedback report has also been presented to the CCAG and opportunity made available for discussion and further analysis of this data. The Quality Improvement Project register identifies a range of quality improvement projects earmarked to be undertaken by CALHN MHD. It is suggested that this body of work is updated and reviewed with regards to identifying the projects that will be inclusive of consumers and/or carers. Further to this suggestion the involvement in review of projects could be tabled at the CCAG for their information and actions and involvement as agreed upon and identified by the group.

The recent implementation of YES survey provides CALHN MHD (with an increase of return rates) with a rich source of consumer feedback data. This is an opportunity for CALHN MHD and consumer leads to include within scope the involvement of consumers in the development of quality improvement activities. It is suggested that in line with this initiative posters are more prominently displayed to raise awareness amongst consumers of the availability and opportunities available to them to provide feedback and in the CALHN MHD YES survey project plan the role of consumers and consumer groups be incorporated and documented. This will clearly identify the consumer role within the YES survey process in the analysis of data and development of action plans.

A further suggestion is to ensure the month/year is included in all project plans and reports and if relevant estimated dates of review.

Consumer partnership in service planning

Ratings

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

Action 2.1.2 Developmental
Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback

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

Surveyor Comment:

There is an amount of work undertaken to recognise and work towards engaging with the ATSI community. CALHN MHD made a decision to focus on the ATSI community but also recognised and acknowledged the other diverse groups within the CALHN catchment.

Surveyor's Recommendation:

No recommendation

Action 2.2.2 Developmental
Consumers and/or carers are actively involved in decision making about safety and quality

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

Surveyor Comment:

This action is rated Met with Merit. The current CALHN MHD Consumer Carer Advisory Group (CCAC) Terms of Reference (ToR) clearly articulates the role of its members of being informed about quality and safety of the organisation. Further evidence sighted by the survey team demonstrates of the former Lived Experience Liaison Group (now the amalgamated CCAC) were involved in decision making process. Consumer representation on the CALHN MDA Quality and Governance meetings further support the active involvement of consumers in decision making on quality and safety.

Surveyor's Recommendation:

No recommendation

Consumer partnership in designing care

Ratings

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

Action 2.6.2 Developmental
Consumers and/or carers are involved in training the clinical workforce

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

Surveyor Comment:

The CALHN Lived Experienced Workforce provide significant well-developed training to the clinical workforce on a range of consumer related topics and areas. This is inclusive of recovery philosophy and practice, working with the peer specialist and peer workforce, consumer engagement; this is delivered at both an organisational level through the Learning Centre and also at a local level; this is in the form of in-services delivered by the peer specialists to the clinical staff.

Surveyor's Recommendation:

No recommendation

Consumer partnership in service measurement and evaluation

Ratings

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

Action 2.8.1 Developmental
Consumers and/or carers participate in the analysis of organisational safety and quality performance

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

Surveyor Comment:

Consumer and carer representatives have the opportunity to participate in the analysis of CALHN MHD Safety and Quality performance through the committees they are active participants. A consumer advisor presents reports on the incidence of complaints and incidents that occur within the CALHN MHD at the Quality and Governance Meeting and minutes sighted by survey team reflect active participation of consumer representatives in these meetings.

Surveyor's Recommendation:

No recommendation

Action 2.8.2 Developmental
Consumers and/or carers participate in the planning and implementation of quality improvements

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

Surveyor Comment:

There are a range of examples that were evident to the survey team on consumer participation in quality improvement projects and initiatives. This is inclusive of the Physical Health Project of which a Lived Experience Resource Group was incorporated as part of the project.

Identification of quality projects has, in one instance, been consumer led with the review of resources available to consumers. Additionally, the Consumer Carer Audit project was again Lived Experience Workforce led.

The YES Survey roll-out although in its infancy will support the development of quality action plans and proposed plan incorporates consumer involvement in these plans.

Surveyor's Recommendation:

No recommendation

STANDARD SUMMARY 3: PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

The survey team was able to verify evidence of a comprehensive infection prevention and control program embedded in the safety and quality culture across mental health.

The CALHN Prevention and Control Std 3 Committee is responsible for the organisational-wide approach to infection prevention, control and surveillance and oversights the implementation of the SA Healthcare Associated Infection Prevention Strategic Framework. The committee meeting minutes and ToR include mental health representation but evidence of infection control information and outcomes disseminated to individual mental health teams could not be verified by team meeting agendas and minutes viewed by the survey team.

Infection prevention and control strategies

Infection control is part of annual mandatory training for staff. The training program for aseptic technique theory and practical competency had excellent compliance with training records indicating over 90% of staff had completed both training. All inpatient and community mental health sites visited were clean, organised and free from clutter.

Personal Protective Equipment (PPE) was available with information on what precautions are required for different conditions including pictures of staff with the required PPE displayed.

Sharps containers were secured and evident. There were concerns expressed by the surveyors around the inconsistency of available hand hygiene stations in the acute inpatient units.

It is suggested that hand rub that does not contain alcohol be used in these areas or personal belt dispensers be available to staff where hand pumps may present a risk to consumers.

No infection control audits had been completed since 2016 for mental health. The allocation and training of 'link' nurses to mental health in March 2018 will help facilitate a more robust system of infection control monitoring. Having consumers audit staff for compliance with hand hygiene before and after a procedure is another way of demonstrating the importance of regular hand washing.

Medication fridges were monitored daily with guidelines if the temperature fell outside the recommended range. However, staff and consumer fridges were not temperature controlled and in several sites food was out-of-date and unlabelled. It is suggested a system be implemented to ensure staff and consumer fridges are temperature controlled and contents checked to ensure all food is labelled and in date. There was no policy or signage on cleaning of consumer washing machines when using cold water. It is suggested that instructions are displayed for cleaning after each use and wipes are available for this purpose. The covering and storage of clean linen in some mental health sites such as Glenside was also problematic with staff unsure of the correct method of storage. There was no evidence of auditing of the linen supply process by contractors (Spotless) in the mental health units.

All new employees have to meet the agreed immunisation requirements and there is an annual vaccination program available for staff.

Managing patients with infections or colonisations

Facilities across CALHN have sufficient capacity to manage the complex needs of consumers requiring additional infection control precautions.
Staff are supplied with equipment and the environment to enable compliance with the standard and transmission-based precautions.

Consumers admitted mental health have a comprehensive assessment completed which includes past or recent infection status.

Routine clinical observations are conducted and any consumers who are medically compromised are treated appropriately.

All inpatient units have a number of single rooms that can be used for isolation purposes.

Antimicrobial stewardship

There is a well-established Antimicrobial Stewardship (AMS) system in place across CALHN. Therapeutic guidelines are available to medical officers and the use of antimicrobials is monitored and recorded with pharmacist involvement.

Cleaning, disinfection and sterilisation

All mental health community and inpatient sites visited by the survey team were clean, inviting and free of clutter and it was obvious staff took pride in their workplace.

Routine cleaning audits are conducted by contractors (Spotless) but unfortunately the results of these audits are not routinely available to all site managers.

No reusable instruments are used and there are processes in place for cleaning reusable devices. Cleaning schedules were in place for sensory modulation equipment and toys that were provided in waiting areas.

Communicating with patients and carers

There was minimal signage advising of hand washing guidelines and providing tips on personal precautions to help decrease the spread of airborne infections.

It is suggested more signage is needed to alert visitors to the importance of clean hands and remind staff of the '5 moments of hand hygiene' to increase awareness and encourage compliance.

Infection control information is not included in the admission literature given to consumers or part of carer/consumer orientation a suggestion is that this be included.

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

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

Action 3.10.1 Core
The clinical workforce is trained in aseptic technique

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

Surveyor Comment:

February 2018-CALHN has undertaken a risk assessment of the aseptic technique competencies required. They have embedded aseptic technique procedures that require use of aseptic principles. In addition, an overarching training package has been implemented on aseptic technique.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

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

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

Surveyor Comment:

No reusable instruments are used and there are processes in place for cleaning reusable devices. Cleaning schedules were in place for sensory modulation equipment and toys that were provided in waiting areas.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD SUMMARY 4: MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

The LHN has three main committees to manage medication safety and quality. Drug and Therapeutics, the Medication Safety and Antimicrobial Stewardship Committees. These peak committees are supported by directorate specific committees with more local responsibility. There is an overarching framework supporting this structure. Minutes provided to the surveyors supported the ToR for these committees. Many improvement activities have been completed and are tracked within the framework. The CALHN medication safety plan demonstrates that a range of reviews and audits have been undertaken to assess some aspects of medication safety systems. The MHS relates to the CALHN structures and is in the process of redeveloping a comprehensive governance structure across MH sites to support medication safety.

As well as conducting NIMC audits, cold chain storage audits, clozapine monitoring audits, clinicians were able to describe immediate responses to MHS medication incidents that were subsequently supported by more robust structured reviews of those incidents. Evidence was provided of monitoring and actions taken to reduce medication related adverse events and incidents.

The surveyors noted the improvement activities that have been undertaken around medication management that were driven by the governance system. These include clozapine training and the development of improved LAI injection techniques to improve IM specific injection rates rather than adipose tissue injections.

The service has recently improved the specific training before doctors are approved for Clozapine prescribing. Otherwise the MHS conforms to local and national requirements for medication authorisation.

Bulletins from SAH and the Office of the Chief Psychiatrist (OCP) identify medication safety themes from the state perspective that are disseminated to clinical staff.

Core action 4.2.1 was assessed as Not Met. The specific safety issues and gaps in the community services are of concern within the community i.e. the MHS service is not routinely aware of medication safety system issues within the community services. The service acknowledged that they had not reviewed completion or evaluation from the last Medication Safety Self-Assessments® MSSA which was a long time prior. Within the community services the teams spoke of a range of difficulties they were aware of with medication safety. Ranging from imprest stock review, prescription and dispensing issues, lack of pharmacy support, reconciliation, difficulties ensuring clarity re which service primary versus MHS were prescribing etc. The surveyors looked for evidence that the community needs had been considered and the audits and reviews were missing a broad community focus apart from some very robust specific foci for e.g. clozapine which was very good indeed. The surveyors concluded that the service needed to conduct a repeat MSSA or equivalent, that they needed to look at medication safety needs broadly, and include the community services within this broad consideration. It was understood that the MSSA was not a community tool. The MHS must complete an MSSA of the MHS and whilst considering the community MHS adopt any aspects of the MSSA or other appropriate structured tool to support a broad medication safety system assessment of the community MHS. The resultant action plans should be developed, implemented and reviewed in a timely fashion and then evaluated within the three-year cycle.

Documentation of patient information

Documentation of medication history, reconciliation of medications, allergies and adverse drug reactions within the inpatient files for the MHS is very good. Reconciliation occurs at a high rate within 24 hours of admission and on discharge. The MHS has demonstrated a number of improvements to reduce the risk of adverse medication incidents. Within the community services it is accepted that there is a low completion rate of the Community Based Information System (CBIS) 180-day medication review. A major effort was made last year to boost completion of medication records in the community but it was not supported by an ongoing system and the rates of completion have now dropped. The lack of a robust system to maintain medication history documentation means that on admission and transfer the system relies on patient self report supplemented by the best possible clinical documentation available. The surveyors have made a recommendation that the MHS improve its documentation of a best possible medication history systems for the community services which they believe will also improve the medication history being available at the point of care.

Medication management processes

A range of decision support tools are available to point of care staff. This includes nationally developed tools but also some local tools including treatment algorithms and training tools for clozapine, and for the management of behavioural disturbance. Medication safety Bulletins generated outside the service are distributed to the clinical workforce. Pharmacy has recently evaluated the barriers experienced by clinicians in accessing medication support tools electronically and have begun the process of implementing an agreed action plan. The medication storage distribution and disposal systems have had a range of site specific activities applied to them. The service may obtain further information from the systematic MSSA process recommended by the surveyors previously that may inform further improvement activities. Cold chain storage systems and processes were adhered to in a consistent and high-quality way in all services reviewed. The risks associated with temperature variation were known to hospital pharmacy staff and had considered in their assessment the likely risks in the community, however some community clinical staff were unsure how to respond in the event of a temperature variance within the medication storage fridges. The service should consider methods to address this gap. Improvement activities were documented for high risk medications, including audits and QIAs.

Continuity of medication management

Within the hospital based services that have on site pharmacists, patients and carers on discharge are provided with a list of medications and an opportunity to receive counselling regarding the prescribed medication. The surveyors note that the service has a 48-hour discharge summary completion rate of 34%. The implications of this for the medication continuity standard is that there is a low rate of provision of a comprehensive medication plan for patients who are being managed within the private system or by primary care.

Communicating with patients and carers

Medication management plan completion rates could be improved for community and acute in patients. However, the service has undertaken a range of activities to increase the provision of specific information to patients and families on medication options and facts that is meaningful and understandable to them.

Governance and systems for medication safety

Ratings

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

Action 4.2.1 Core
The medication management system is regularly assessed

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

Surveyor Comment:

The surveyors noted that the MSSAs have not been reviewed or repeated since the last survey in 2013. The usual frequency of completion would be every three years. The service has identified that it has not yet reviewed completion of all the action items from the previous MSSA. The MHS has informally identified significant gaps in medication safety systems within the community mental health teams. The audits that have been conducted across MH regarding the management of the medication safety systems do not provide sufficient coverage to allow confidence that the MHS has systems in place to ensure the medication management system is safe. The MHS must complete an MSSA with associated action plans of the whole of the MHS including community sites as soon as possible.

Surveyor's Recommendation:

The MHS must complete an MSSA with associated action plans of the whole of the MHS including community sites as soon as possible.

Risk Level: Moderate

Risk Comments:

The lack of a recent MSSA exposes the MHS to the risk that aspects of their medication management system are not as safe and effective as they believe them to be.

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Documentation of patient information

Ratings

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

Action 4.6.1 Core
A best possible medication history is documented for each patient

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

Surveyor Comment:

Evidence was provided by CALHN MHS that community completion of medication history within the CBIS reviewed every 180 days was very low and had been low for some time. Within the narrative of the community notes it was unclear where one could routinely find the best possible medication history.

Surveyor's Recommendation:

Ensure that a best possible medication history is documented for each patient within the community file. CALHN MHS must implement a system to maintain medication documentation rates on an ongoing basis.

Risk Level: Moderate

Risk Comments:

The risk of inappropriate medication use is increased because of the difficulty in accessing a best possible medication history.

Medication management processes

Ratings

Action	Organisation	Surveyor
4.9.1	SM	SM
4.9.2	SM	SM
4.9.3	SM	SM
4.10.1	SM	SM
4.10.2	SM	SM
4.10.3	SM	SM

4.10.4	SM	SM
4.10.5	SM	SM
4.10.6	SM	SM
4.11.1	SM	SM
4.11.2	SM	SM

Continuity of medication management

Ratings

Action	Organisation	Surveyor
4.12.1	SM	SM
4.12.2	SM	SM
4.12.3	SM	NM
4.12.4	SM	NM

Action 4.12.3 Core
A current comprehensive list of medicines is provided to the receiving clinician during clinical handover

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

Surveyor Comment:

The surveyors noted that the discharge summary completion rate within 48 hours lies at 34%. The discharge summary is the main communication tool for medication management to primary care and secondary tier community mental health service providers.

Surveyor's Recommendation:

The MHS ensure that clinical service providers such as GPs and private practitioners, are routinely provided with a comprehensive medication list on transfer from Inpatient care. The surveyors recommend that this be achieved by improving the timely discharge summary completion rate close to target and ensuring that this discharge summary is provided in a timely fashion to relevant clinical services external to the public mental health service. This is also a recommendation in Action 6.3.3.

Risk Level: Moderate

Risk Comments:

Clinicians on IP units consistently described a process whereby they would verbally communicate with other service providers prior to discharge mitigating some of the risk of unsafe medication prescribing; secondary to lack of provision of a comprehensive medication list on discharge.

Action 4.12.4 Core
Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover

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

Surveyor Comment:

The MHS is aware of the low rates of discharge summary completion and the implications for primary and secondary care providers outside of the public mental health service. However, systematic action has not been taken to address the issue.

Surveyor's Recommendation:

The MHS ensure that a system is put in place to ensure GPs and private practitioners receive a discharge summary within a timely period.

Risk Level: Moderate

Risk Comments:

GPs and private practitioners are not being provided with current information required for the ongoing care and treatment of the patient post discharge.

Communicating with patients and carers

Ratings

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

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

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

Surveyor Comment:

Medication management plan completion rates for community patients and acute in-patients is low. Good rates of completion however were noted for Glenside rehabilitation areas. The Medication Management Plan Advisory A16/04 advises that Action 4.14.1 is met if Actions 4.12.1, 4.12.2 and 4.12.4 are met. Action 4.12.4 in the CALHN MHS is not met.

Surveyor's Recommendation:

Ensure that an agreed medication management plan developed in collaboration with consumers and their families or other carers, is documented in the clinical record. Take steps to address the recommendation associated with 4.12.4.

Risk Level: Low

STANDARD SUMMARY 5: PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

CALHN MHS have policies in place to ensure that approved patient identifiers are in place for every patient. The three identifiers are used whenever clinical handover, patient transfer or discharge documentation is used.

The audit criteria for Nursing Shift to shift handover includes - Where three patient identifiers used with wards/units do not meet target of 90%, strategies for improvement are identified, written into an action plan by the Nurse Unit Manager/Nurse Consultant, and submitted to the MHS Quality Support Co-ordinator for further monitoring.

A combined CALHN NSQHSS Standard 5 audit is undertaken including the RAH, TQEH and the Mental Health Inpatient Service. The aim is to improve compliance with the patient identification matching systems based on relevant policies, procedures and protocols with a risk rating applied to the outcomes.

Processes to transfer care

The patient identification and matching system is in place and is a component of the audit process. The question in the audit is “Have receiving staff actively accepted responsibility for the patient at the nursing Shift to Shift Handover?”

ISBAR is used when a patient is handed over verbally to the Emergency Services, SA Ambulance Service (SAAS) or SA Police (SAPOL) accompanied by the relevant documentation.

Processes to match patients and their care

At TQEH the time out process in ECT does not include confirmation of the presence of a valid consent to further ensure the patient identification and procedure matching is a component of the time out process. At Glenside the time out includes sighting of the consent but not a formal confirmation that the consent is valid. The service is encouraged to put in place a single approach to time out for ECT across all campuses that incorporates a more formal confirmation of the presence of a valid consent.

NSQHSS MH IDR

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

STANDARD SUMMARY 6: CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

The single service multi-site underpinning of CALHN is important in considering Standard 6. Multiple IT systems, and partial EPAS roll out, all emphasise the need for robust handover processes. The MHS has clear CALHN wide OWIs that set the expectations for the structure of clinical handover. Handovers are audited regularly and the results reviewed across CALHN with service wide and also local responses to improve handover. The MHS recognises that there is a need to continue to review the handover processes so that they meet the specific needs of mental health.

Clinical handover processes

Handover processes are based around ISBAR and are supported by patient journey boards, smart phone apps, CBIS, and the SA, CALHN and MH procedures. Handover incidents are reported and reviewed. The ISBAR format was variably applied within the handovers the surveyors observed. The service is encouraged to improve the use of the ISBAR structured format within handovers. Local care staff are involved in the auditing and review of handover. Consumer and families have not as yet been involved in reviewing handover processes. The surveyors encourage the mental health service to formally audit the handovers that occur outside of the shift to shift IP handovers. These might include medical handover for on call matters, transfers between CALHN MH services and handovers within the community mental health services. Discharge summary completion rates remain low across the service and this has been addressed in the medication criteria as well as in a recommendation in this standard.

Patient and carer involvement in clinical handover

The MHS handover audit demonstrates that patient carer involvement is stated as Not Applicable in bedside clinical handover, handovers conducted at the bed-side, and were relatives/visitors actively involved. The MHS is encouraged to include the patient family or carer whenever appropriate.

The service does not routinely involve consumers or their families in the formal MDT or shift to shift handovers across the sites.

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Action 6.3.2 Developmental
Local processes for clinical handover are reviewed in collaboration with clinicians, patients and carers

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

Surveyor Comment:

The surveyors could not identify any evidence that patients and carers have been involved in review of handover processes.

Surveyor's Recommendation:

Ensure that local processes for clinical handover are reviewed in collaboration with patients and carers as well as clinical staff.

Risk Level: Low

Action 6.3.3 Core
Action is taken to increase the effectiveness of clinical handover

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

Surveyor Comment:

Discharge summary completion rates are low across the service and have been for some time. This is particularly an issue for clinical handover of a comprehensive clinical summary to GPs and private clinical providers as CBIS allows for handover within the public mental health system of the available clinical material.

Surveyor's Recommendation:

Action be taken to improve the discharge summary completion rate for patients whose care is being taken on wholly, or in part, by primary care or private health providers. That the service ensures that the completed discharge summary is provided to the appropriate health providers in a timely manner.

Risk Level: Moderate

Risk Comments:

Not providing information to GPs could impact on safe care for the patient.

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	NM

Action 6.5.1 Developmental
Mechanisms to involve a patient and, where relevant, their carer in clinical handover are in use

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

Surveyor Comment:

Consumers and their families are not routinely involved in handover processes. The service does follow up with consumers after handover and is clear that regular meeting and information exchanges and treatment planning regularly occurs, and is demonstrable within clinical files.

Surveyor's Recommendation:

Ensure that mechanisms are in use to involve the patient, and where relevant their carer, in the mental health inpatient clinical handover itself.

Risk Level: Moderate

Risk Comments:

Important information that the consumer of carer is aware of may be lost to the clinical team because handovers do not occur with the consumer. The opportunity to improve the therapeutic alliance with the consumer by including them in handover is lost.

STANDARD SUMMARY 7: BLOOD AND BLOOD PRODUCTS

Surveyor Summary

The CALHN MHS does not have the capacity to administer blood or blood products to patients admitted to the MHS. If a patient of the MHS requires blood or blood products they would be medically assessed and transferred to an acute hospital.

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

Not Applicable

Documenting patient information

Not Applicable

Managing blood and blood product safety

Not Applicable

Communicating with patients and carers

Not Applicable

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

Ratings

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

Action 7.1.1 Core
Blood and blood product policies, procedures and/or protocols are consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.1.2 Core
The use of policies, procedures and/or protocols is regularly monitored

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.1.3 Core
Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.2.1 Core
The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.2.2 Core
Action is taken to reduce the risks associated with transfusion practices and the clinical use of blood and blood products

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.3.1 Core
Reporting on blood and blood product incidents is included in regular incident reports

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.3.2 Core
Adverse blood and blood product incidents are reported to and reviewed by the highest level of governance in the health service organisation

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.3.3 Core
Health service organisations participate in relevant haemovigilance activities conducted by the organisation or at state or national level

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.4.1 Core
Quality improvement activities are undertaken to reduce the risks of patient harm from transfusion practices and the clinical use of blood and blood products

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Documenting patient information

Ratings

Action	Organisation	Surveyor
7.5.1	SM	N/A
7.5.2	SM	N/A
7.5.3	SM	N/A
7.6.1	SM	N/A
7.6.2	SM	N/A
7.6.3	SM	N/A

Action 7.5.1 Core
A best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.5.2 Core
The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.5.3 Core
Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.6.1 Core
Adverse reactions to blood or blood products are documented in the patient clinical record

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.6.2 Core
Action is taken to reduce the risk of adverse events from administering blood or blood products

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

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

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Managing blood and blood product safety

Ratings

Action	Organisation	Surveyor
7.7.1	SM	N/A
7.7.2	SM	N/A
7.8.1	SM	N/A
7.8.2	SM	N/A

Action 7.7.1 Core
Regular review of the risks associated with receipt, storage, collection and transport of blood and blood products is undertaken

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.7.2 Core
Action is taken to reduce the risk of incidents arising from the use of blood and blood product control systems

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.8.1 Core
Blood and blood product wastage is regularly monitored

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.8.2 Core
Action is taken to minimise wastage of blood and blood products

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
7.9.1	SM	N/A
7.9.2	SM	N/A
7.10.1	SM	N/A
7.11.1	SM	N/A

Action 7.9.1 Core
Patient information relating to blood and blood products, including risks, benefits and alternatives, is available for distribution by the clinical workforce

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.9.2 Developmental
Plans for care that include the use of blood and blood products are developed in partnership with patients and carers

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.10.1 Developmental
Information on blood and blood products is provided to patients and their carers in a format that is understood and meaningful

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

Action 7.11.1 Developmental
Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation

Organisation's Self Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Not Applicable to the MHS.

STANDARD SUMMARY 8: PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

Mental Health have had no acquired pressure injuries for the last three years. Any incidents of pressure injuries are reported to the Mental Health Quality and Governance Committee for review and action.

Although the incidence of pressure injury is low in mental health there was evidence that considerable work has been done to focus on Pressure Injury Management.

Routine screening on admission of all consumers has been introduced across mental health. The Braden Pressure Injury Risk Assessment although forming part of the consumer physical assessment was not routinely completed in the medical records viewed by the survey team. A number of audits have been implemented to evaluate prevention and management practices and the survey team believes that more education is needed to improve completion rates. Screening and management of pressure care is done extremely well by the older persons teams.

Preventing pressure injuries

Any incidents of pressure injury are reported on the SLS with stages specified and escalated to management for review to ensure actions are determined and implemented.

Staff across the organisation have a good understanding of the reporting process and although most consumers admitted to mental health are ambulant there needs to be ongoing vigilance in the assessment and maintenance of pressure injuries.

Managing pressure injuries

Routine assessment practice and physical screening helps ensure that existing pressure injuries are identified at the time of admission.

Equipment is available if needed for control and prevention of pressure areas with supporting information on staging and choice of pressure relieving devices.

The physical health monitoring stations in the community sites are also a way of ensuring consumers are aware of the importance of mobility.

Communicating with patients and carers

There is no information provided to consumers/carers on admission to the service regarding skin care. Information pamphlets were not evident or routinely provided on discharge.

If information is discussed with consumers on admission there was no evidence to support this and it is suggested that information be provided that is meaningful and understandable.

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

The MHS has CALHN policies and procedures that they use as the foundation of their standard 9 practice. However, the service has then gone on to develop a number of modifications of these processes and policies so that they more appropriately fit into the Mental Health context. The MHS has a coordinator for standard 9 who reviews all incidents related to recognising and responding to deterioration and provides a feedback loop to clinical teams. Feedback on the effectiveness of the system is actively sought using a specific data capture sheet for MER/Code blue calls. All sudden and unexpected deaths are subject to structured review. A range of improvements to the recognition and response system were cited including the not yet completed family escalation of care process that for Glenside campus has involved negotiation with SAAS to ensure that if families have concerns that are not met by the home clinical team that they can require an ambulance be called to facilitate medical review in ED. The team also saw the development of clear expectations that staff have BLS skills on site but that ALS not be required as an improvement as it enabled rapid escalation of care to very competent staff in the event of acute physical deterioration. The service should consider undertaking a survey of the safety and quality culture of the organisation to support meeting this standard.

Recognising clinical deterioration and escalating care

An organisation-wide RDR chart is used for recording vital signs which conforms with national expectations and allows for modifications to parameters in individual clinical circumstances. Compliance with completion and use of appropriate modifications within this chart is regularly audited with completion rates around 90% across IPUs. The service is developing a modification of this RDR monitoring concept to allow for community use within CBIS. The service routinely audits whether escalation of care processes are being used appropriately and has a process to address any deficits in responsiveness. In the community the MHS has a practice that has not yet been supported by a CALHN OWI to monitor the physical health of patients on long term psychotropics that adversely affect metabolic health. This was developed initially to support consumers on Clozapine and this monitoring has been taken up as a state-wide initiative. Within CALHN excellent results are obtained for physical health monitoring of patients on Clozapine. Monitoring for those on LAIs is improving. The MHS is also now looking at how to improve response to adverse metabolic findings. Community services are being encouraged to set up health hubs in their waiting rooms where consumers can check their BMI, WHR and record their results. This is part of an ongoing project Physical Health Action Team.

Responding to clinical deterioration

The service has determined that in the event of acute deterioration on campuses that do not have an attached acute health service will lead to SAAS call. On Glenside campus this is a four minute response time. BLS mandatory training is more than 90% for the service clinical staff and most clinical sites have BLS trainers on site. All incidents associated with MER or ambulance calls are subject to structured review. The MHS has established a physical health team to improve monitoring and response to physical health care in conjunction with NEAMI.

Communicating with patients and carers

Recommendations are open from the previous survey in actions 9.7.1, 9.9.1, 9.9.2, 9.9.3, 9.9.4. These recommendations will be transferred into this survey so that they essentially will remain open. The MHS has not yet implemented the "You're worried, we're listening" project which will formalise the escalation of care for physical health processes within IPUs. Nevertheless, the MHS has negotiated an SAAS response for Glenside campus to enable implementation of this project.

The service does have a process for the development of advance care directives, and for engaging consumers and families in discussions about end-of-life care.

NSQHSS MH IDR

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Action 9.6.1 Core
The clinical workforce is trained and proficient in basic life support

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

Surveyor Comment:

Basic Life Support (BLS) completion rates for MHS clinical staff is 93% - February 2018.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

Action 9.7.1 Developmental
Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include:
• the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce
• local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration

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

Surveyor Comment:

This Action will remain not met until the policies and systems around the 'You're worried, We're listening' project has been completed.

Surveyor's Recommendation:

Ensure that information is provided to patients, family and carers, in a format that is understood and meaningful, on the importance of communicating indications of deterioration, and local systems through which they can raise their concerns.

Risk Level: Low

Action 9.9.1 Developmental
Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response

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

Surveyor Comment:

This Action will remain not met until the policies and systems around the 'You're worried, We're listening' project has been completed.

Surveyor's Recommendation:

Provide evidence to demonstrate that mechanisms are in place for a patient, family member or carer to initiate an escalation of care response.

Risk Level: Moderate

Risk Comments:

It is important that patients, families and carers have information provided to them by the MHS on how to initiate an escalation of care response should this be required. This is to be documented in the clinical file that a discussion or written material ie a brochure has been provided to the patient, family member or carer.

Action 9.9.2 Developmental
Information about the system for family escalation of care is provided to patients, families and carers

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

Surveyor Comment:

This Action will remain not met until the policies and systems around the 'You're worried, We're listening' project has been completed.

Surveyor's Recommendation:

Ensure that information about the system for family escalation of care is provided to patients, families and carers.

Risk Level: Moderate

Risk Comments:

Ensure that the information provided regarding the CALHN MHS escalation of care response whether verbal or written has been documented in the clinical file.

Action 9.9.3 Developmental
The performance and effectiveness of the system for family escalation of care is periodically reviewed

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

Surveyor Comment:

This Action will remain not met until the policies and systems around the 'You're worried, We're listening' project has been completed.

Surveyor's Recommendation:

Periodically review the effectiveness and performance of the system for family escalation of care.

Risk Level: Moderate

Risk Comments:

The information given to a patient, family member or carer on an escalation of care response is to be dated and documented in the clinical file. Inclusion in the documentation audit will allow for review and demonstrate the continued effectiveness and adherence to the requirement of Recognising and Responding to Clinical Deterioration.

Action 9.9.4 Developmental
Action is taken to improve the system performance for family escalation of care

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

Surveyor Comment:

This Action will remain not met until the policies and systems around the 'You're worried, We're listening' project has been completed.

Surveyor's Recommendation:

Ensure that action is taken to improve the system for family escalation of care.

Risk Level: Low

STANDARD SUMMARY 10: PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

There is evidence of good governance structures aligned with executive accountability to support the organisation in implementing systems to prevent patient falls and minimise harm from falls.

Mental Health are represented on the CALHN Community Falls Leadership Group which is the peak governance committee responsible for the development and monitoring of systems of care for falls in accordance with National Guidelines. A Central Mental Health Directorate Falls Prevention working group has been established and falls policies and procedures are available for all clinical staff via the intranet.

In response to SLS data a quality improvement action plan has been implemented and specific falls prevention procedures have been developed. The transfer of MH Older Persons service from NALHN to CALHN has demonstrated an increase in falls by represented data but this is recognised and implemented actions will be monitored.

Screening and assessing risks of falls and harm from falling

All consumers are currently required to have a falls risk assessment / screening undertaken upon admission. The audit results indicate a variation across sites in the completion of the falls assessment and screening tools were not universally completed. Strategies to increase the number of consumers risk assessed to improve falls prevention and management are ongoing and the proposed introduction of 'site falls leaders' and associated training will improve consistency of practice. The falls screening was well documented by the mental health older persons’ inpatient and community teams who, following assessment implement appropriate strategies if needed to reduce the risk of falls.

Preventing falls and harm from falling

The Aged Person's Mental Health teams demonstrated a high level of compliance with screening and a focus on minimising falls.

It was noted that security staff are used in the MHS inpatient units to special patients, including older patients, with behavioural problems who have been identified as a falls risk.

It is acknowledged that falls discharge planning has low compliance rates and the proposed introduction of the community falls assessment tool will assist discharge planning as it identifies risk factors.

Communicating with patients and carers

It is suggested that more information related to falls is available for consumers and carers on admission to the mental health service as many presentations include medical issues and medication management.

As consumers/carers are becoming increasingly involved in their own care injury management and prevention strategies falls need to be included where necessary in ongoing care planning.

There was limited signage on Falls Risk in the sites visited by the survey team with the exception of the Older Persons service and Elpida House Community Rehabilitation Centre who had signage advising residents of correct footwear.

There are no formal mechanisms in place to assess and evaluate the consumers/or carers understanding of falls information that is available. It is suggested obtaining feedback regarding the value and appropriateness of providing this information to patients and carers would be valued falls prevention information.

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Governance and systems for the prevention of falls

Ratings

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

Screening and assessing risks of falls and harm from falling

Ratings

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

Preventing falls and harm from falling

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Central Adelaide Local Health Network

NATIONAL STANDARDS FOR MENTAL HEALTH SERVICES (NSMHS) (Unmapped Criteria)

The Australian Council on Healthcare Standards -
Based on ACHSQH Accreditation Workbook for Mental Health Services March 2014

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

STANDARD 1 Rights and responsibilities

The rights and responsibilities of people affected by mental health problems and / or mental illness are upheld by the mental health service (MHS) and are documented, prominently displayed, applied and promoted throughout all phases of care.

Surveyor Summary

1.9 The MHS is upholding the rights of the consumer to be treated in the least restrictive environment

The Central Adelaide LHN Mental Health Directorate (CALHN MHD) must adhere to the Mental Health Act of South Australia 2009 and ensure the seclusion rooms in the CALHN Emergency Departments are used for seclusion only. This is subject to recommendations in the NMHS 2.2 and the NSQHC Action 1.2.2. The MHD are providing a stepped model of care ranging from Psychiatric Intensive Care Units (PICU) through to community based residential care. The different stages of care a patient moves do is based on assessment of risk by the Consultant Psychiatrist. The MHD has a Restraint Reduction project plan in place is active on the CALHN Challenging Behaviours Committee and the Office of the Chief Psychiatrist (OCP) state-wide Trauma Informed Care Working Group. These groups are focussed on reducing restrictive practice. MHD staff are trained in the use of de-escalation techniques rather than the use of restrictive practice and a third level of staff are trained to provide continuous engagement/observation of patients as a less restrictive intervention.

1.15 The rights of the consumer to access advocacy and support services

Consumers/patients and carers are advised in both welcome packs and by the display of posters of available external advocacy services. A consumer advisor is available to assist consumers/patients and carers with complaints/feedback mechanisms and direct them to the Office of the Chief Psychiatrist (OCP), Disability Advocacy and the Complaints Service of South Australia, the Disability Rights Advocacy Service Inc. and the Community Services Complaints Commissioner if required. This information is all available on the OCPs main web-site page.

1.17 The rights of the consumer to access a staff member of their own gender.

The CALHN MHD Sexual Safety audits identified that 86% of inpatient units considered the requirements for specific carer gender in their allocation and rostering decisions with separate gender sleeping areas available in all inpatient units. An OCP state-wide directive provides guidance to all MHD clinicians on sexual safety principles

Criterion 1.9

The MHS upholds the right of the consumer to be treated in the least restrictive environment to the extent that it does not impose serious risk to the consumer or others.

Surveyor's Rating	Met

Criterion 1.15

The MHS upholds the right of the consumer to access advocacy and support services.

Surveyor's Rating	Met

Criterion 1.17	
The MHS upholds the right of the consumer, wherever possible, to access a staff member of their own gender.	
Surveyor's Rating	Met

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

STANDARD 2 Safety

The activities and environment of the MHS are safe for consumers, carers, families, visitors, staff and its community.

Surveyor Summary

2.1 The MHS promotes optimal consumer safety and ensures all consumers are protected from abuse and exploitation

The CALHN links all incident reports, complaint data, incident reviews and audit outcomes to safety and quality initiatives aimed at improving the safety and wellbeing of all consumers attending the service in whatever capacity. The MHD current initiatives include restraint and absconding reduction sexual safety and physical health action plans. Suicide response training, trauma informed care, the Aboriginal Nurse Practitioner candidate and the development of short stay units are all focussed on promoting safety for all and ensuring all those seeking treatment within the CALHN MHD are protected from abuse and exploitation.

2.2 The MHS reduces and where possible eliminates the use of restraint and seclusion

This is subject to a recommendation in NSMHS Criterion 2.2 and the NSQHSS Action 1.2.2.

2.5 The MHS complies with relevant commonwealth/state/territory transport guidelines including current national safe transport principles

The CALHN Transporting and Escorting of Consumers aligns to the SA Mental Health Act 2009 and the SA National Safe Transport Principles.

Criterion 2.1

The MHS promotes the optimal safety and wellbeing of the consumer in all mental health settings and ensures that the consumer is protected from abuse and exploitation.

Surveyor's Rating	Met

Criterion 2.2

The MHS reduces and where possible eliminates the use of restraint and seclusion within all MHS settings.

Surveyor's Rating	Not Met

Surveyor Comments:

The Seclusion rooms in the Emergency Departments of the Royal Adelaide and Queen Elizabeth Hospitals are being used on occasions to sleep patients due to the unavailability of a MHD bed.

Surveyor's Recommendation:

The MHD adhere to the Mental Health Act of South Australia 2009 and ensure all seclusion beds in CALHN are used for seclusion only. This recommendation is cross referenced to NSQHSS Recommendation - Action 1.2.2.

Criterion 2.5	
The MHS complies with relevant Commonwealth and state / territory transport policies and guidelines, including the current National Safe Transport Principles.	
Surveyor's Rating	Met

STANDARD 3 Consumer and carer participation

Consumers and carers are actively involved in the development, planning, delivery and evaluation of services.

Surveyor Summary

3.4 Consumers/carers have the right to determine who represents their views to the MHS

There is evidence to support consumer engagement and information provision of consumers right to seek independent advocacy services if required to represent their views. Information brochures on Community Visitors and the HCCC are provided throughout all sites. Consumers reported they were advised of the options available to them if required.

Criterion 3.4

Consumers and carers have the right to independently determine who will represent their views to the MHS.

Surveyor's Rating	Met

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

STANDARD 4 Diversity responsiveness

The MHS delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care.

Surveyor Summary

4.1, 4.2 The MHS defines diverse groups who access the service and review the needs of its community and communicates this to staff

Consumers have access to a range of support services and all population groups have equal access to all available services. There are dedicated age specific services/teams that include age appropriate CALD admission criteria. Religious beliefs are respected and an appropriate diet is available if needed. Rights and Responsibilities information is provided on entry to the mental health service and these are available in a range of different languages. The diverse needs of mental health consumers are captured on admission and an interpreter service is available. Aboriginal Clinical Practice Guidelines were evident and the recruitment of an Aboriginal Nurse Practitioner has provided a cultural ATSI resource for mental health and external partners. There is a range of culturally diverse staff employed within the organisation, providing culturally sensitive care for both inpatient and community consumers.

4.4, 4.5, 4.6 The MHS demonstrates engagement with other diverse groups service providers and that non-discriminatory practices are in place

Consumers referred to the mental health service are triaged and assessed without stigma and discrimination. There was evidence in the community teams visited by the surveyors of links with the CALD community to support and engage mental health consumers prior to discharge. Information is provided to older Aboriginal consumers via the South Australian government website on available services and the multicultural website provides a comprehensive list of services and programs for migrants although no cultural awareness training has been available to mental health services staff since 2016. The previous training had a low attendance rate and the survey team has been informed an Aboriginal Cultural learning course will be available in 2018. A recommendation will be against 4.5 to ensure all mental health staff are provided with knowledge and understanding of the diverse needs of consumers. There is an expectation of staff that they work within the context of the CALHN code of conduct and recognition exists of unconscious bias with this addressed in staff annual performance reviews and ongoing senior staff supervision.

Criterion 4.1

The MHS identifies the diverse groups (Aboriginal and Torres Strait Islander, Culturally And Linguistically Diverse (CALD), religious / spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status) that access the service.

Surveyor's Rating	Met

Criterion 4.2

The MHS whenever possible utilises available and reliable data on identified diverse groups to document and regularly review the needs of its community and communicates this information to staff.

Surveyor's Rating	Met

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Criterion 4.4

The MHS has demonstrated knowledge of and engagement with other service providers or organisations with diversity expertise / programs relevant to the unique needs of its community.

Surveyor's Rating	Met

Criterion 4.5

Staff are trained to access information and resources to provide services that are appropriate to the diverse needs of its consumers.

Surveyor's Rating	Not Met

Surveyor Comments:

Cultural awareness training had low attendance rates and was available for Mental Health staff until the end of 2016. No training has been available in 2017 with Aboriginal Culture learning courses to be offered in 2018.

Surveyor's Recommendation:

Cultural awareness training be made available for all mental health services staff in 2018 and the attendance monitored and reported on to ensure the MHS workforce are provided with appropriate knowledge and understanding of the diverse needs of the consumers in their care.

Criterion 4.6

The MHS addresses issues associated with prejudice, bias and discrimination in regards to its own staff to ensure non-discriminatory practices and equitable access to services.

Surveyor's Rating	Met

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

STANDARD 5 Promotion and prevention

The MHS works in partnership with its community to promote mental health and address prevention of mental health problems and / or mental illness.

Surveyor Summary

5.1, 5.2, 5.3 The MHS promotes mental health to the community, addresses early identification and prevention and ensures consumers/carers are included in developing these strategies and activities

South Australian Health promotes mental health wellbeing through some state-wide approaches and CALHN provides strategies and activities to its population. Different parts of the Mental Health Division promote mental health in different ways to its discrete communities, such as presenting at aged care facilities, education for Police Cadets. Other examples provided included those done by the Psychosocial Rehabilitation team such as “Anxiety Busters”, “Depression Busters” and “Guilt Busters”. In recent times, the organisation undertook a cultural awareness survey which resulted in art work being commissioned by childcare services. A number of pieces of art have been completed and this collaboration has been seen as partly community development and mental health awareness raising. While a range of activities are provided, some including consumers and carers, the survey team were advised that this is not always a priority due to other pressures on time and “constant changes within CALHN”.

5.4, 5.5, 5.6 The MH demonstrates it evaluates strategies and activities with its service provider partners and ensures its workforce is adequately trained in rights and responsibilities.

The Principal Clinical Psychologist is the accountable person in the Mental Health Directorate to ensure promotion and prevention activities are developed, implemented and evaluated. No evidence of formal evaluations of health promotion and prevention strategies, implementation plans or sustainability was available to the survey team. The comment above that mental health promotion is not seen as a priority and another statement that this “hasn’t been on the agenda for years” has led the survey team to suggest that the organisation should review the requirements of this Standard. Accordingly, Criterion 5.4 is considered not met.

Criterion 5.1

The MHS develops strategies appropriate to the needs of its community to promote mental health and address early identification and prevention of mental health problems and / or mental illness that are responsive to the needs of its community, by establishing and sustaining partnerships with consumers, carers, other service providers and relevant stakeholders.

Surveyor's Rating	Met

Criterion 5.2

The MHS develops implementation plans to undertake promotion and prevention activities, which include the prioritisation of the needs of its community and the identification of resources required for implementation, in consultation with their partners.

Surveyor's Rating	Met

Criterion 5.3	
The MHS, in partnership with other sectors and settings supports the inclusion of mental health consumers and carers in strategies and activities that aim to promote health and wellbeing.	
Surveyor's Rating	Met

Criterion 5.4	
The MHS evaluates strategies, implementation plans, sustainability of partnerships and individual activities in consultation with their partners. Regular progress reports on achievements are provided to consumers, carers, other service providers and relevant stakeholders.	
Surveyor's Rating	Not Met
Surveyor Comments:	
No evidence was available to demonstrate that the MHS had strategies in place to ensure there is consistent approach in ensuring appropriate progress reports are provided to consumers, carers other service providers and relevant stakeholders.	
Surveyor's Recommendation:	
The MHS provide evidence of regular consultation and documented progress reporting to ensure the sustainability of all partnerships.	

Criterion 5.5	
The MHS identifies a person who is accountable for developing, implementing and evaluating promotion and prevention activities.	
Surveyor's Rating	Met

Criterion 5.6	
The MHS ensures that their workforce is adequately trained in the principles of mental health promotion and prevention and their applicability to the specialised mental health service context with appropriate support provided to implement mental health promotion and prevention activities.	
Surveyor's Rating	Not Met
Surveyor Comments:	
The MHS ensure staff are provided with Mental Health promotion and prevention training and education to demonstrate that promotion and prevention activities are an important component of the direction CALHN MHS for all staff.	
Surveyor's Recommendation:	
The MHS to include on the staff education calendar training in Mental Health Promotion and Prevention principles.	

STANDARD 7 Carers

The MHS recognises, respects, values and supports the importance of carers to the wellbeing, treatment, and recovery of people with a mental illness.

Surveyor Summary

7.1, 7.2, 7.3 The MHS can identify carers, implements and maintains ongoing engagement with carers as partners in the delivery of care soon as possible and a policy is in place where a consumer refuses to name a carer

Whilst systems and mechanisms are in place for carers to be identified it was found in checking in medical records that there was not enough evidence to support the meeting of this requirement - whilst the Information Sharing Protocol supports the sharing of information for the CALHD MHD service for consumer who refuse to nominate a carer - carers reported that they needed to initiate contact with the Mental Health service to be able to engage in the delivery of care for the consumer - it was also found that although in some instance the consumer was known to have family involvement in their care this was not clearly documented and did not reflect what was occurring in practice . Further carers stated that they felt disenfranchised by the process of being part of the delivery of care for their loved ones and reported having to lodge significant complaints to be part of the process and be engaged.

7.6, 7.8 The MHS has a policy that identifies the special needs of children or aged persons as carers and carers are identified in the health record

There are a range of services available for this cohort of consumers to access - Children support COPMI services are available to children of consumers with a metal illness. Of note however ageing carers and the supports available to them are limited. It is suggested that the CALHN MHD or a non-government agency investigate further the resources available to this cohort of carers.

7.9, 7.11, 7.13 Evidence that the MHS is providing carers with non-personal information, involving carers in relapse prevention plans and providing information on access to other services as required.

Evidence which was sighted and discussed with carers reported a range of support services available to carers in the form of respite and support - Organisations such as Skylight provide a range of opportunities for carers to receive support for their caring role - Consumers also stated that found these services helpful. In the development of consumer relapse prevention plans - carers were not highly visible as an integral part of this process.

Criterion 7.1

The MHS has clear policies and service delivery protocols to enable staff to effectively identify carers as soon as possible in all episodes of care, and this is recorded and prominently displayed within the consumer’s health record.

Surveyor's Rating	Met

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Criterion 7.2

The MHS implements and maintains ongoing engagement with carers as partners in the delivery of care as soon as possible in all episodes of care.

Surveyor's Rating	Not Met

Surveyor Comments:

Carers identified that they do not feel engaged in the delivery of care for the consumer - this is further evidenced in the care plan. In conversation with the survey team it was noted that not all consumers were aware that they could have carer involvement and a number stated they did have a family member actively supporting them.

Surveyor's Recommendation:

The CALHN MHD actively review the involvement of carers in consumer treatment and document in consumer care plans the engagement and level of carer involvement for the consumer.

Criterion 7.3

In circumstances where a consumer refuses to nominate their carer(s), the MHS reviews this status at regular intervals during the episode of care in accordance with Commonwealth and state / territory jurisdictional and legislative requirements.

Surveyor's Rating	Met

Criterion 7.6

The MHS considers the special needs of children and aged persons as carers and makes appropriate arrangements for their support.

Surveyor's Rating	Met

Criterion 7.8

The MHS ensures information regarding identified carers is accurately recorded in the consumer's health record and reviewed on a regular basis.

Surveyor's Rating	Met

Criterion 7.9

The MHS provides carers with non-personal information about the consumer's mental health condition, treatment, ongoing care and if applicable, rehabilitation.

Surveyor's Rating	Met

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Criterion 7.11	
The MHS actively encourages routine identification of carers in the development of relapse prevention plans.	
Surveyor's Rating	Not Met
Surveyor Comments:	
It has been identified that carers are not actively engaged in the development of consumer relapse prevention plans.	
Surveyor's Recommendation:	
Ensure there is a mechanism for carer input and feedback to support consumers in the development of their relapse prevention plans.	

Criterion 7.13	
The MHS provides information about and facilitates access to services that maximise the wellbeing of carers.	
Surveyor's Rating	Met

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

STANDARD 8 Governance, leadership and management

The MHS is governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services.

Surveyor Summary

8.2 The MHS ensures strategies for the promotion, early identification and prevention of mental health illness

The Mental Health Directorate is led by a Clinical Director and Nursing Co-Director. The Eastern and Western Services each have a Service Manager, Director of Quality and Practice and a Nursing Director. The Older Persons Mental Health Service has a Service Manager, Head of Unit and Nursing Director and a Manager of Business Operations for Corporate Services. These executive positions oversee a range of services responsible for the development of models of care and service delivery pertinent to the cohorts of consumers in their services.

Criterion 8.2

The MHS has processes to ensure accountability for developing strategies to promote mental health and address early identification and prevention of mental health problems and / or mental illness.

Surveyor's Rating	Met

National Standards for Mental Health Services (NSMHS)
(Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

STANDARD 9 Integration

The MHS collaborates with and develops partnerships within in its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and carers.

Surveyor Summary

9.1, 9.2, 9.5 The MHS ensures a designated person is available for care coordination, interdisciplinary care teams are supported and formal processes are in place to develop and collaborate with interagency and intersectoral links

The Metropolitan Adelaide Adult Integrated Community Mental Health Services Clinical Business Rules states that all team members will act as a care coordinator. (It is noted that the document provided as evidence is watermarked as final draft and dated 22 July 2011). During discussions with staff from various clinical units, there was discussion regarding care coordination. Surveyors were advised that this may vary upon the clinical setting. Each unit representatives stated that someone coordinates care and various models of care discuss care coordination. However, the NSMHS criterion 9.1 states that "a person responsible for the coordination of care is available". In the pre-survey assessment provided to the survey team, it was noted that all community consumers have a care coordinator allocated. Audit results proved in evidence did not show any compliance reporting to confirm that this is the case. It is suggested that future audits include a question about this, which will help the organisation demonstrate compliance against NSMHS 9.1 rather than it being anecdotal evidence.

Criterion 9.1

The MHS ensures that a person responsible for the coordination of care is available to facilitate coordinated and integrated services throughout all stages of care for consumers and carers.

Surveyor's Rating	Met

Criterion 9.2

The MHS has formal processes to support and sustain interdisciplinary care teams.

Surveyor's Rating	Met

Criterion 9.5

The MHS has formal processes to develop inter-agency and intersectoral links and collaboration.

Surveyor's Rating	Met

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

STANDARD 10 Delivery of Care

The MHS assists consumers to exit the service and ensures re-entry according to the consumer's needs.

Surveyor Summary

10.1 Supporting Recovery
10.1.1, 10.1.3, 10.1.4, 10.1.5, 10.1.7, 10.1.9, .10.1.10 The MHS supports and promotes recovery principles, recognises the lived experience of consumers, promotes the enhancement of social connections and has a comprehensive knowledge of community resources

The CALHN Mental Health Directorate Models of Care has recovery at its "essence". The recovery principles are expected in all areas of the service and CALHN uses one of its Consumer Consultants to provide education on Recovery Based Practice. The employment of Peer Specialists and Carer Consultants and their availability to consumers across the services is significant in supporting the recovery based approach to health care. There are many agencies with whom mental health services liaise and work with to provide a holistic approach to care and support. In some instances, formal memoranda of understanding are in place. An area for further development is in the involvement of carers in care planning and support for consumers. There is other commentary regarding this against criteria 7.2 and 7.11. The April 2016 Clinical Documentation Audit showed only 44% of carers had involvement with care planning across CALHN Mental Health Services. Evidence of carer involvement in assessment in the Eastern Service was shown to be 29%. Discussions were held by the survey team with carers and feedback was that carers did not feel adequately involved in care planning or relapse prevention. It was stated that they only felt included when they made an approach; that is, it was not the norm. As such, criterion 10.1.10 is considered not met.

10.2 Access
10.2.1, 10.2.2, 10.2.3, 10.2.4 The MHS demonstrates access and available services to address the needs of its community in a timely manner

The Mental Health Triage Service is available 24/7 to the population of Adelaide. Using a mental health triage rating, a determination is made on how soon a person needs to be seen by the mental health service. Links with community mental health teams can facilitate a response within an hour if needed. In cases of immediate emergencies, police and ambulance services are involved. This is the case after 9.30 pm when community mental health staffing ends and in cases when a response is required before the following day. The community mental health team has the ability to provide acute home based care, with home visits and / or telephone calls several times a day to support consumers. On a visit to the SA Prison Service, surveyors were advised that some prisoners choose not to go to hospital as they do not feel they are afforded privacy, as they are shackled and handcuffed. This may not be specific to accessing mental health services. The survey team observed an example in the outpatient clinic, with a prisoner in full view of everyone with shackles and handcuffed. The survey team understand the need for the restraints and suggest the organisation consider if there can be a way to improve the privacy and dignity of prisoners attending the hospital.

10.3 Entry
10.3.1, 10.3.2, 10.3.3, 10.3.4, 10.3.5, 10.3.7, 10.3.8 the MHS demonstrates entry inclusion and exclusion criteria, has a documented system for prioritising risk, service specific entry points and policies for involuntary admissions

The mental health triage services use a mental health triage scale on receiving a call to its service. The outcome of this determines the timing for response. If needed, community mental health services can respond with a hour between 8.00 am and 10.00 pm. Ambulance and Police services would be used outside of these hours if needed. The models of care state that there are no barriers to entry and referrals are accepted from a variety of sources. Risk assessments are undertaken as part of a broader mental health state examination. Following assessment, or as appropriate, at triage, a determination is made

regarding the appropriateness for service, referral to a mental health service or support in accessing a more appropriate service. Admissions under the Mental Health Act are done as a last resort. Community Treatment Orders are used as appropriate. It was reported to the survey team about the occasional cases of mental health patients needing to stay in the Emergency Departments for up to 72 hours before they could be admitted to a mental health unit. It is noted that there are no forensic beds in CALHN which may impact the stays of some patients.

From data provided as evidence, the 2016/2017 length of stay of less than 4 hours for mental health patients in emergency departments was 38.2%. Mental health presentations with an admission HoNOS rating completed was around 15.7%. It was also reported that because of bed pressures, there was a higher threshold for patients to be admitted, leading to an eventual higher acuity. This can be expected to have a flow on to care and recovery planning. Accordingly, criterion 10.3.5 (“Entry to the MHS minimises delay and the need for duplication in assessment, treatment, care and recovery planning and care delivery) is considered not met.

10.4 Assessment/Review
10.4.2, 10.4.4, 10.4.6, 10.4.7, 10.4.8 the MHS conducts assessment/review of treatment, care and recovery plans for voluntary and involuntary at least every 3/12 (by qualified staff) and where appropriate with the consumer/carer and has a procedure in place for patients who decline follow up

The Admission Checklist does not explicitly include the development of a care plan, with the consumer/ carer as appropriate. The use of clinician and consumer rated measures such as National Outcomes and Casemix Collection (NOCC) and Kessler 10 appeared to be intermittent on case file reviews by the survey team. Where there was evidence of the use of NOCC, only clinician ratings were evident. It is understood that the use of NOCC is a requirement of SA Health. It is suggested that the organisation review its compliance with the requirement, especially with the inclusion of consumer ratings. The Community Business Rules outline what should be done in cases when a consumer declines to be involved with the mental health service. This, of course, is dependent upon the consumers’ legal status under the Mental Health Act. The use of consumer and other clinical measures was the subject of discussion with clinicians. There is commentary regarding this under Standard 1 of the National Safety and Quality Health Services Standards.

10.5 Treatment/Support
10.5.4, 10.5.5 Informed consent is obtained for participation in clinical trials or experimental treatments and the MHS Provides the least restrictive environment, consideration given to a consumer’s needs, availability and support and safety of all involved

Flexible arrangements to provide clinical support and intervention was found across the mental health services. Multi-agency input can be provided as appropriate. It is noted that there are issues regarding the duress system in the new Royal Adelaide Hospital mental health unit. As this is not functioning at present, the use of security staff to mitigate risks of aggression and violence was evident. It is unclear as to how long this arrangement will be needed. The survey team had concerns about an increase in the use of restraint and seclusion. It is noted that a working party has been established to review data and consider and recommend strategies to address this. In discussions with staff, it was stated that possible causes may relate to illicit drug intoxication, forensic patients being shackled and counted as being restrained, the introduction of smoke free environments and a need to increase staff confidence in knowing who can cease seclusion episodes. At present the Working Party does not include a consumer or anyone from specialist drug and alcohol services. Given the benefits of having a consumer perspective and input from drug and alcohol services regarding the illicit drug use, it is suggested the organisation consider their inclusion.

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

10.5.12, 10.5.13, 10.5.14, 10.5.15, 10.5.16, 10.5.17 The MHS demonstrates it facilitates access to appropriate agencies to meet consumers needs for recreation, education, work, accommodation and self-care programs.

There are a number of activities and programmes provided to support consumers in the area of recreation, education work and self-care. A multidisciplinary team approach addresses various aspects of needs. Social Workers provide a care coordination role especially regarding accommodation issues. Network meeting with external service providers including Housing SA, Western Adelaide Homeless Service, Department for Education and Child Development and many more.

10.6 Exit / Re-entry
10.6.1, 10.6.2, 10.6.3, 10.6.5, 10.6.6, 10.6.7, 10.6.8 The MHS demonstrates the consumer has access to services that promote recovery, commences an exit plan on consumers access to the service, ease of access for re-entry and follow up within 7 days

When a consumer is discharged from an inpatient unit, they are referred to a community service if appropriate. Community team care coordinators may in-reach into an inpatient unit if one of their consumers is admitted. The community teams are keen to received referrals as soon as possible to ensure a seamless care flow. Results of the latest available audit of clinical documentation (November-December 2015) showed community in-reach prior to transferring in the Western Service as 37.5%. Mechanisms are in place to allow for ease of re-entry to the mental health service should that be required within a two year period. While many of the processes and practices relating to a consumer exiting the service were appropriate, the survey team had concerns in a couple of areas. For prisoners receiving antipsychotic medication as a depot injection while in prison, upon release they are referred to community mental health services for follow up. Surveyors were advised that if a prisoner is on oral antipsychotic medication then no referral is made. Surveyors were advised that there is no policy or procedures for this and that it is part of cultural practice. This and another area of concern for the survey team links between this Standard and the National Standard 4, actions 4.12.3 and 4.12.4 regarding medication management at handover of care. There was discussion regarding the procedure for follow up of consumers within seven days of discharge from inpatient care. On reviewing the evidence provided there were examples where there was no documentation in a number of services where there had been a failure to make contact with a consumer after three attempts. Anecdotally, clinicians considered they were doing a reasonable job of follow ups. The evidence provided to the survey team was such that it is considered an area of risk for consumers and the organisation if this requirement for follow up within seven days does not occur. In view of the comments above, criteria 10.6.1 and 10.6.8 are considered not met.

STANDARD 10.1 Supporting recovery

Criterion 10.1.1

The MHS actively supports and promotes recovery oriented values and principles in its policies and practices.

Surveyor's Rating	Met

Criterion 10.1.3

The MHS recognises the lived experience of consumers and carers and supports their personal resourcefulness, individuality, strengths and abilities.

Surveyor's Rating	Met

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Criterion 10.1.4	
The MHS encourages and supports the self-determination and autonomy of consumers and carers.	
Surveyor's Rating	Met

Criterion 10.1.5	
The MHS promotes the social inclusion of consumers and advocates for their rights of citizenship and freedom from discrimination.	
Surveyor's Rating	Met

Criterion 10.1.7	
The MHS supports and promotes opportunities to enhance consumers' positive social connections with family, children, friends and their valued community.	
Surveyor's Rating	Met

Criterion 10.1.9	
The MHS has a comprehensive knowledge of community services and resources and collaborates with consumers and carers to assist them to identify and access relevant services.	
Surveyor's Rating	Met

Criterion 10.1.10	
The MHS provides access for consumers and their carer(s) to a range of carer-inclusive approaches to service delivery and support.	
Surveyor's Rating	Met

STANDARD 10.2 Access

The MHS is accessible to the individual and meets the needs of its community in a timely manner

Criterion 10.2.1	
Access to available services meets the identified needs of its community in a timely manner.	
Surveyor's Rating	Met

Criterion 10.2.2

The MHS informs its community about the availability, range of services and methods for establishing contact with its service.

Surveyor's Rating	Met

Criterion 10.2.3

The MHS makes provision for consumers to access acute services 24 hours per day by either providing the service itself or information about how to access such care from a 24/7 public mental health service or alternate mental health service.

Surveyor's Rating	Met

Criterion 10.2.4

The MHS, wherever possible, is located to provide ease of physical access with special attention being given to those people with physical disabilities and / or reliance on public transport.

Surveyor's Rating	Met

STANDARD 10.3 Entry

The entry process to the MHS meets the needs of its community and facilitates timeliness of entry and ongoing assessment.

Criterion 10.3.1

The MHS has a written description of its entry process, inclusion and exclusion criteria and means of facilitating access to alternative care for people not accepted by the service.

Surveyor's Rating	Met

Criterion 10.3.2

The MHS makes known its entry process, inclusion and exclusion criteria to consumers, carers, other service providers, and relevant stakeholders including police, ambulance services and emergency departments.

Surveyor's Rating	Met

Criterion 10.3.3

The MHS has a documented system for prioritising referrals according to risk, urgency, distress, dysfunction and disability with timely advice and / or response to all those referred, at the time of assessment.

Surveyor's Rating	Met

Criterion 10.3.4

The entry process to the MHS is a defined pathway with service specific entry points that meet the needs of the consumer, their carer(s) and its community that are complementary to any existing generic health or welfare intake systems.

Surveyor's Rating	Met

Criterion 10.3.5

Entry to the MHS minimises delay and the need for duplication in assessment, treatment, care and recovery planning and care delivery.

Surveyor's Rating	Met

Criterion 10.3.7

When the consumer requires involuntary admission to the MHS the transport occurs in the safest and most respectful manner possible and complies with relevant Commonwealth and state / territory policies and guidelines, including the National Safe Transportation Principles.

Surveyor's Rating	Met

Criterion 10.3.8

The MHS ensures that a consumer and their carer(s) are able to identify a nominated person responsible for coordinating their care and informing them about any changes in the care management.

Surveyor's Rating	Met

STANDARD 10.4 Assessment and review

Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carer(s).

Criterion 10.4.2

Assessments are conducted during the consumer’s first contact with the MHS by appropriately qualified staff experienced and trained in assessing mental health problems, and where possible in a consumer’s preferred setting with consideration of safety for all involved.

Surveyor's Rating	Met

Criterion 10.4.4

The MHS actively plans as early as possible in the course of psychiatric inpatient admission, for the discharge of the consumer from inpatient care.

Surveyor's Rating	Met

Criterion 10.4.6

The MHS conducts assessment and review of the consumer's treatment, care and recovery plan, whether involuntary or voluntary, at least every three months (if not previously required for reasons stated in criteria 10.4.5 above).

Surveyor's Rating	Met

Criterion 10.4.7

The MHS has a procedure for appropriate follow-up of those who decline to participate in an assessment.

Surveyor's Rating	Met

Criterion 10.4.8

There is a current individual interdisciplinary treatment, care and recovery plan, which is developed in consultation with and regularly reviewed with the consumer and with the consumer's informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them.

Surveyor's Rating	Met

STANDARD 10.5 Treatment and support

The MHS provides access to a range of evidence based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promotes their recovery.

Criterion 10.5.4

Any participation of the consumer in clinical trials and experimental treatments is subject to the informed consent of the consumer.

Surveyor's Rating	Met

Criterion 10.5.5

The MHS provides the least restrictive and most appropriate treatment and support possible. Consideration is given to the consumer's needs and preferences, the demands on carers, and the availability of support and safety of those involved.

Surveyor's Rating	Met

Criterion 10.5.12

The MHS facilitates access to an appropriate range of agencies, programs, and / or interventions to meet the consumer's needs for leisure, relationships, recreation, education, training, work, accommodation and employment in settings appropriate to the individual consumer.

Surveyor's Rating	Met

Criterion 10.5.13

The MHS supports and / or provides information regarding self-care programs that can enable the consumer to develop or re-develop the competence to meet their everyday living needs.

Surveyor's Rating	Met

Criterion 10.5.14

The setting for the learning or the re-learning of self-care activities is the most familiar and / or the most appropriate for the skills acquired.

Surveyor's Rating	Met

Criterion 10.5.15

Information on self-care programs or interventions is provided to consumers and their carer(s) in a way that is understandable to them.

Surveyor's Rating	Met

Criterion 10.5.16

The MHS endeavours to provide access to a range of accommodation and support options that meet the needs of the consumer and gives the consumer the opportunity to choose between these options.

Surveyor's Rating	Met

Criterion 10.5.17

The MHS promotes access to vocational support systems, education and employment programs.

Surveyor's Rating	Met

STANDARD 10.6 Exit and re-entry

The MHS assists consumers to exit the service and ensures re-entry according to the consumer's needs.

Criterion 10.6.1

The MHS ensures that on exiting the service the consumer has access to services that promote recovery and aim to minimise psychiatric disability and prevent relapse.

Surveyor's Rating	Not Met

Surveyor Comments:

Prior to a consumer/patient exiting the service the treating clinical teams liaise with the consumer's General Practitioner, existing supports and the Non-Government Sector (NGO) to provide ongoing support to prevent relapse and to manage their disability. Case reviews are documented in CBIS detailing the exit plan. and the relevant contacts.

Surveyor's Recommendation:

Ensure all information is sent to the General Practitioner (GP) or designated support service/s within the designated timelines as per policy and documented.

Criterion 10.6.2

The consumer and their carer(s) are provided with understandable information on the range of relevant services and support available in the community.

Surveyor's Rating	Met

Criterion 10.6.3

The MHS has a process to commence development of an exit plan at the time the consumer enters the service.

Surveyor's Rating	Met

Criterion 10.6.5

The MHS provides consumers, their carers and other service providers involved in follow-up with information on the process for re-entering the MHS if required.

Surveyor's Rating	Met

Criterion 10.6.6

The MHS ensures ease of access for consumers re-entering the MHS.

Surveyor's Rating	Met

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Criterion 10.6.7	
Staff review the outcomes of treatment and support as well as ongoing follow-up arrangements for each consumer prior to their exit from the MHS.	
Surveyor's Rating	Met

Criterion 10.6.8	
The MHS, in conjunction with the treating clinician, has a procedure for appropriate follow-up of all consumers within 7 days after discharge from inpatient care wherever possible, and has a follow-up procedure for those consumers who do not keep the planned follow-up arrangements.	
Surveyor's Rating	Not Met

Surveyor Comments:

The first audit conducted of Transfer of Care from CALHN MHD inpatient services without adequate follow-up from some MHD wards/units demonstrated further improvement is required. Patients leaving hospital after an admission for an episode of mental illness have heightened vulnerability and without adequate follow-up may relapse or require re-admission.

Surveyor's Recommendation:

Ensure consumers receive a telephone call and clinical assessment within seven days of discharge and this is documented in CBIS seven-day PDFU section. Ensure unsuccessful attempts are escalated to the ward/area/unit Nurse Unit Manager and the Medical Head of Unit and ensure a continuing focus on those areas that did not meet the target rate of 60%.

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Rating Summary

STANDARD 1	
1.9	Met
1.15	Met
1.17	Met

STANDARD 2	
2.1	Met
2.2	Not Met
2.5	Met

STANDARD 3	
3.4	Met

STANDARD 4	
4.1	Met
4.2	Met
4.4	Met
4.5	Not Met
4.6	Met

STANDARD 5	
5.1	Met
5.2	Met
5.3	Met
5.4	Not Met
5.5	Met
5.6	Not Met

STANDARD 7	
7.1	Met
7.2	Not Met
7.3	Met
7.6	Met
7.8	Met
7.9	Met
7.11	Not Met
7.13	Met

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

STANDARD 8	
8.2	Met
STANDARD 9	
9.1	Met
9.2	Met
9.5	Met
STANDARD 10	
STANDARD 10.1	
10.1.1	Met
10.1.3	Met
10.1.4	Met
10.1.5	Met
10.1.7	Met
10.1.9	Met
10.1.10	Met
STANDARD 10.2	
10.2.1	Met
10.2.2	Met
10.2.3	Met
10.2.4	Met
STANDARD 10.3	
10.3.1	Met
10.3.2	Met
10.3.3	Met
10.3.4	Met
10.3.5	Met
10.3.7	Met
10.3.8	Met
STANDARD 10.4	
10.4.2	Met
10.4.4	Met
10.4.6	Met
10.4.7	Met
10.4.8	Met

National Standards for Mental Health Services (NSMHS) (Unmapped Criteria)

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

STANDARD 10.5	
10.5.4	Met
10.5.5	Met
10.5.12	Met
10.5.13	Met
10.5.14	Met
10.5.15	Met
10.5.16	Met
10.5.17	Met

STANDARD 10.6	
10.6.1	Not Met
10.6.2	Met
10.6.3	Met
10.6.5	Met
10.6.6	Met
10.6.7	Met
10.6.8	Not Met

The Australian Council on Healthcare Standards

Central Adelaide Local Health Network

Recommendations from Previous Survey

- **CALHN 'Main' Survey Recommendations from Previous Survey**
- **CALHN Mental Health In-Depth Review (IDR) Recommendations from Previous Survey**

Central Adelaide Local Health Network

NSQHSS SURVEY

RECOMMENDATIONS FROM PREVIOUS SURVEY

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Governance and quality improvement systems
Action: 1.4.2 Annual mandatory training programs to meet the requirements of these Standards

Recommendation: NSQHSS Onsite Review 0317.1.4.2

Recommendation:

Ensure that the annual mandatory training programs meet the requirements of these standards.

Action:

Mandatory training requirements are clearly communicated to all staff through the Learning Management System. There are currently 8 Mandatory training requirements for all staff in addition to orientation to the organisation and workplace. There are further mandated training items related to specific roles within the organisation. (See document CALHN Mandatory Training List by Staff Groups).

Mandatory training requirements are aligned to relevant legislation, SA government directives and the NSQHSS standards.

Changes to mandatory training requirements are requested through the Learning, Education and Development Committee. Requests are made through this group for recommendations to add mandatory training requirements for specific groups. (See OWI-40409 Mandatory Training). Once recommendations are accepted by the Learning Education and Development committee these recommendations are sent to the Executive Management Team for final approval and the LMS is updated.

Reports from the LMS are available for access however accurate reporting still remains an issue due to three key factors. The first factor is a number of CALHN mandated training is hosted on external sites. As such, any training completed on these external systems requires verification through additional processes by the end user to upload data onto the CALHN LMS. This approach results in a lot of staff completing requirements but failing to place the data in our own system and records. The second key factor is sourcing consistent, dynamic data that accurately reflects the training managerial hierarchy within the organisation. We currently base our training hierarchy from HR and Financial data which does not always accurately reflect reporting lines for training. In addition, the data configuration group we rely on to supply this data currently supply an update every 4-6 weeks instead of daily or weekly. This results in further inaccuracies in the reports.

The third key factor is ongoing difficulty being experienced in sourcing resources to enable a new vendor to assist in meeting organisational needs and resources to implement the current Learning Management System. This continues to impact on the quality and accuracy of reporting to the organisation, with the following risks for the organisation remaining logged on the Risk Register:

1.Inability to provide accurate reports on mandatory training and meet other training reporting requirements for CALHN
2.Inability to provide and meet the increasing expectation of accessible online learning to the CALHN workforce, including RAH training (pre and post transition)
3.Reputation of the organisation in not being able to meet the learning needs of the workforce
4.Safety and quality of clinical services provided

A briefing to resource a new vendor and ongoing support for the new LMS has been accepted in principle by Executive. Once funding has been identified the process to commence transfer to the new vendor can be commenced. A further briefing to being developed to identify FTE to support the LMS is being developed.
Current FTE is based on a service previously delivered to nursing staff at the Royal Adelaide Hospital only. Additional FTE and transfer to a new vendor are anticipated to assist in delivering increased reliability solutions for reporting of data.

Completion Due By: Dec-18

Responsibility: Director of Learning and Development

Organisation Completed: No

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

Compliance with mandatory training requirements across the services is still variable. A new recommendation is made in the report.

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

Recommendation: NSQHSS Onsite Review 0317.2.2.1

Recommendation:

Review the mechanisms for engaging consumers and/or carers in the organisation and implement changes to support and coordinate consumer involvement across all services.

Action:

CALHN has historically engaged consumers through the Consumer Advocacy Committee process, with one committee for each major site and an overarching CALHN wide committee. CALHN acknowledges that this process has not served the organisation or its consumers well. The engagement of the consumer voice in the development of the new RAH has therefore been limited and transactional in nature. The involvement of consumers in the strategic planning and ongoing governance of the organisation is as a result, limited. CALHN is currently undergoing a strategic planning process, following from SA Health's system wide 2017 strategic planning process, and our consumer committees will be involved in consultation on the development of this.

Recognising the importance of CALHN deeply understanding and engaging with the consumer as both customer and owner of the health system, CALHN has established an agreement with the Health Consumers Alliance of SA to develop a contemporary consumer and community engagement strategy.

This is a 2-year contract based agreement aiming to enhance safety and quality across CALHN through a greater focus on consumer-centred care, and will include as part of the scope leadership and culture, governance, infrastructure and capacity building for a sustainable system. This work will be supported by a HCA staffing resource working within CALHN, and will be under the auspices of the Director of Clinical Governance. Other activities currently underway:

- Continuation of the current Open Disclosure Training program – widely available to clinical staff and delivered under a contract with Cognitive Institute
- Removal of protection from Incident Review Panel and Clinical Incident investigation, with the intention that the results serious incident investigations will be widely available to both staff and consumers
- The deliberate involvement of consumers in the investigation of most serious incidents with a particular focus on service improvement in response
- Consumers are involved in Intentional Rounding, a recent initiative of the Nursing profession at the new facility This has led to the development of the Intentional Rounding Procedure which is now rolled out at RAH and is for implementation at TQEH in 2018

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

There is a reporting process and governance framework for engagement of consumers and carers. This will however be further strengthened by the development of the Consumer and Community Engagement Strategy for CALHN.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 2.2.2 Consumers and/or carers are actively involved in decision making about safety and quality

Recommendation: NSQHSS Onsite Review 0317.2.2.2

Recommendation:

Implement processes to encourage and support the active involvement of consumers in decision making about safety and quality.

Action:

CALHN is committed to improving care delivery, and recognises that to achieve this, the consumer voice must be meaningfully heard in the design, delivery, monitoring and evaluation of care.

In 2018, in part in association with the HCASA work, CALHN will be developing an organisational Quality Plan which speaks to the organisational, directorate, and unit level quality. The consumer experience of care will be central to this approach, which will be based in a Triple Aim model at organisation, directorate and unit level. In order to better drive this work, CALHN is reconfiguring its peak Quality Committee, and will have expert consumer voices at the peak decision-making table. This will be replicated over 2018 at Directorate level and subsequently at unit level, as the HCASA strategy is developed and rolled out. At the moment, our ability to have sufficient capacity of expert consumer voices to support unit level work is limited, as is the engagement of many clinical teams.

Consumer feedback data has been presented to consumers in previous years. This generally takes the form of

1.The SA Health SACESS report – aggregating consumer feedback from a post discharge survey.

Common themes have been presented repeatedly around food, access and communication.

CALHN is awaiting the feedback from this report in relation to the RAH facility.

2.Receiving reports on deidentified individual complaints and compliments.

The Consumer Advocacy Council is developing a plan at the January 2018 meeting to determine work required for the next 12 months in driving changes in response to consumer feedback.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

This item is closed as there have been processes developed to support active involvement of consumers in decision making about safety and quality. There will however be another recommendation for Action 2.2.2 as the intent of this Action needs to be more systematically achieved across the organisation.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 2.3.1 Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role

Recommendation: NSQHSS Onsite Review 0317.2.3.1

Recommendation:

Review the current orientation and ongoing training system for consumers and implement changes to ensure that training enables them to fulfil their partnership role.

Action:

CALHN is aware of the need to ensure that consumers are effectively supported in their work for and with the organisation. To date this has been rudimentary. From 2018 consumer orientation is being expanded and refined, with a revision of the Orientation Guide planned for Q1 2018.

Further, online training is accessible through Learning Central. Increased training opportunities are available through HCA for consumers and CALHN is committed to supporting consumers to undertake this training. Expanding CALHN’s consumer capacity will be a key focus of the HCASA work over the next 2 years.

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Training is now a CAC agenda item. Training plans include providing Learning Central access to all consumer representatives. CAC members currently focus on one Learning Central area each month i.e. Hand Hygiene. CAC have determined the training that consumer representative wish to access ongoing.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

Training is provided through CALHN and in conjunction with partners such as Health Consumers Alliance SA.

Standard: Partnering with Consumers
Criterion: Consumer partnership in designing care
Action: 2.5.1 Consumers and/or carers participate in the design and redesign of health services

Recommendation: NSQHSS Onsite Review 0317.2.5.1

Recommendation:

Identify and implement a mechanism for the involving of consumers and/or carers in the design and redesign of the health service.

Action:

CALHN continues to undertake a considerable body of work to redesign its facilities and services. The proposed redevelopment of TQEH and the shift of services from Hampstead Rehabilitation Centre to TQEH in 2-3 years include consumer input. More needs to be done and this will again be a focus of the HCASA work.

In the RAH, management of the facility is not CALHN's primary responsibility. As a result, concerns have been expressed by consumers at signage and wayfinding. Work is being done to address this, and the consumer Advisory Council is involved with this, with their walkarounds providing valuable insights into the functionality of the new building.

Both the overarching CALHN Consumer Advocacy Council and site-specific Consumer Advisory Groups will be goal setting in January 2018 to decide on their focus for upcoming year. This work has the full support of the Quality Support Team and the Director of Clinical Governance, who is involved where possible in Consumer meetings. In addition, the CALHN CEO speaks regularly with key consumer representatives.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

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

There have been mechanisms developed for involving consumers and carers in the design and redesign of the health service. There will however be a new recommendation made in relation to this Action to ensure more consistent application.

Standard: Partnering with Consumers
Criterion: Consumer partnership in designing care
Action: 2.6.2 Consumers and/or carers are involved in training the clinical workforce

Recommendation: NSQHSS Onsite Review 0317.2.6.2

Recommendation:

Identify and implement a mechanism for the involving of consumers and/or carers in the training of the clinical workforce.

Action:

A consumer is now involved in the General Orientation of CALHN Nursing, Allied Health and Administration staff. This will be further expanded with the induction of all new staff as the HCASA engagement strategy is developed throughout 2018. Further, CALHN is proposing that there be a proposal for the inclusion of a patient story presentation at Quality Meetings and in CALHN Executive. This will be further explored throughout 2018.

Consumers currently attend Education and Training sessions at TQEH following feedback/complaints.

An Expression of Interest has been developed by the Consumer Advisor team to encourage consumers to tell their story at staff educational events, and this will provide a pool of consumers to tell their story.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

This recommendation is closed but there will be a further recommendation as it could be expanded and more consistently applied across CALHN.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.8.1 Consumers and/or carers participate in the analysis of organisational safety and quality performance

Recommendation: NSQHSS Onsite Review 0317.2.8.1

Recommendation:

Identify and implement a mechanism to engage consumers and carers in the analysis of the health service's safety and quality performance.

Action:

To date this is limited. Consumers do however contribute actively to committee processes including through the various National Standards committees (notably medication safety and in a recently established group looking at end of life care). Agenda items, minutes and other records of meetings document involvement of consumers in the analysis of safety and quality performance.

The roll out of a new CALHN committee structure throughout 2018 will increase the opportunity for consumers to be involved in organisational governance and in particular in service or unit level governance.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

This recommendation is closed as there are examples of consumer and care involvement in the analyses of CALHN safety and quality performance. There will however be a new recommendation about the systematic application of this involvement.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.8.2 Consumers and/or carers participate in the planning and implementation of quality improvements

Recommendation: NSQHSS Onsite Review 0317.2.8.2

Recommendation:

Identify and implement a mechanism to engage consumers and carers in the planning and implementation of quality improvements.

Action:

CALHN is working with CAC and CAGs to develop and implement a plan which defines activities for the committees and which can then be evaluated. Further, an organisation wide Quality Plan will be developed throughout 2018 – this will require considerable consumer involvement at every stage, as it is intended that this plan signal the organisation's renewed and meaningful commitment to putting the consumer at the heart of its work.This work will be informed by the HCASA.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

This recommendation is closed as there is involvement of consumers and cares in the planning and implementation of quality improvement activities. There will however be a new recommendation in relation to the more systematic application of consumer and carer involvement in the implementation of quality improvements.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.9.1 Consumers and/or carers participate in the evaluation of patient feedback data

Recommendation: NSQHSS Onsite Review 0317.2.9.1

Recommendation:

Develop a process that enables consumers and /or carers to participate in the evaluation of patient feedback data.

Action:

Feedback from consumers is currently presented to CAG and CAC meetings. This is considered by the committees and recommendations are made and where feasible, acted upon. Work is required to encourage more robust discussion of feedback at these meetings – this too will form part of the work of the HCASA project. Examples of matters for discussion include:

- Distribution of SACESS mini reports to CAC/CAG members and Measuring Consumer Experience 2016 report
- Partnering with Consumers Newsletters and Action Plan
- SLS feedback - reports describing feedback to consumers - report tabled at CAC

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

This recommendation is closed as there are processes for consumers and carers to participate in the evaluation of patient feedback data.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.9.2 Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data

Recommendation: NSQHSS Onsite Review 0317.2.9.2

Recommendation:

Develop a process that will enable and support consumer participation in the implementation of quality activities relating to patient feedback data.

Action:

To date, CALHN consumers have had little involvement in developing improvement work. Consumers have however assisted through walk arounds and have made suggestions both through the CAC/CAG process and directly to organisational leaders on improvements.

Consumers were actively involved in identifying areas for improvement following the RAH move:

- surveys in the area of meal management and OPD at the RAH, both of which have been subject to dramatic process change with the opening of the new facility;
- wayfinding and signage in OPD, resulting in updating of flat signage to more easily visible signs, and OPD screens having prompts for check in;
- Wayfinding volunteers in RAH foyer and at kiosks;
- consumer representation on hospital Food Service Working Groups;
- consumer participation on End of Life Working Group;
- project on Patient Communication Boards;
- relocation of Enquiries Desk in RAH foyer to ensure wheelchair access for consumers;
- additional RAH cashier window to ensure wheelchair accessibility;
- Escalation paper produced by RAH CAC on issues to be solved i.e. car parking - have been worked through and solved;
- RAH consumer maps updated online to ensure toilet facilities were easier to find.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

This recommendation is closed as there are processes to support the consumer participation in the implementation of quality activities relating to patient feedback data.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Standard: Medication Safety
Criterion: Communicating with patients and carers
Action: 4.14.1 An agreed medication management plan is documented and available in the patient's clinical record

Recommendation: NSQHSS Survey 1213.4.14.1

Recommendation:

Evidence of audit results of the medication plans need to be available to consumers and carers and signed off.

Action:

Plan of Action

Medication Record Service Plan to be developed and included within CBIS

Audit to be built into management reports

Process to capture percentage of medication plans discussed with the consumer to be developed

Progress report

Medication Record Service Plan developed and ready for release in CBIS

MEDSREC to be included in all consumer medical records.

November 2015 Update:

The Medication Record Service Plan is active in CBIS (Community Based Information System) and compliance is captured in monthly management reports.

The Medication Record should be reviewed at every Medication Support and Review, or Medication Review contact by a medical officer or nurse practitioner with prescribing rights.

In October 2015, for Eastern Community Central Adelaide Mental Health, between 2.9% (Hallett) and 6.1% (Depot) medication records had been reviewed by a medical officer or nurse practitioner.

SA Health has established a MEDSREC Implementation Reference Group which meets regularly, and aims to increase completion rates of MEDSREC in CBIS. This group monitors the number of current (2015) mental health episodes for each Mental Health team compared to the number of CBIS Medications Records (MEDSREC) completed. In 2015 a 'forcing' mechanism was implemented in the MEDSREC Service Plan to ensure that doctors took responsibility for changes to the prescription details.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

January 2017 Update:

The Medication Record Service Plan is active in CBIS (Community Based Information System) and compliance is captured in monthly management reports. It is to be mandatory for every consumer to have a medication record reviewed at every Medication Support and Review, or Medication Review contact by a medical officer or nurse practitioner (with prescribing rights). In 2015 a 'forcing' mechanism was implemented in the MEDSREC Service Plan to ensure that doctors took responsibility for changes to the prescription details.

The figures for compliance remain small across the state with CALHN Mental Health Directorate's latest figures for completion 10.8% in West (Feb 2016 SMHQIC Performance Indicator Report).

In May 2016, the Safety, Quality and Risk Management Coordinators in each Local Health Network were tasked to look into the issues and barriers to the use of the Medication Record (MEDSREC) within CBIS in an attempt at identifying potential areas for improvement.

A discussion paper that identifies the barriers to the use of MEDSREC screen in CBIS is to be tabled at the March MH Quality & Governance Committee seeking agreement for the paper being submitted to the SMHQIC for discussion and a way forward.

The Safety, Quality and Risk Management Coordinator will provide the Mental Health Directorate with the outcomes accordingly.

There has been substantial improvement overall in this area in the Eastern Community Mental Health Services. Currently, December (2016) performance data for Eastern Community Central Adelaide Mental Health showed medication records that had been reviewed by a medical officer or nurse practitioner as follows:

- Glynburn - Medication records entered by all clinicians 23.0%, Reviewed by medical officer/nurse practitioner 10.3%
- Hallett - Medication records entered by all clinicians 60.5%, Reviewed by medical officer/nurse practitioner 60.5%

Western Community Mental Health:

- Port Medical - Medication records entered by all clinicians 6.0%, Reviewed by medical officer/nurse practitioner 6.0%
- West Medical - Medication records entered by all clinicians 7.4%, Reviewed by medical officer/nurse practitioner 7.4%

December 2017 Update:

The last SMHQI report for the 6 months prior to August 2017 provides the following data: East 15.5% completion.

The state-wide Psychotropic Committee monitors the data and compliance across the state is low.

The Executive Lead for Standard 4 will keep the Mental Health Service informed through the MH Quality meeting. A CALHN Mental Health Medication meeting is being established to address local issues. Action will be taken to address low compliance rates after discussion with Clinical Director.

Completion Due By: Dec-16

Responsibility: Executive Director Mental Health

Organisation Completed: No

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

This previous recommendation is specific to the Mental Health Service. The surveyors have been provided with evidence to show that actions required under this recommendation are now substantially in place – thus, the recommendation can be recorded as complete.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.7.1 Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include:
• the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient’s condition, to the clinical workforce
• local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration

Recommendation: NSQHSS Survey 1213.9.7.1

Recommendation:

Ensure that information is provided to patients, family and carers – on the importance of communicating indications of deterioration, and local systems through which they can raise their concerns, in a format that is understood and meaningful.

Action:

The Standard 9 Committee are currently developing a consumer recognition and response process. A literature review of systems in use has been undertaken. The Committee agreed on development of a hybrid of the CARE (ACT) and REACH (NSW) systems. The committee have worked closely with the Central Adelaide Consumer Advisory Service to ensure the process meets consumer needs. The system is being developed to align with the SA Health standardised recognition and response observation chart. A poster and handouts are part of the development. Currently, staff continue to verbally educate patients and families about raising concerns as early as possible. At present, consultation is occurring across the various central Adelaide sites to address practical issues prior to submission of a formal proposal to Executive early in 2015.

November 2015 Update:

A state-wide system for family escalation of care is awaiting implementation by SA Health (piloting planned in limited sites in early 201 6 - see Recommendation 1213.9.9.4).

The information on the system for family escalation of care is provided verbally to patients/carers at admission for elective patients, and in the Emergency Department for non-elective. Patients/carers are told who they need to discuss concerns with, and how to escalate if they are not satisfied their concerns are being addressed. This process is reinforced by staff who are in regular contact with the patient and families.

Information is also provided to patients/carers on discharge, on how to communicate with the hospital/GP if deterioration occurs.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

The 2013 audit data showed 73 - 98% of patients/family understood how to escalate care (n=203). An audit process will be developed to support implementation of the state-wide system, and re-auditing of patient/family understanding of the escalation system will be undertaken after implementation.

When the state-wide system is implemented by SA Health, information will be disseminated by:

- Posters which can be used within hospitals and clinics
- A 30 second YouTube clip
- A short audio clip for radio
- A 4 minute video clip that can be used to promote the process via in-house televisions.

February 2017 Update:

A state-wide system for patient / family escalation of care is to be implemented in 2017. The Local Health Networks met with SA Health twice in 2016 to agree on the basic principles that need to be followed. It is expected that this will include a policy/ guideline for an agreed escalation process, standard title, plus standard communication posters and patient focused video.

Following review of other systems, widespread consultation, including consumer input, CALHN is developing a consumer escalation process. This is nearing completion and expected to be implemented across CALHN in April 2017. As well as supporting episodes of clinical deterioration, the process will also seek to address broader clinically related concerns that the patient / family may raise. Members of the Consumer Advisory Councils have been active members of the sub-group involved in this work. An Organisation-Wide Instruction (procedure) has been developed to support staff education. This should be published in late March 2017.

Currently, patients / family are educated about how to raise concerns, and how to escalate issues if they are not satisfied that their concerns are being addressed. The process is reinforced by staff in regular contact with the patients and families. Information is also provided to patients / families on discharge on how to communicate with the hospital or GP if deterioration occurs.

December 2017 Update:

As indicated in the previous update, a CALHN wide strategy to allow patients, family and carers to escalate concerns relating to patient clinical deterioration, plus other clinical issues, has been finalised and is to be rolled out in January 2018. Consumers were actively involved in development of the CALHN model. Education of staff is to commence in December 2017.

Completion Due By: Dec-16

Responsibility: Chair, Resuscitation and Clinical Deterioration Co

Organisation Completed: No

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

The requirements of this action are still not met. A new recommendation is made in the body of the report.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.1 Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response

Recommendation: NSQHSS Survey 1213.9.9.1

Recommendation:

Provide evidence to demonstrate that mechanisms are in place for a patient, family member or carer to initiate an escalation of care response.

Action:

CALHN Resuscitation and Clinical Deterioration Committee are undertaking development of a hybrid of the CARE (ACT) and REACH (NSW) systems. The Committee are working with the Central Adelaide Consumer Advisory Service for advice and consideration. The system will align with the SA Health standardised recognition and response observation chart. Posters and Handouts are also in development. Staff continue to verbally educate patients and families about raising concerns as early as possible. Consultation in progress to address practical issues prior to submission of a proposal to Executive.

November 2015 Update:

Auditing of consumer knowledge of how to escalate care was undertaken in late 2013. This demonstrated good compliance with education of patients and family (73 - 98% compliance, n=203).

An agreement was reached with SA Health early in 2015 that a standardised state-wide approach would be taken regarding escalation of a patient's clinical deterioration.

Since then, SA Health have worked with a team from Flinders University and the Consumer Health Care Alliance to develop tools to meet the consumer's requirements. In October 2015, Flinders University held a progress update for staff and consumer groups about what has been developed:

- Posters which can be used within hospitals and clinics
- A 30 second YouTube clip
- A short audio clip for radio
- A 4-minute video clip which can be used to promote the process via in-house televisions and to support training of healthcare staff.

At present the system is entitled 'You're Worried, We're Listening'.

Work is also occurring to allow escalation of care directly to a medical emergency team via the phone system available at the patient's bedside.

These systems will be piloted at specific SA Health sites in early 2016 prior to full implementation.

An audit process will be developed to support implementation of the state-wide system, and re-auditing of patient/family understanding of the escalation system will be undertaken after implementation.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

February 2017 Update:

Formal auditing of patient / family knowledge on how to escalate concerns was last undertaken in late 2013. This demonstrated good compliance with education of patients and families (73-98% compliance n=203). Since then, any incidents of this nature are reported on the Safety Learning Incident Management System (SLS) and reviewed by either the; Safety and Quality Unit, Medical Emergency Response (MER) Committees at either RAH, TQEH, HRC; the CALHN Standard 9 Committee; or the CALHN Incident Review Panel (IRP). Managers within clinical units review all incidents reported via SLS.

An Organisation Wide Instruction (procedure) on patient / family escalation has recently been developed. Rollout of staff education is to be initiated in April 2017. It is expected that an SA Health Policy will be available late 2017 and CALHN will need to make changes to its organisational instruction to ensure alignment with SA Health policy.

December 2017 Update:

An Organisation Wide Instruction (OWI) directs staff to educate patients and their families / carers about how to escalate concerns at key points across the patient journey.

Similar to models introduced in other states, the system involves a three-step escalation process:

Step 1: The consumer raising his / her concerns with the local nurse or doctor
Step 2: If the consumer feels that the concern has not being adequately addressed, he/she asks to speak to a more senior staff member who will assess the patient (includes communication with the consultant)
Step 3: If concern remains unresolved, escalation to the Medical Emergency Team would occur

In addition, the above process, a pathway is included to allow escalation of a consumer's clinical concern that does not specifically relate to clinical deterioration and would not require escalation to the Medical Emergency Team. Escalation along this pathway includes involvement of senior staff and the Consumer Advisor.

Completion Due By: Feb-18

Responsibility: Chair, Resuscitation and Clinical Deterioration Co

Organisation Completed: No

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

The requirements of this action are still not met. A new recommendation is made in the body of the report.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.2 Information about the system for family escalation of care is provided to patients, families and carers

Recommendation: NSQHSS Survey 1213.9.9.2

Recommendation:

Ensure that information about the system for family escalation of care is provided to patients, families and carers.

Action:

Staff verbally educate patients and families on how to raise concerns as early as possible. This process will continue until implementation of the formal consumer escalation of care system in early-mid 2015.

November 2015 Update:

A state-wide system for family escalation of care is awaiting implementation by SA Health (piloting planned in limited sites in early 201 6 - see Recommendation 1213.9.9.4).

At present, consumers will raise concerns with the staff providing immediate care to them or their family member. If the consumer is not satisfied with the staff response, the concerns are escalated to a more senior staff member i.e. nurse in charge/senior medical officer or consumer advisor.

The information on the system for family escalation of care is provided verbally to patients/carers at admission for elective patients, and in the Emergency Department for non-elective.

Information is also provided to patients/carers on discharge, on how to communicate with the hospital/GP if deterioration occurs.

When the state-wide system is implemented by SA Health, information will be disseminated by:

1. Posters which can be used within hospitals and clinics
2. A 30 second YouTube clip
3. A short audio clip for radio
4. A 4-minute video clip that can be used to promote the process via in-house televisions.

February 2017 Update:

Staff verbally educate patients and families on how to raise any concerns as early as possible. This is reinforced in the patient information booklet “We want to hear from you.” This process will continue until implementation of the new system articulated in Recommendation 1213.9.7.1, which includes development of state-wide standardised pamphlets, posters and videos by SA Health. As an interim measure until SA Health release these, CALHN will develop posters and pamphlets to support the new CALHN escalation system.

December 2017 Update:

All patients are to be provided with a written Consumer Information Sheet and the information reinforced verbally at key points in the patient journey. As previously indicated, the Organisation Wide Instruction (OWI) “Patient and Family /Care Activated Escalation of Care” directs staff to:

- Educate patients and their families / carers regarding how to escalate concerns regarding clinical care on, or prior to admission (i.e. at pre-admission)
- Reinforce education whenever a patient transfers between departments / wards / wings (i.e. when transferring from the Emergency Department to a ward, during inter-ward transfer, or on transfer for specific tests i.e. x-ray)
- Provide reminders to patients and their family members during other regular activities, including bedside handover and medical rounds

As well as patient pamphlets, posters have been designed to be prominently displayed in all relevant patient and visitor related rooms across sites. At the RAH, information is being displayed on patient television monitors as at present, staff are not allowed to place posters on walls. Actions to display patient safety information on walls is currently being worked though with the building “owners” of the RAH site.

SA Health are planning for a standardised poster and pamphlet to be developed that will used across all SA Health sites later in 2018.

Completion Due By: Dec-16

Responsibility: Chair, Resuscitation and Clinical Deterioration Co

Organisation Completed: No

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

The requirements of this action are still not met. A new recommendation is made in the body of the report.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.3 The performance and effectiveness of the system for family escalation of care is periodically reviewed

Recommendation: NSQHSS Survey 1213.9.9.3

Recommendation:

Periodically review the effectiveness and performance of the system for family escalation of care.

Action:

Auditing of consumer knowledge of how to escalate care was undertaken in late 2013. This demonstrated good compliance with education of patients and family. An ongoing auditing schedule is being built into the consumer escalation of care process to be implemented in 2015.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

November 2015 Update:

A state-wide system for family escalation of care is awaiting implementation by SA Health (piloting planned in limited sites in early 201 6 - see Recommendation 1213.9.9.4).

The 2013 audit data showed 73 - 98% of patients/family understood how to escalate care (n=203). An audit process will be developed to support implementation of the state-wide system, and re-auditing of patient/family understanding of the escalation system will be undertaken after implementation.

The Standard 9 Committee reviews audits and reported incidents about consumer deterioration, including where consumer concerns may not have been addressed appropriately. Feedback from consumers via Consumer Liaison services is also addressed via the appropriate channels.

February 2017 Update:

SA Health have been requested to provide a standardised evaluation tool for the Local Health Networks. As this information is not expected to be delivered until the second half of 2017, CALHN are seeking to develop interim tools. These will include (at a minimum); evaluation of all episodes that reach the third stage (escalation of issue to senior consultant), and consumer feedback about the effectiveness of the system.

A review of the SA Health Patient Observation and Escalation Chart is currently underway and it is planned for the patient / family escalation tool to be incorporated into the revised chart.
The Standard 9 and Medical Emergency Response Committees have circulated a clinician survey to gain this feedback. It is expected that the revisions will allow us to incorporate questions into our regular National Standards Combined Audit concerning the effectiveness of patient / family escalation episodes.

December 2017 Update:

Staff will be required to report episodes of patient / family escalation into the Safety Learning (Incident Management) System in accordance with the OWI. A report will be generated from the SLS database prior to being reviewed at Directorate, Standard 9 and Medical Emergency Response (MER) Committee level. Feedback will be provided to the Executive Quality and Governance Committee at periodic intervals as part of the quarterly Standard 9 Committee's brief.

Completion Due By: Feb-18

Responsibility: Chair, Resuscitation and Clinical Deterioration Co

Organisation Completed: No

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

The requirements of this action are still not met. A new recommendation is made in the body of the report.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.4 Action is taken to improve the system performance for family escalation of care

Recommendation: NSQHSS Survey 1213.9.9.4

Recommendation:

Ensure that action is taken to improve the system for family escalation of care.

Action:

On completion and establishment of the new consumer escalation of care system, regular auditing will be included in the CALHN auditing program.

November 2015 Update:

An agreement was reached with SA Health early in 2015 that a standardised state-wide approach would be taken regarding escalation of a patient's clinical deterioration.

Since then, SA Health have worked with a team from Flinders University and the Consumer Health Care Alliance to develop tools to meet the consumer's requirements. In October 2015, Flinders University held a progress update for staff and consumer groups about what has been developed.

After holding focus groups to identify media that could be used to promote consumer escalation of care, it was agreed to develop four different formats;

1. Posters which can be used within hospitals and clinics
2. A 30 second YouTube clip
3. A short audio clip for radio
4. A 4-minute video clip which can be used to promote the process via in-house televisions and to support training of healthcare staff.

At present the system is entitled 'You're Worried, We're Listening'.

Work is also occurring to allow escalation of care directly to a medical emergency team via the phone system available at the patient's bedside.

These systems will be piloted at specific SA Health sites in early 2016 prior to full implementation.

February 2017 Update:

Standard 9 Committee is currently reviewing strategies to audit the effectiveness of the patient and family escalation of care system that is currently being developed and instigated. Options discussed include;

- reporting patient / family escalation via the SLS incident reporting system,
- implementing a patient and family questionnaire (based on the REACH model example) to gain consumer feedback, and;
- adding extra questions to the clinician feedback questionnaire already in use.

Results would be tabled and discussed at the CALHN Standard 9 Committee and reported to Executive and CALHN directorates.

December 2017 Update:

As indicated within the previous recommendation, patient / family escalation of concern that reaches step two or three is to be reported into the SLS. A strategy is being planned to obtain feedback from consumers who have escalated their concerns. It is envisaged that a patient and family questionnaire (based on the REACH model example) will be used to gain this form of consumer feedback.

Discussion has also occurred concerning adding extra questions to the clinician feedback questionnaire already in use to gain the staff opinions of staff to the system. Information from these processes will be used as part of a formal review of the model by the CALHN Resuscitation and Deteriorating Patient Committee, six months post implementation to allow us to revise areas where required.

Completion Due By: Feb-18

Responsibility: Chair, Resuscitation and Clinical Deterioration Co

Organisation Completed: No

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

The requirements of this action are still not met. A new recommendation is made in the body of the report.

Central Adelaide Local Health Network

MENTAL HEALTH IN-DEPTH REVIEW (IDR)

RECOMMENDATIONS FROM PREVIOUS SURVEY

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Governance and quality improvement systems
Action: 1.4.2 Annual mandatory training programs to meet the requirements of these Standards

Recommendation: NSQHSS Onsite Review 0317.1.4.2

Recommendation:
Ensure that the annual mandatory training programs meet the requirements of these standards.

Action:

Mandatory training requirements are clearly communicated to all staff through the Learning Management System. There are currently 8 Mandatory training requirements for all staff in addition to orientation to the organisation and workplace. There are further mandated training items related to specific roles within the organisation. (See document CALHN Mandatory Training List by Staff Groups).

Mandatory training requirements are aligned to relevant legislation, SA government directives and the NSQHSS standards.

Changes to mandatory training requirements are requested through the Learning, Education and Development Committee. Requests are made through this group for recommendations to add mandatory training requirements for specific groups. (See OWI-40409 Mandatory Training). Once recommendations are accepted by the Learning Education and Development committee these recommendations are sent to the Executive Management Team for final approval and the LMS is updated.

Reports from the LMS are available for access however accurate reporting still remains an issue due to three key factors. The first factor is a number of CALHN mandated training is hosted on external sites. As such, any training completed on these external systems requires verification through additional processes by the end user to upload data onto the CALHN LMS. This approach results in a lot of staff completing requirements but failing to place the data in our own system and records. The second key factor is sourcing consistent, dynamic data that accurately reflects the training managerial hierarchy within the organisation. We currently base our training hierarchy from HR and Financial data which does not always accurately reflect reporting lines for training. In addition, the data configuration group we rely on to supply this data currently supply an update every 4-6 weeks instead of daily or weekly. This results in further inaccuracies in the reports.

The third key factor is ongoing difficulty being experienced in sourcing resources to enable a new vendor to assist in meeting organisational needs and resources to implement the current Learning Management System. This continues to impact on the quality and accuracy of reporting to the organisation, with the following risks for the organisation remaining logged on the Risk Register:

1.Inability to provide accurate reports on mandatory training and meet other training reporting requirements for CALHN
2.Inability to provide and meet the increasing expectation of accessible online learning to the CALHN workforce, including nRAH training (pre and post transition)
3.Reputation of the organisation in not being able to meet the learning needs of the workforce
4.Safety and quality of clinical services provided

A briefing to resource a new vendor and ongoing support for the new LMS has been accepted in principle by Executive. Once funding has been identified the process to commence transfer to the new vendor can be commenced. A further briefing to being developed to identify FTE to support the LMS is being developed. Current FTE is based on a service previously delivered to nursing staff at the Royal Adelaide Hospital only. Additional FTE and transfer to a new vendor are anticipated to assist in delivering increased reliability solutions for reporting of data.

Completion Due By: Dec-18

Responsibility: Director of Learning and Development

Organisation Completed: No

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

The CALHN MHD has met the intent of this recommendation therefore this recommendation is now closed.

Recommendation: NSQHSS Onsite Review 0317.1.4.2

Recommendation:
Ensure that the annual mandatory training programs meet the requirements of these standards.

Action:

Mandatory training requirements are clearly communicated to all staff through the Learning Management System. There are currently 8 Mandatory training requirements for all staff in addition to orientation to the organisation and workplace. There are further mandated training items related to specific roles within the organisation. (See document CALHN Mandatory Training List by Staff Groups).

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Completion Due By: Dec-18

Responsibility: Director of Learning and Development

Organisation Completed: No

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

The CALHN MHD has met the intent of the recommendation therefore this recommendation is now closed.

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

Recommendation: NSQHSS Onsite Review 0317.2.2.1

Recommendation:
Review the mechanisms for engaging consumers and/or carers in the organisation and implement changes to support and coordinate consumer involvement across all services.

Action:

CALHN has historically engaged consumers through the Consumer Advocacy Committee process, with one committee for each major site and an overarching CALHN wide committee. CALHN acknowledges that this process has not served the organisation or its consumers well. The engagement of the consumer voice in the development of the new RAH has therefore been limited and transactional in nature. The involvement of consumers in the strategic planning and ongoing governance of the organisation is as a result, limited. CALHN is currently undergoing a strategic planning process, following from SA Health’s system wide 2017 strategic planning process, and our consumer committees will be involved in consultation on the development of this.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Recognising the importance of CALHN deeply understanding and engaging with the consumer as both customer and owner of the health system, CALHN has established an agreement with the Health Consumers Alliance of SA to develop a contemporary consumer and community engagement strategy. This is a 2-year contract based agreement aiming to enhance safety and quality across CALHN through a greater focus on consumer-centred care, and will include as part of the scope leadership and culture, governance, infrastructure and capacity building for a sustainable system. This work will be supported by a HCA staffing resource working within CALHN, and will be under the auspices of the Director of Clinical Governance. Other activities currently underway:

- Continuation of the current Open Disclosure Training program – widely available to clinical staff and delivered under a contract with Cognitive Institute
- Removal of protection from Incident Review Panel and Clinical Incident investigation, with the intention that the results serious incident investigations will be widely available to both staff and consumers
- The deliberate involvement of consumers in the investigation of most serious incidents with a particular focus on service improvement in response
- Consumers are involved in Intentional Rounding, a recent initiative of the Nursing profession at the new facility This has led to the development of the Intentional Rounding Procedure which is now rolled out at RAH and is for implementation at TQEH in 2018

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

The CALHN MHD has demonstrated that they have mechanisms in support consumer and carer involvement and participation through the establishment of the CAG; this was formerly two groups in Eastern and Western known as the Lived Experience. The newly established CAG has as part of its process consumer representative on the Mental Health Quality and Governance Committee and also on the CALHN Consumer Advocacy Group. The Lived Experience Co-co is also consulted in strategic and operational planning and an example of this was the build and operational design of the new RAH.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 2.2.2 Consumers and/or carers are actively involved in decision making about safety and quality

Recommendation: NSQHSS Onsite Review 0317.2.2.2

Recommendation:
Implement processes to encourage and support the active involvement of consumers in decision making about safety and quality.

Action:
CALHN is committed to improving care delivery, and recognises that to achieve this, the consumer voice must be meaningfully heard in the design, delivery, monitoring and evaluation of care.
In 2018, in part in association with the HCASA work, CALHN will be developing an organisational Quality Plan which speaks to the organisational, directorate, and unit level quality.

The consumer experience of care will be central to this approach, which will be based in a Triple Aim model at organisation, directorate and unit level. In order to better drive this work, CALHN is reconfiguring its peak Quality Committee, and will have expert consumer voices at the peak decision-making table. This will be replicated over 2018 at Directorate level and subsequently at unit level, as the HCASA strategy is developed and rolled out. At the moment, our ability to have sufficient capacity of expert consumer voices to support unit level work is limited, as is the engagement of many clinical teams. Consumer feedback data has been presented to consumers in previous years. This generally takes the form of:

1. The SA Health SACESS report – aggregating consumer feedback from a post discharge survey. Common themes have been presented repeatedly around food, access and communication. CALHN is awaiting the feedback from this report in relation to the RAH facility.
2. Receiving reports on deidentified individual complaints and compliments.

The Consumer Advocacy Council is developing a plan at the January 2018 meeting to determine work required for the next 12 months in driving changes in response to consumer feedback.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

The MHD CAG are included and provided with information with regards to changes within the mental health service that relate to quality and safety.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 2.3.1 Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role

Recommendation: NSQHSS Onsite Review 0317.2.3.1

Recommendation:

Review the current orientation and ongoing training system for consumers and implement changes to ensure that training enables them to fulfil their partnership role.

Action:
CALHN is aware of the need to ensure that consumers are effectively supported in their work for and with the organisation. To date this has been rudimentary. From 2018 consumer orientation is being expanded and refined, with a revision of the Orientation Guide planned for Q1 2018.

Further, online training is accessible through Learning Central. Increased training opportunities are available through HCA for consumers and CALHN is committed to supporting consumers to undertake this training. Expanding CALHN's consumer capacity will be a key focus of the HCASA work over the next 2 years.

Training is now a CAC agenda item. Training plans include providing Learning Central access to all consumer representatives. CAC members currently focus on one Learning Central area each month ie. Hand Hygiene. CAC have determined the training that consumer representative wish to access ongoing.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

MHD has systems in place to ensure that the peer specialist are well orientated to their role as peer specialists. There are also regular Professional Development Days of which all the Peer Specialist workforce attends. Additional to this the Lived Experience Coordinator is placed as the professional lead and holds regular Peer Specialist Team Meetings at which training needs and issues are discussed.

Standard: Partnering with Consumers
Criterion: Consumer partnership in designing care
Action: 2.5.1 Consumers and/or carers participate in the design and redesign of health services

Recommendation: NSQHSS Onsite Review 0317.2.5.1

Recommendation:

Identify and implement a mechanism for the involving of consumers and/or carers in the design and redesign of the health service.

Action:

CALHN continues to undertake a considerable body of work to redesign its facilities and services. The proposed redevelopment of TQEH and the shift of services from Hampstead Rehabilitation Centre to TQEH in 2-3 years include consumer input. More needs to be done and this will again be a focus of the HCASA work.

In the RAH, management of the facility is not CALHN's primary responsibility. As a result, concerns have been expressed by consumers at signage and wayfinding. Work is being done to address this, and the consumer Advisory Council is involved with this, with their walkarounds providing valuable insights into the functionality of the new
building.

Both the overarching CALHN Consumer Advocacy Council and site-specific Consumer Advisory Groups will be goal setting in January 2018 to decide on their focus for upcoming year. This work has the full support of the Quality Support Team and the Director of Clinical Governance, who is involved where possible in Consumer meetings. In addition, the CALHN CEO speaks regularly with key consumer representatives.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

There are mechanisms in place to support consumer involvement in the design and redesign; this is through the CAG. Some examples inclusive of the Physical Health Project that had a Lived Experience Reference Group.

Standard: Partnering with Consumers
Criterion: Consumer partnership in designing care
Action: 2.6.2 Consumers and/or carers are involved in training the clinical workforce

Recommendation: NSQHSS Onsite Review 0317.2.6.2

Recommendation:
Identify and implement a mechanism for the involving of consumers and/or carers in the training of the clinical workforce.

Action:
A consumer is now involved in the General Orientation of CALHN Nursing, Allied Health and Administration staff. This will be further expanded with the induction of all new staff as the HCASA engagement strategy is developed throughout 2018. Further, CALHN is proposing that there be a proposal for the inclusion of a patient story presentation at Quality Meetings and in CALHN Executive. This will be further explored throughout 2018.

Consumers currently attend Education and Training sessions at TQEH following feedback/complaints. An Expression of Interest has been developed by the Consumer Advisor team to encourage consumers to tell their story at staff educational events, and this will provide a pool of consumers to tell their story.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

The Peer Specialist Workforce and consumer representatives are active in delivering training to the clinical workforce across the MHD. This is both at local level through local in-service and at an MHD level that is available to all staff within the MHD.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.8.1 Consumers and/or carers participate in the analysis of organisational safety and quality performance

Recommendation: NSQHSS Onsite Review 0317.2.8.1

Recommendation:
Identify and implement a mechanism to engage consumers and carers in the analysis of the health service's safety and quality performance.

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Action:

To date this is limited. Consumers do however contribute actively to committee processes including through the various National Standards committees (notably medication safety and in a recently established group looking at end of life care). Agenda items, minutes and other records of meetings document involvement of consumers in the analysis of safety and quality performance.

The roll out of a new CALHN committee structure throughout 2018 will increase the opportunity for consumers to be involved in organisational governance and in particular in service or unit level governance.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

The range of committees that have consumer representative involvement are receiving data and information on the health services safety and quality performance and a mechanism is in place to undertake same.

Recommendation: NSQHSS Onsite Review 0317.2.8.1

Recommendation:
Identify and implement a mechanism to engage consumers and carers in the analysis of the health service's safety and quality performance.

Action:
To date this is limited. Consumers do however contribute actively to committee processes including through the various National Standards committees (notably medication safety and in a recently established group looking at end of life care). Agenda items, minutes and other records of meetings document involvement of consumers in the analysis of safety and quality performance. The roll out of a new CALHN committee structure throughout 2018 will increase the opportunity for consumers to be involved in organisational governance and in particular in service or unit level governance.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

Mechanisms have been identified within the MHD to support the analysis of Health services quality and safety performance; this is through consumer representation on the Quality and Governance Committee and the CAG.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.8.2 Consumers and/or carers participate in the planning and implementation of quality improvements

Recommendation: NSQHSS Onsite Review 0317.2.8.2

Recommendation:
Identify and implement a mechanism to engage consumers and carers in the planning and implementation of quality improvements.

Action:
CALHN is working with CAC and CAGs to develop and implement a plan which defines activities for the committees and which can then be evaluated. Further, an organisation wide Quality Plan will be developed throughout 2018 – this will require considerable consumer involvement at every stage, as it is intended that this plan signal the organisation's renewed and meaningful commitment to putting the consumer at the heart of its work. This work will be informed by the HCASA.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

The Lived Experience Coordinator is an active participant in a range of quality improvement activities. Consumers are also engaged with the service at local levels that identify quality improvement in programs delivered by the service.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.9.1 Consumers and/or carers participate in the evaluation of patient feedback data

Recommendation: NSQHSS Onsite Review 0317.2.9.1

Recommendation:
Develop a process that enables consumers and /or carers to participate in the evaluation of patient feedback data.

Action:

Feedback from consumers is currently presented to CAG and CAC meetings. This is considered by the committees and recommendations are made and where feasible, acted upon. Work is required to encourage more robust discussion of feedback at these meetings – this too will form part of the work of the HCASA project. Examples of matters for discussion include:

Distribution of SACESS mini reports to CAC/CAG members and Measuring Consumer Experience 2016 report Partnering with Consumers Newsletters and Action Plan SLS feedback - reports describing feedback to consumers - report tabled at CAC.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

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

The YES Survey has resulted in the opportunity for consumers to provide feedback and evaluation of patient feedback data. A process is in place to incorporate this within the process of the stages of the YES Survey.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.9.2 Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data

Recommendation: NSQHSS Onsite Review 0317.2.9.2

Recommendation:
Develop a process that will enable and support consumer participation in the implementation of quality activities relating to patient feedback data.

Action:

To date, CALHN consumers have had little involvement in developing improvement work. Consumers have however assisted through walk arounds and have made suggestions both through the CAC/CAG process and directly to organisational leaders on improvements.

Consumers were actively involved in identifying areas for improvement following the RAH move:

- surveys in the area of meal management and OPD at the RAH, both of which have been subject to dramatic process change with the opening of the new facility;
- wayfinding and signage in OPD, resulting in updating of flat signage to more easily visible signs, and OPD screens having prompts for check in;
- Wayfinding volunteers in RAH foyer and at kiosks;
- consumer representation on hospital Food Service Working Groups;
- consumer participation on End of Life Working Group;
- project on Patient Communication Boards;
- relocation of Enquiries Desk in RAH foyer to ensure wheelchair access for consumers;
- additional RAH cashier window to ensure wheelchair accessibility;
- Escalation paper produced by RAH CAC on issues to be solved ie. car parking - have been worked through and solved;
- RAH consumer maps updated online to ensure toilet facilities were easier to find.

Completion Due By: Dec-18

Responsibility: Director Clinical Governance

Organisation Completed: No

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

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

This recommendation has been entered as both 2.9.1 and 2.9.2.

Evidence for closure of this recommendation has been entered under 2.9.1.

Standard: Medication Safety
Criterion: Communicating with patients and carers
Action: 4.14.1 An agreed medication management plan is documented and available in the patient's clinical record

Recommendation: NSQHSS Survey 1213.4.14.1

Recommendation:

Evidence of audit results of the medication plans need to be available to consumers and carers and signed off.

Action:

Plan of Action

Medication Record Service Plan to be developed and included within CBIS

Audit to be built into management reports

Process to capture percentage of medication plans discussed with the consumer to be developed

Progress report

Medication Record Service Plan developed and ready for release in CBIS

MEDSREC to be included in all consumer medical records.

November 2015 Update:

The Medication Record Service Plan is active in CBIS (Community Based Information System) and compliance is captured in monthly management reports.

The Medication Record should be reviewed at every Medication Support and Review, or Medication Review contact by a medical officer or nurse practitioner with prescribing rights.
In October 2015, for Eastern Community Central Adelaide Mental Health, between 2.9% (Hallett) and 6.1% (Depot) medication records had been reviewed by a medical officer or nurse practitioner.

SA Health has established a MEDSREC Implementation Reference Group which meets regularly, and aims to increase completion rates of MEDSREC in CBIS. This group monitors the number of current (2015) mental health episodes for each Mental Health team compared to the number of CBIS Medications Records (MEDSREC) completed. In 2015 a 'forcing' mechanism was implemented in the MEDSREC Service Plan to ensure that doctors took responsibility for changes to the prescription details.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

January 2017 Update:

The Medication Record Service Plan is active in CBIS (Community Based Information System) and compliance is captured in monthly management reports. It is to be mandatory for every consumer to have a medication record reviewed at every Medication Support and Review, or Medication Review contact by a medical officer or nurse practitioner (with prescribing rights). In 2015 a 'forcing' mechanism was implemented in the MEDSREC Service Plan to ensure that doctors took responsibility for changes to the prescription details.

The figures for compliance remain small across the state with CALHN Mental Health Directorate's latest figures for completion 10.8% in West (Feb 2016 SMHQIC Performance Indicator Report).

In May 2016, the Safety, Quality and Risk Management Coordinators in each Local Health Network were tasked to look into the issues and barriers to the use of the Medication Record (MEDSREC) within CBIS in an attempt at identifying potential areas for improvement.

A discussion paper that identifies the barriers to the use of MEDSREC screen in CBIS is to be tabled at the March MH Quality & Governance Committee seeking agreement for the paper being submitted to the SMHQIC for discussion and a way forward.

The Safety, Quality and Risk Management Coordinator will provide the Mental Health Directorate with the outcomes accordingly.

There has been substantial improvement overall in this area in the Eastern Community Mental Health Services. Currently, December (2016) performance data for Eastern Community Central Adelaide Mental Health showed medication records that had been reviewed by a medical officer or nurse practitioner as follows:

- Glynburn - Medication records entered by all clinicians 23.0%, Reviewed by medical officer/nurse practitioner 10.3%
- Hallett - Medication records entered by all clinicians 60.5%, Reviewed by medical officer/nurse practitioner 60.5%

Western Community Mental Health:

- Port Medical - Medication records entered by all clinicians 6.0%, Reviewed by medical officer/nurse practitioner 6.0%
- West Medical - Medication records entered by all clinicians 7.4%, Reviewed by medical officer/nurse practitioner 7.4%

December 2017 Update:

The last SMHQI report for the 6 months prior to August 2017 provides the following data: East 15.5% completion.

The state-wide Psychotropic Committee monitors the data and compliance across the state is low. The Executive Lead for Standard 4 will keep the Mental Health Service informed through the MH Quality meeting. A CALHN Mental Health Medication meeting is being established to address local issues. Action will be taken to address low compliance rates after discussion with Clinical Director.

Completion Due By: Dec-16

Responsibility: Executive Director Mental Health

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Organisation Completed: No

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

This recommendation is outside of usual practice and therefore can be closed.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.7.1 Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include:
• the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce
• local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration

Recommendation: NSQHSS Survey 1213.9.7.1

Recommendation:
Ensure that information is provided to patients, family and carers – on the importance of communicating indications of deterioration, and local systems through which they can raise their concerns, in a format that is understood and meaningful.

Action:

The Standard 9 Committee are currently developing a consumer recognition and response process. A literature review of systems in use has been undertaken. The Committee agreed on development of a hybrid of the CARE (ACT) and REACH (NSW) systems. The committee have worked closely with the Central Adelaide Consumer Advisory Service to ensure the process meets consumer needs. The system is being developed to align with the SA Health standardised recognition and response observation chart. A poster and handouts are part of the development. Currently, staff continue to verbally educate patients and families about raising concerns as early as possible. At present, consultation is occurring across the various central Adelaide sites to address practical issues prior to submission of a formal proposal to Executive early in 2015.

November 2015 Update:
A state-wide system for family escalation of care is awaiting implementation by SA Health (piloting planned in limited sites in early 201 6 - see Recommendation 1213.9.9.4).

The information on the system for family escalation of care is provided verbally to patients/carers at admission for elective patients, and in the Emergency Department for non-elective. Patients/carers are told who they need to discuss concerns with, and how to escalate if they are not satisfied their concerns are being addressed. This process is reinforced by staff who are in regular contact with the patient and families.

Information is also provided to patients/carers on discharge, on how to communicate with the hospital/GP if deterioration occurs.

The 2013 audit data showed 73 - 98% of patients/family understood how to escalate care (n=203). An audit process will be developed to support implementation of the state-wide system, and re-auditing of patient/family understanding of the escalation system will be undertaken after implementation.

When the state-wide system is implemented by SA Health, information will be disseminated by:

- Posters which can be used within hospitals and clinics
- A 30 second YouTube clip
- A short audio clip for radio
- A 4-minute video clip that can be used to promote the process via in-house televisions.

February 2017 Update:

A state-wide system for patient / family escalation of care is to be implemented in 2017. The Local Health Networks met with SA Health twice in 2016 to agree on the basic principles that need to be followed. It is expected that this will include a policy/ guideline for an agreed escalation process, standard title, plus standard communication posters and patient focused video.

Following review of other systems, widespread consultation, including consumer input, CALHN is developing a consumer escalation process. This is nearing completion and expected to be implemented across CALHN in April 2017. As well as supporting episodes of clinical deterioration, the process will also seek to address broader clinically related concerns that the patient / family may raise. Members of the Consumer Advisory Councils have been active members of the sub-group involved in this work. An Organisation-Wide Instruction (procedure) has been developed to support staff education. This should be published in late March 2017.

Currently, patients / family are educated about how to raise concerns, and how to escalate issues if they are not satisfied that their concerns are being addressed. The process is reinforced by staff in regular contact with the patients and families. Information is also provided to patients / families on discharge on how to communicate with the hospital or GP if deterioration occurs.

December 2017 Update:

As indicated in the previous update, a CALHN wide strategy to allow patients, family and carers to escalate concerns relating to patient clinical deterioration, plus other clinical issues, has been finalised and is to be rolled out in January 2018. Consumers were actively involved in development of the CALHN model. Education of staff is to commence in December 2017.

Completion Due By: Dec-16

Responsibility: Chair, Resuscitation and Clinical Deterioration Co

Organisation Completed: No

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

This recommendation is closed and a new recommendation has been written.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.1 Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response

Recommendation: NSQHSS Survey 1213.9.9.1

Recommendation:
Provide evidence to demonstrate that mechanisms are in place for a patient, family member or carer to initiate an escalation of care response.

Action:

CALHN Resuscitation and Clinical Deterioration Committee are undertaking development of a hybrid of the CARE (ACT) and REACH (NSW) systems. The Committee are working with the Central Adelaide Consumer Advisory Service for advice and consideration. The system will align with the SA Health standardised recognition and response observation chart. Posters and Handouts are also in development. Staff continue to verbally educate patients and families about raising concerns as early as possible. Consultation in progress to address practical issues prior to submission of a proposal to Executive.

November 2015 Update:
Auditing of consumer knowledge of how to escalate care was undertaken in late 2013. This demonstrated good compliance with education of patients and family (73 - 98% compliance, n=203).

An agreement was reached with SA Health early in 2015 that a standardised state-wide approach would be taken regarding escalation of a patient's clinical deterioration.

Since then, SA Health have worked with a team from Flinders University and the Consumer Health Care Alliance to develop tools to meet the consumer's requirements. In October 2015, Flinders University held a progress update for staff and consumer groups about what has been developed:

- Posters which can be used within hospitals and clinics
- A 30 second YouTube clip
- A short audio clip for radio
- A 4-minute video clip which can be used to promote the process via in-house televisions and to support training of healthcare staff.

At present the system is entitled 'You're Worried, We're Listening'.

Work is also occurring to allow escalation of care directly to a medical emergency team via the phone system available at the patient's bedside.

These systems will be piloted at specific SA Health sites in early 2016 prior to full implementation.

An audit process will be developed to support implementation of the state-wide system, and re-auditing of patient/family understanding of the escalation system will be undertaken after implementation.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

February 2017 Update:

Formal auditing of patient / family knowledge on how to escalate concerns was last undertaken in late 2013. This demonstrated good compliance with education of patients and families (73-98% compliance n=203). Since then, any incidents of this nature are reported on the Safety Learning Incident Management System (SLS) and reviewed by either the; Safety and Quality Unit, Medical Emergency Response (MER) Committees at either RAH, TQEH, HRC; the CALHN Standard 9 Committee; or the CALHN Incident Review Panel (IRP). Managers within clinical units review all incidents reported via SLS.

An Organisation Wide Instruction (procedure) on patient / family escalation has recently been developed. Rollout of staff education is to be initiated in April 2017. It is expected that an SA Health Policy will be available late 2017 and CALHN will need to make changes to its organisational instruction to ensure alignment with SA Health policy.

December 2017 Update:

An Organisation Wide Instruction (OWI) directs staff to educate patients and their families / carers about how to escalate concerns at key points across the patient journey.

Similar to models introduced in other states, the system involves a three step escalation process:

Step 1: The consumer raising his / her concerns with the local nurse or doctor

Step 2: If the consumer feels that the concern has not being adequately addressed, he/she asks to speak to a more senior staff member who will assess the patient (includes communication with the consultant)

Step 3: If concern remains unresolved, escalation to the Medical Emergency Team would occur

In addition the above process, a pathway is included to allow escalation of a consumer's clinical concern that does not specifically relate to clinical deterioration and would not require escalation to the Medical Emergency Team. Escalation along this pathway includes involvement of senior staff and the Consumer Advisor.

Completion Due By: Feb-18

Responsibility: Chair, Resuscitation and Clinical Deterioration Co

Organisation Completed: No

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

This recommendation is closed and a new recommendation has been written.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.2 Information about the system for family escalation of care is provided to patients, families and carers

Recommendation: NSQHSS Survey 1213.9.9.2

Recommendation:
Ensure that information about the system for family escalation of care is provided to patients, families and carers.

Action:

Staff verbally educate patients and families on how to raise concerns as early as possible. This process will continue until implementation of the formal consumer escalation of care system in early-mid 2015.

November 2015 Update:
A state-wide system for family escalation of care is awaiting implementation by SA Health (piloting planned in limited sites in early 201 6 - see Recommendation 1213.9.9.4).

At present, consumers will raise concerns with the staff providing immediate care to them or their family member. If the consumer is not satisfied with the staff response, the concerns are escalated to a more senior staff member ie. nurse in charge/senior medical officer or consumer advisor.

The information on the system for family escalation of care is provided verbally to patients/carers at admission for elective patients, and in the Emergency Department for non-elective.

Information is also provided to patients/carers on discharge, on how to communicate with the hospital/GP if deterioration occurs.

When the state-wide system is implemented by SA Health, information will be disseminated by:

1. Posters which can be used within hospitals and clinics
2. A 30 second YouTube clip
3. A short audio clip for radio
4. A 4-minute video clip that can be used to promote the process via in-house televisions.

February 2017 Update:

Staff verbally educate patients and families on how to raise any concerns as early as possible. This is reinforced in the patient information booklet "We want to hear from you." This process will continue until implementation of the new system articulated in Recommendation 1213.9.7.1, which includes development of state-wide standardised pamphlets, posters and videos by SA Health. As an interim measure until SA Health release these, CALHN will develop posters and pamphlets to support the new CALHN escalation system.

December 2017 Update:

All patients are to be provided with a written Consumer Information Sheet and the information reinforced verbally at key points in the patient journey. As previously indicated, the Organisation Wide Instruction (OWI) "Patient and Family /Care Activated Escalation of Care" directs staff to:

- Educate patients and their families / carers regarding how to escalate concerns regarding clinical care on, or prior to admission (i.e. at pre-admission)

- Reinforce education whenever a patient transfers between departments / wards / wings (i.e. when transferring from the Emergency Department to a ward, during inter-ward transfer, or on transfer for specific tests i.e. x-ray)
- Provide reminders to patients and their family members during other regular activities, including bedside handover and medical rounds

As well as patient pamphlets, posters have been designed to be prominently displayed in all relevant patient and visitor related rooms across sites. At the RAH, information is being displayed on patient television monitors as at present, staff are not allowed to place posters on walls. Actions to display patient safety information on walls is currently being worked though with the building “owners” of the RAH site.

SA Health are planning for a standardised poster and pamphlet to be developed that will used across all SA Health sites later in 2018.

Completion Due By: Dec-16

Responsibility: Chair, Resuscitation and Clinical Deterioration Co

Organisation Completed: No

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

This recommendation has been closed and a new recommendation has been written.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.3 The performance and effectiveness of the system for family escalation of care is periodically reviewed

Recommendation: NSQHSS Survey 1213.9.9.3

Recommendation:
Periodically review the effectiveness and performance of the system for family escalation of care.

Action:

Auditing of consumer knowledge of how to escalate care was undertaken in late 2013. This demonstrated good compliance with education of patients and family. An ongoing auditing schedule is being built into the consumer escalation of care process to be implemented in 2015.

November 2015 Update:
A state-wide system for family escalation of care is awaiting implementation by SA Health (piloting planned in limited sites in early 201 6 - see Recommendation 1213.9.9.4).

The 2013 audit data showed 73 - 98% of patients/family understood how to escalate care (n=203). An audit process will be developed to support implementation of the state-wide system, and re-auditing of patient/family understanding of the escalation system will be undertaken after implementation.

The Standard 9 Committee reviews audits and reported incidents about consumer deterioration, including where consumer concerns may not have been addressed appropriately. Feedback from consumers via Consumer Liaison services is also addressed via the appropriate channels.

February 2017 Update:

SA Health have been requested to provide a standardised evaluation tool for the Local Health Networks. As this information is not expected to be delivered until the second half of 2017, CALHN are seeking to develop interim tools. These will include (at a minimum); evaluation of all episodes that reach the third stage (escalation of issue to senior consultant), and consumer feedback about the effectiveness of the system.

A review of the SA Health Patient Observation and Escalation Chart is currently underway and it is planned for the patient / family escalation tool to be incorporated into the revised chart. The Standard 9 and Medical Emergency Response Committees have circulated a clinician survey to gain this feedback. It is expected that the revisions will allow us to incorporate questions into our regular National Standards Combined Audit concerning the effectiveness of patient / family escalation episodes.

December 2017 Update:

Staff will be required to report episodes of patient / family escalation into the Safety Learning (Incident Management) System in accordance with the OWI. A report will be generated from the SLS database prior to being reviewed at Directorate, Standard 9 and Medical Emergency Response (MER) Committee level. Feedback will be provided to the Executive Quality and Governance Committee at periodic intervals as part of the quarterly Standard 9 Committee's brief.

Completion Due By: Feb-18

Responsibility: Chair, Resuscitation and Clinical Deterioration Co

Organisation Completed: No

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

This recommendation has been closed and a new recommendation has been written.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.4 Action is taken to improve the system performance for family escalation of care

Recommendation: NSQHSS Survey 1213.9.9.4

Recommendation:
Ensure that action is taken to improve the system for family escalation of care.

Action:

On completion and establishment of the new consumer escalation of care system, regular auditing will be included in the CALHN auditing program.

November 2015 Update:
An agreement was reached with SA Health early in 2015 that a standardised state-wide approach would be taken regarding escalation of a patient's clinical deterioration.
Since then, SA Health have worked with a team from Flinders University and the Consumer Health Care Alliance to develop tools to meet the consumer's requirements. In October 2015, Flinders University held a progress update for staff and consumer groups about what has been developed.

Recommendations from Previous Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

After holding focus groups to identify media that could be used to promote consumer escalation of care, it was agreed to develop four different formats;

1. Posters which can be used within hospitals and clinics
2. A 30 second YouTube clip
3. A short audio clip for radio
4. A 4-minute video clip which can be used to promote the process via in-house televisions and to support training of healthcare staff.

At present the system is entitled 'You're Worried, We're Listening'.

Work is also occurring to allow escalation of care directly to a medical emergency team via the phone system available at the patient's bedside.

These systems will be piloted at specific SA Health sites in early 2016 prior to full implementation.

February 2017 Update:

Standard 9 Committee is currently reviewing strategies to audit the effectiveness of the patient and family escalation of care system that is currently being developed and instigated. Options discussed include;

- reporting patient / family escalation via the SLS incident reporting system,
- implementing a patient and family questionnaire (based on the REACH model example) to gain consumer feedback, and;
- adding extra questions to the clinician feedback questionnaire already in use.

Results would be tabled and discussed at the CALHN Standard 9 Committee and reported to Executive and CALHN directorates.

December 2017 Update:

As indicated within the previous recommendation, patient / family escalation of concern that reaches step two or three is to be reported into the SLS. A strategy is being planned to obtain feedback from consumers who have escalated their concerns. It is envisaged that a patient and family questionnaire (based on the REACH model example) will be used to gain this form of consumer feedback.

Discussion has also occurred concerning adding extra questions to the clinician feedback questionnaire already in use to gain the staff opinions of staff to the system. Information from these processes will be used as part of a formal review of the model by the CALHN Resuscitation and Deteriorating Patient Committee, six months post implementation to allow us to revise areas where required.

Completion Due By: Feb-18

Responsibility: Chair, Resuscitation and Clinical Deterioration Co

Organisation Completed: No

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

This recommendation has been closed and a new recommendation has been written.

The Australian Council on Healthcare Standards

2018 AC90 REPORT

Central Adelaide
Local Health Network

Excluding Mental Health Directorate (see separate document)

This AC90 report contains relevant parts of the original 19-23 February 2018 Survey Report plus commentary following the AC90 Review on 30-31 May 2018

NSQHSS AC Onsite Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

SURVEY OVERVIEW

Central Adelaide Local Health Network (CALHN) is a tertiary provider of health services to the people of Adelaide and South Australia. CALHN also manages some of the State-Wide Services including Clinical Support Services, Intermediate Care and Prison Health Services which were included in this survey scope.

Assessment was against the National Safety and Quality Health Service Standards. A separate in-depth survey of the Mental Health Services was undertaken at the same time as this assessment. The reports from external reviews were provided to the surveyors.

The surveyors met with staff and patients when they visited the Royal Adelaide Hospital (RAH), The Queen Elizabeth Hospital (TQEH) Hampstead Rehabilitation Hospital (HRH), St Margaret's and the Pregnancy Advisory Centre (PAC). Primary care services and six sites of the SA Prison Health Service were also visited.

The organisation has gone through significant change under the SA Health Transforming Health agenda.

The relatively new Executive team is now in place with permanent medical leadership appointments. The clinical services moved into the new RAH in September 2017.

The new RAH is being managed within a private-public partnership. Celsus is the corporate entity which operates and services the building and Celsus subcontracts to Spotless for a range of services such as cleaning, food services and security. DXE technologies provides information and communication technology. The contract with Celsus is managed by SA Health. CALHN provides the health services within the building. The relationship is complex and does require good communication and effective governance. The CALHN Facilities Operation Team is monitoring performance on a daily basis and a structured governance framework is in place.

There are three clinical support services that are managed by CALHN and provided on a State-wide basis. These are: Medical Imaging, Pathology, Pharmacy, and SA Breast Screen is to join in the near future. In addition, Biomedical Engineering is also a State-wide service but is independent of CALHN and reports directly to the SA Health Department.

Even though these services are provided State-wide the management of the services falls under the responsibility of CALHN in that the Executive Manager of State-wide services formally reports to the Chief Executive of CALHN. However, there is a frequent and important relationship with the central Health Department.

There have been improvements made to the governance structures and processes since the last survey however changes continue to be made and variability is still apparent across services.

There were areas for improvement identified at the CALHN (excluding MH) NSQHSS onsite Organisation Wide Survey (OWS) of 19-23 February 2018 in governance, consumer participation, medication management, medical handover, blood management and the deteriorating patient.

However, at the NSQHSS OWS the majority of the NSQHS Standards Actions were assessed as Satisfactorily Met (SM).

A number of Developmental Actions were rated Not Met, and seven Core Actions (1.5.2, 1.6.1, 2.6.1, 4.2.1, 4.12.3, 4.12.4 and 6.3.3 were identified as Not Met; the Core NM actions were reassessed at AC90 Review.

NSQHSS AC Onsite Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Advanced Completion (AC) 90 Review - 30-31 May 2018

The AC 90 review was conducted by two surveyors from the previous survey teams.

The primary aim of the AC 90 Review was to ensure that the NSQHSS Not Met Core Actions had been addressed within the 90-day period for CALHN and for CALHN Mental Health; also concurrently assessed at AC were the Not Met Criteria in the those criteria of National Standards for Mental Health Services (NSMHS) which were not mapped to the NSQHS Standards.

Note: *This AC90 Review Report relates to CALHN excluding Mental Health, which is subject to separate AC90 documentation. Assessment report components should be reviewed in conjunction. Final outcomes will be included in the overall report.*

The surveyors found that extensive work had been undertaken supported by the CALHN Executive in consultation and collaboration with clinicians, health professionals and consumers.

The new structures, systems and policies that have been introduced were closely examined and the survey team was assured that CALHN have the relevant systems in place that not only address the seven Core Not Met Actions but will continue to provide good standards of patient care.

The CALHN Executive demonstrated a willingness and a recognition that quality and safety standards will continue to be assessed to protect the public from harm and to continue to improve the quality of patient care that CALHN is providing.

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

Surveyor Summary

Governance and quality improvement systems

CALHN has been managing significant challenges for a number of years and the organisation has not been helped by the many leadership changes. The current Executive, although relatively new, are providing the stable leadership that will support the organisation going forward. Staff speak positively of the new direction and the supportive environment.

Changes continue to be made to service delivery and facilities. There were many delays to the move to the new hospital which was difficult for staff morale however the move went well and staff state that they are pleased to finally get into the new building. The building provides a pleasant environment for patients, families and staff with single rooms with ensuites for patients and many internal gardens. There are however some, not totally unexpected, impacts from the design and space issues which require workarounds currently and may require some building alterations at some point. There is a high awareness of the issues in the emergency department. And staff are managing although care needs to be taken that workarounds do not become accepted practice. This is particularly so in the triage area of the emergency department where maintaining confidentiality of information is a challenge in the very small triage and waiting area.

A working group with consumers has been formed to address the signage and other information provision issues throughout the building. Volunteers are staffing the foyer and they offer their assistance to patients and families.

The survey team noted a different approach being taken with the planning of the new QEH where a comprehensive clinician and consumer engagement process is beginning to inform the design of the facility.

The relationship with the Private Public Partnership partners is going through a settling in period. The Enterprise Patient Administration System (EPAS) is in place at TQEH and Hampstead Rehabilitation Centre but is yet to be rolled out in full to RAH.

(Additional Note: ACHS has been advised that following the survey a new government was appointed and the implementation of the electronic record has been suspended pending a formal review.)

CALHN also manages State-wide Clinical Support Services (SCSS). This reporting relationship adds a degree of complexity to the management of the services and from a governance perspective is somewhat confusing. All LHNs must have absolute clarity regarding the governance of these services. Though these services are not actually in the hospital management structures they, nevertheless, relate closely to the hospital in which they work; this being particularly so for the pharmacy service.

However, there is an advantage in providing services in this manner; the big advantage being realised particularly by the peripheral health services, is where staff can be provided at relatively short notice to fill gaps. Also, there is a significant advantage in being able to standardise practices for clinical activities across the whole of the State. The disadvantage observed by the surveyors is that there is an additional level of bureaucracy which has the potential to slow down decision-making and the introduction of change. CALHN advises that it is continuing to work through this issue with other LHN's, and that governance of SCSS may change further with the advent of the new state Government in March 2018.

It is suggested that clarity be sought about the responsibilities and accountabilities in regard to clinical governance.

There have in the last two years been a significant number of external and internal reviews which have resulted in numerous recommendations. Many are duplicated or cover a similar theme which results in time consuming effort with minimal progress.

It is within this context that the actions from the Clinical Governance review in 2016 are being implemented. However, given the findings of that review, it is important that the changes required to create a culture of safety and improvement along with clinician and consumer engagement, are made.

The actions arising from the review were also subject to a recommendation at the last survey.

The governance structures and systems continue to slowly evolve. The new clinical governance framework is developed but not yet implemented.

At an Executive level, the monitoring of quality and risk is regular and structured and the survey team noted the improvements in the past year however across CALHN quality processes are variable. Quality and safety committee meetings are convened at directorate level whilst standards committees provide governance over the requirements of those standards. It was noted that not all committees were active and the emphasis appears to be on meeting the requirements of accreditation rather than ongoing improvement.

CALHN is developing a plan for building capability in quality & safety for both its Directorate staff and its quality, safety and risk coordinators.

The quality and safety systems are supported by both SA Health, CALHN Executive and local policies and procedure documents. Those developed by CALHN are controlled and available electronically on eCentral as are guidelines and other documents such as patient information. The organisation is encouraged to continue the task of refining the number and amalgamating similar documents from different services.

Performance indicators are set and monitored by SA Health and the CALHN Governing Council, although surveyors noted that the Governing Council has no formal Governance role. Benchmarking occurs. While the organisation collects data, there are ongoing difficulties with accessing timely and accurate information required to measure compliance and enable service improvements. The problems are known and effort is being made to improve this at a state and local level.

It was noted that the new hospital has nothing on the walls, as per policy, however that means limited data or information for patients is being displayed. Journey Boards have been used in the old hospital and are in place in other hospitals. This is currently under discussion with the PPP.

All staff are advised of their quality and safety responsibilities and locums and agency staff are managed and monitored.

Orientation and training is provided to all staff. The Learning Management System (LMS) is still not able to provide accurate data but workarounds are in place. Mandatory training has not been a priority for some areas during the move and this is evident in the compliance rates.

The SA Health Risk Management Policy is followed by the organisation. Since the last survey an Executive risk management committee is monitoring the risk register which is organisation-wide and at a directorate level. Risks are understood and managed well at the at Executive level. There is also a Risk and Audit committee for CALHN that is advisory to the CEO and reports up to the SA Health Risk and Audit committee. As well as risks arising from the directorates, there is the risk and issues register used for the nRAH project and this will soon be handed over from the project for management by CALHN. There is not yet a clear understanding of what is a risk and what is an issue. A new approach is in place to identify and manage shared risks between CALHN and the Private partners at the RAH.

A new risk consultant has been appointed to CALHN.

The risk treatment and control chart is detailed and shows that there are still ineffective controls in some areas of the business. Whilst these appear to be monitored it was noted that risks that have been addressed (the installation of a generator at St Margaret's for example) have not been closed off or updated to reflect current status.

Overall there has been improvement in many areas however there is still not consistency in the implementation and monitoring of quality and safety systems and processes. Developmental Actions 1.4.2 and Core Actions 1.5.2 and 1.6.1 are rated as Not Met; the core actions rated NM are subject to reassessment at AC90 Review.

Advanced Completion (AC) 90 Review – 30 May 2018

CALHN has further developed processes to support risk management throughout the organisation. The Executive Management Team provides high level governance and closely monitors the risk management system. CALHN has also developed resources to guide staff in relation to risk management. A staff training and education program in risk management is in place.

Risk and issues registers have been established in all directorates/ services/units. Formal processes to escalate risks including to the Executive Management Team are in place. Processes are in place to regularly review risks. At the time of survey Surveyors noted that CALHN had no recorded risks that were overdue for review.

Since the full survey, the MHS ligature audit has been extended service wide and will be conducted annually or as required. Actions related to the risks identified have now been completed.

Surveyors acknowledge the substantial work CALHN has undertaken to strengthen its organisation wide risk management system.

The CALHN Clinical Governance Framework and the CALHN Quality Plan have been distributed throughout the organisation. CALHN is also establishing a series of "Priority Care" committees to replace the current "standards" committees.

CALHN is promoting a culture of patient safety and high-quality patient care via a variety of means. This includes through specific staff training and through discussions at meetings and workshops. Quality improvement actions are included in directorate/service operational plans and support is being provided to implement the clinical governance framework at directorate/service/unit levels.

Surveyors acknowledge the comprehensive approach being taken by the Executive and the wider leadership team in implementing the CALHN clinical governance framework. Surveyors noted that CALHN has actively fostered clinical engagement and a team approach in its efforts.

Actions 1.5.2 and 1.6.1 have been re-rated to Satisfactorily Met.

Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.5.2	SM	SM
1.6.1	SM	SM

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

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

Surveyor Comment:

The risk management systems and processes have evolved over the last year and at an organisation wide level and directorate level the systems appear to work effectively for those risks that are identified and accepted; although review of the register shows some updates are overdue. Accountability and responsibility for risk management is not at the unit level and the surveyors found engagement and knowledge at that level was variable. Some frustration was voiced at not having more control over risk whilst others were content with the directorate structure. The surveyors concern was that some risks are not being identified or if they are then not accepted but still remain a risk at a unit level.

Assessments are carried out by the quality, safety and risk team. The assessments are very detailed and time consuming and can often than not be accepted as a risk at a directorate level.

Other processes are then found to solve the perceived problem e.g. calling it a quality improvement and putting it on the quality register. The risk however may not be resolved or escalated. There is not a clear understanding of what is a risk and what is an issue as both terms are used in the activation of the new RAH.
A risk profiling exercise was due to start at the time of survey. This has not been done for some time and was a recommendation from a SA Health internal audit last year. This is targeting the directorate level.

Advanced Completion (AC) 90 Review – 30 May 2018

CALHN has further developed processes to support risk management throughout the organisation. The Executive Management Team provides high level governance and closely monitors the risk management system.

A CALHN “Risk Management” OWI is in place. CALHN has also developed resources to guide staff in relation to risk management. This includes a series of “On A Page” guidelines such as “Organisational Risk Decision Tree”, “Risk Profile Worksheet”, “Risk Terminology” and “Risk Profiling Process”.

A staff training and education program in risk management is in place. This includes the “Introduction to Risk Management” e learning module. Surveyors noted that there is a good uptake of on line risk management training. The Quality Support Team provides a presentation on risk management at staff orientation.

Risk and issues registers have been established in all directorates/services/units. Risk profiling sessions are also being conducted in each area. Formal processes to escalate risks including to the Executive Management Team are in place. The "Risk Governance and Escalation Flowchart" provides guidance to staff.

Processes are in place to regularly review risks. At the time of survey Surveyors noted that CALHN had no recorded risks that were overdue for review.

A ligature audit had been undertaken by the Mental Health Service (MHS) at the time of full survey. However, at that time the risks identified had not been actioned and therefore remained as risks. Since the full survey, the MHS ligature audit has been extended service wide and will be conducted annually or as required. Actions related to the risks identified have now been completed.

Surveyors acknowledge the substantial work CALHN has undertaken to strengthen its organisation wide risk management system.

This action has been re-rated SM.

Surveyor's Recommendation:

No recommendation

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

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

Surveyor Comment:

The report on the 'Review of the Safety and Quality Systems, Leadership and Functions report' was finalised in December 2016 and a comprehensive action plan was developed to address the issues identified in the review. There has been progress in addressing actions and developing a framework to support clinical governance and develop a culture of safety and improvement in the organisation however, the last year has also been a time of significant change in the organisation with the move to the new hospital, service restructures and new senior leadership becoming established in their roles. This has impacted on the organisation's ability to move forward on a number of initiatives including the implementation of the new clinical governance framework. The move towards a safety and improvement culture requires change in the supporting structure. The quality and safety team will benefit from planned training to increase capability.

"Our commitment to quality" a statement to support delivery of safe and effective care was sent to all staff in September 2017. This sets out expectations in terms of safe quality service provision and clinical

governance and was endorsed by the leaders of the organisation. It does not appear to be widely understood and whilst the structure for safety and quality remains in place at a directorate level the participation of staff across the organisation in quality activities is variable. The directorates are large and complex and the ward or unit level are not always engaged. Mortality and morbidity committee meetings are improving however there is variability across clinical services. These meetings plus Mortality Review and the Incident Review Panel are having protection lifted and this will provide greater transparency. The planned structure will clarify reporting lines and accountabilities.

There is not a clear definition of quality that staff relate too neither is there yet a quality plan.

There were examples of clinical engagement noted by the survey team however this is still very variable.

The quality and safety unit staff do much of the documentation, reporting and monitoring review of the quality register and recommendations register show there are difficulties in meeting reporting requirements. Audits are undertaken although there is variability in follow up and repeat audits to address non-compliance are not always undertaken.

Advanced Completion (AC) 90 - 30 May 2018

The CALHN Clinical Governance Framework and the CALHN Quality Plan have been distributed throughout the organisation. CALHN is also establishing a series of “Priority Care” committees to replace the current “standards” committees. The terms of reference of the Priority Care Committees have been developed and strongly support clinical governance.

CALHN is promoting a culture of patient safety and high-quality patient care via a variety of means. This includes through specific staff training and through discussions at meetings and workshops. There is also a focus on communication regarding clinical governance themes, such as through the safety and quality newsletter and the distribution of the “Our Commitment to Quality” document.

Quality improvement actions are included in directorate/service operational plans and support is being provided to implement the clinical governance framework at directorate/service/unit levels.

Surveyors acknowledge the comprehensive approach being taken by the Executive and the wider leadership team in implementing the CALHN clinical governance framework. Surveyors noted that CALHN has actively fostered clinical engagement and a team approach in its efforts.

The action has been re-rated to SM.

Surveyor's Recommendation:

No recommendation

STANDARD SUMMARY 2: PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

CALHN has strengthened its structures for involvement of consumers and the community in the clinical and organisational governance of the organisation and there has been strong support for these by senior organisational Executives. These structures provide the foundation for a well-connected system for CALHN with its Consumer Advisory Council and its representative membership from across the various CALHN services and special interest groups. The linkage between the Consumer Advisory Council and the CALHN Governing Council has also been improved with the Chair of the Consumer Advisory Council being a member of the Governing Council. The 2017 appointment of a Consumer Manager is also acknowledged as an enabler for the organisation.

In the capital development of the new RAH there has been a very significant inclusion of a culturally appropriate space for Aboriginal people within its design. There is also strong work undertaken in Aboriginal and Migrant Health Services through the Intermediate Care and the SA Prison Health Service. There is however recognition that the consumer, carer and community participation in CALHN needs to be more inclusive of all communities served, especially in relation to vulnerable groups.

In early 2018, CALHN supported wide participation of its consumers, carers and volunteers in the organisation's strategic planning workshop and participants have expressed an expectation that their involvements were valued by CALHN and that is will continue.

CALHN has recognised the need to strengthen its consumer partnership in service planning and has entered into an agreement with the Health Consumers Alliance of South Australia in developing the CALHN Consumer and Carer Engagement Strategy that will be implemented in 2018-19.

The Developmental Actions 2.1.2, 2.2.2, 2.5.1, 2.6.2, 2.8.1 and 2.8.2 are rated NM; Core Action 2.6.1 rated NM will be reassessed at AC90.

<u>Advanced Completion (AC) 90 Review – 30 May 2018</u>

CALHN has developed a comprehensive approach to the training of staff and the promotion of a culture of patient and family centred care. An overarching CALHN “Person Centred Care: Training and Practice Change” Strategy and a related Patient Centred Care Training Action Plan have been developed.

A key initiative relates to the rollout of the “Best Practice Spotlight Organisation” Person and Family Centred Care module across all of CALHN’s sites. In addition, CALHN has signed an agreement with Health Consumers Alliance SA to develop a CALHN consumer and community engagement strategy. A further initiative relates to the promotion of the SA Health e learning module “Partnering with Consumers and Community” to CALHN staff. Surveyors noted that there has already been strong staff uptake of the training module.

CALHN is also increasing the use of patient stories and the involvement of consumers in patient and family centred care training for staff.

Action 2.6.1 has been re-rated to Satisfactorily Met.

Consumer partnership in designing care

Ratings

Action	Organisation	Surveyor
2.6.1	SM	SM

Action 2.6.1 Core
Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care

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

Surveyor Comment:

There are SA Health guiding resources to lead this practice including the: Framework for Active Partnership with Consumers and the Community; Partnering with Carers Policy Directive; and the Guide for Engaging with Consumers and the Community.

There is also a training program available on Partnering with Consumers and Community but little evidence of pickup of this training or of how the organisation is implementing the SA Health strategies.

There was an example of local training in patient-centred care being given to clinical leaders, senior managers and the workforce at Hampstead Rehabilitation Hospital and discussion that this training might be rolled out at TQEH in 2018 but no firm plans at this time.

There was no other evidence on a CALHN approach for clinical leaders, senior managers and the workforce being supported to facilitate consumer engagement and maintain ongoing partnerships with them.

It is not evident therefore that the developed SA Health approach to patient-centred care is being implemented across CALHN as the examples of such practice were only observed in parts of the organisation.

Advanced Completion (AC) 90 Review – 30 May 2018

CALHN has developed a comprehensive organisation wide approach to the training of staff and the promotion of a culture of patient and family centred care.

An overarching CALHN "Person Centred Care: Training and Practice Change" Strategy and a related Patient Centred Care Training Action Plan have been developed. The strategy and action plan describe a variety of initiatives to deliver patient and family centred care training to CALHN staff.

A key initiative relates to the rollout of the "Best Practice Spotlight Organisation" Person and Family Centred Care module across all of CALHN's sites. This is being managed by a steering committee and an implementation plan has been developed.

In addition, CALHN has signed an agreement with Health Consumers Alliance SA to develop a CALHN consumer and community engagement strategy. A project officer has commenced and is being supported by the “Making Care Better Group”.

A further initiative relates to the promotion of the SA Health e learning module “Partnering with Consumers and Community” to CALHN staff. Surveyors noted that there has already been strong staff uptake of the training module.

CALHN is introducing a “Hello My Name Is” program and is also increasing the use of patient stories and the involvement of consumers in patient and family centred care training for staff.

The action has been re-rated to SM.

Surveyor's Recommendation:

No recommendation

STANDARD SUMMARY 4: MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

The medication management processes across CALHN are complex and varied. For example, The Queen Elizabeth Hospital is using an electronic prescribing system (EPAS) and a manual supply and dispensing system. On the other hand, the Royal Adelaide Hospital has a highly automated supply system but are still using manual paper-based prescribing. The Mental Health Service and Prison Health Service are essentially “manual”. Furthermore, significant changes are planned for the Royal Adelaide Hospital should EPAS be introduced.

(Additional Note: ACHS has been advised that following the survey a new government was appointed and the implementation of the electronic record has been suspended pending a formal review.)

The CALHN pharmacy service and medication management system is one of the components of the State-wide services. Thus, a number of the policies governing the service are centrally mandated and governed. Nevertheless, CALHN, and the individual hospitals within the local health network, at a functional level, are more or less independent.

A Medication Governance Framework for CALHN has been prepared and was reviewed by the surveyors in its draft form. It is a well-written document and appears to deal with all aspects of medication management. It is now important that this framework is escalated through the various management committees, is signed off and adopted.

Unfortunately, there has been no formal assessment of the medication management system since 2013.

Even though there is a lack of a formal service-wide assessment there is ample evidence that there have been individual, focused assessments on various aspects of the medication management systems and as a result of these assessments changes to practices have occurred. As an example, there have been increased, robust requirements placed around the prescribing and administration of chemotherapy agents.

Pharmacists, medical officers and nursing staff are all required, on appointment, to undergo orientation into medication management. Nurses have regular competency requirements and pharmacists are required to demonstrate continuing professional development for their regular annual registration. There are specific competencies for those clinical staff working in high-risk areas such as chemotherapy units. Furthermore, there are rigid requirements for all staff in these high-risk areas to follow strict protocols which, in the main, result in double checking of all prescribing and administration of chemotherapeutic agents.

As mentioned in the overview there have been significant changes in the hospitals that make up the CALHN over the past three or four years. This has required significant up-skilling of all clinical staff earning to use electronic prescribing and to use the ward dispensing systems now in place at the Royal Adelaide Hospital. It is also noted that in both the iPharmacy system and in EPAS there are mechanisms to recognise fraudulent prescribing thus increasing the integrity of the process and making it especially difficult for illegal use of medications.

A number of incident reports were reviewed, one of which resulted in an RCA, and noted that the process followed accepted standards and the recommendations arising from the reports have been implemented in a timely fashion. It is noted that all staff have mandatory training in the SLS incident reporting system and viewed data which suggests that the system is being used well and appropriately.

Core Action 4.2.1 is rated NM and is subject to review at AC90.

Advanced Completion (AC) 90 Review – 30 May 2018

CALHN has completed Medication Safety Self Assessments (MSSA) for its inpatient services using the NSW Clinical Excellence Commission MSSA tool. Multidisciplinary teams undertook the self-assessments. Actions identified have been risk rated and documented in action plans. Action plans are being monitored through the CALHN medication safety governance structures.

Continuity of medication management

The surveyors observed frequent examples of a comprehensive list of medications being available at in-house clinical handovers. At the RAH this was largely achieved through reference to the medication charts located immediately outside patients' rooms. At TQEH the medication chart is accessible via EPAS on mobile computers.

Unfortunately, the transfer of a comprehensive medication list to community clinicians is not well-managed – this reflects the relatively poor performance with completion of patient discharge summaries in a timely fashion. However, there will be recommendation under this standard aimed at addressing the provision of detailed medication information – at least as an interim arrangement until the completion of discharge summaries is significantly improved.

It is expected that discharge summaries will include a list of medications to be continued in the community. General practitioners may ask for a list of these medications to be provided. It is further noted that wherever possible, patients on discharge are given a comprehensive and up-to-date listing of their current medications. This list also records changes in the medication that may have occurred while in hospital. It was suggested that this list should, at the top, have a statement in bold type, recommending that the patient takes this list when next they have to visit the general practitioner. This is seen as a stopgap measure but will go some way to address this shortcoming.

The Core Actions 4.12.3 and 4.12.4 are rated NM, to be reassessed at AC90 Review.

Advanced Completion (AC) 90 Review – 30 May 2018

CALHN has reviewed organisation wide medical discharge summary processes with the assistance of a multidisciplinary working party. The working party included acute and mental health representatives. Liaison with senior and junior medical staff has also occurred. The review included the provision of discharge medication information which is a key component of the overall medical discharge summary.

The most recent audit indicated that 85% of medical discharge summaries across CALHN were completed and distributed within 48 hours of discharge. The discharge summaries include discharge medication information. Ongoing audits are scheduled.

Surveyors noted that as result of a detailed review of its discharge medication information processes, CALHN identified an issue related to OACIS software medication information content. CALHN is liaising with key stakeholders regarding a potential resolution of this matter. In the meantime, pharmacists and medical officers are closely monitoring the discharge medication information accessed from OACIS to ensure its accuracy.

Actions 4.2.1, 4.12.3 and 4.12.4 have been re-rated Satisfactorily Met.

Governance and systems for medication safety

Ratings

Action	Organisation	Surveyor
4.2.1	SM	SM

Action 4.2.1 Core
The medication management system is regularly assessed

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

Surveyor Comment:

A regular comprehensive review of medication management using a recognised tool is an essential component of risk management. The organisation last undertook such a review in 2013 – five years ago.

Much has changed in this time which may well have had an effect on the medication management system.

It is recognised that specific assessments have taken place over this period but these, in the main, have been focused assessments resulting from a reported incident or recognised problem. The intention of this criterion is to ensure that assessments are carried out in order to detect potential service shortcomings and correct them before an incident occurs.

These reviews are time-consuming but are necessary. Furthermore, in a time of change such structures, assessments are probably even more important. Though the National Standards did not stipulate how frequently such an assessment should take place it is generally accepted that a review every three years is appropriate.

Advanced Completion (AC) 90 Review – 30 May 2018

CALHN has completed Medication Safety Self Assessments (MSSA) for its inpatient services using the NSW Clinical Excellence Commission MSSA tool. Multidisciplinary teams undertook the self-assessments. Actions identified have been risk rated and documented in action plans. Action plans are being monitored through the CALHN medication safety governance structures.

The action has been re-rated to SM.

Surveyor's Recommendation:

No recommendation

Continuity of medication management

Ratings

Action	Organisation	Surveyor
4.12.3	SM	SM
4.12.4	SM	SM

Action 4.12.3 Core
A current comprehensive list of medicines is provided to the receiving clinician during clinical handover

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

Surveyor Comment:

The clinical pharmacists in each service unit ensure wherever possible, that patients on discharge are given a comprehensive and up-to-date listing of their medications. This list also records changes in the medication that may have occurred while in hospital. Upon request, additional copies can be printed for subsequent health care providers.

The patient's list can be made available to the patient's receiving clinician – but only on request from the clinician. Thus, this particular criterion is not met as there was no evidence to show that this important information is made available. Satisfactory compliance with this criterion is closely related to improvement in the completion of discharge summaries.

Advanced Completion (AC) 90 Review – 30 May 2018

CALHN has reviewed organisation wide medical discharge summary processes with the assistance of a multidisciplinary working party. The working party included acute and mental health representatives. Liaison with senior and junior medical staff has also occurred. The review included the provision of discharge medication information which is a key component of the overall medical discharge summary.

The most recent audit indicated that 85% of medical discharge summaries across CALHN were completed and distributed within 48 hours of discharge. The discharge summaries include discharge medication information. Ongoing audits are scheduled.

Surveyors noted that as result of a detailed review of its discharge medication information processes, CALHN identified an issue related to OACIS software medication information content. CALHN is liaising with key stakeholders regarding a potential resolution of this matter. In the meantime, pharmacists and medical officers are closely monitoring the discharge medication information accessed from OACIS to ensure its accuracy.

The action has been re-rated to SM. This action links with actions 4.12.4 and 6.3.3.

Surveyor's Recommendation:

No recommendation

Action 4.12.4 Core
Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover

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

Surveyor Comment:

This recommendation is a rider to the previous recommendation. As part of the plan to address 4.12.3 it is recommended that robust monitoring processes are established to ensure sustainability.

Advanced Completion (AC) 90 Review – 30 May 2018

CALHN has reviewed organisation wide medical discharge summary processes with the assistance of a multidisciplinary working party. The working party included acute and mental health representatives. Liaison with senior and junior medical staff has also occurred. The review included the provision of discharge medication information which is a key component of the overall medical discharge summary.

The most recent audit indicated that 85% of medical discharge summaries across CALHN were completed and distributed within 48 hours of discharge. The discharge summaries include discharge medication information. Ongoing audits are scheduled.

The action has been re-rated to SM. This action links with actions 4.12.3 and 6.3.3.

Surveyor's Recommendation:

No recommendation

STANDARD SUMMARY 6: CLINICAL HANDOVER

Surveyor Summary

Clinical handover processes

The surveyors observed several CALHN clinical handover events, including nursing bedside handovers and Emergency Department and Intensive Care Unit clinical handovers.

The multidisciplinary Emergency Department and Intensive Care Unit clinical handovers were noted to be thorough and well-constructed using ISBAR principles. Clinicians commented that feedback regarding their experiences with clinical handover is sought, supporting the evolution of clinical handover processes to maximise their effectiveness.

The surveyors observed that nursing bedside handovers have some inconsistency in the way they are conducted, most notably in relation to active patient identification. These surveyor observations are consistent with findings in CALHN annual clinical handover audits. The clinical handover audits indicate that whilst several bedside handover parameters are showing positive trends and are at reasonably high compliance levels, patient identification remains an area needing further attention. CALHN is encouraged to continue the focus on ensuring active patient identification is consistently undertaken at bedside nursing handover, as described the “Handover: Nursing Shift to Shift - Bedside” OWI. The clinical handover portfolio nurses may be a valuable resource to support this undertaking. Surveyors also suggest that it may be useful to implement bedside handover audits more frequently than the current annual audits to ensure that improvements occur and are maintained. Surveyors noted that the current annual audit tool does not include feedback from patients/carers regarding their experiences with clinical handover.

The surveyors noted that brief daily or twice daily multidisciplinary huddles have been widely introduced across inpatient clinical areas. The Intermediate Care Service also routinely uses multidisciplinary huddles. Surveyors received very positive feedback from many clinicians regarding the effectiveness of the brief multidisciplinary huddles, particularly as a communication tool. CALHN is acknowledged for this valuable initiative.

As noted above, Interns are advised of the expectations of their directorates/clinical specialities with regards to medical discharge summaries at the commencement of their rotations. Surveyors received feedback that Interns receive varying and sometimes conflicting advice from consultants and registrars regarding discharge summaries. Some registrars and consultants emphasise the importance of medical discharge summaries and others reportedly show less concern and interest. Whilst CALHN OWIs state “The discharge summary is a concise summary of the patient’s episode of care in hospital”, in some units a high level of detail is expected to fulfil additional audit and research imperatives. In addition, Interns reported that often on commencement of a new rotation there are large numbers of discharge summaries to be completed on patients cared for by the previous Interns. Surveyors suggest that CALHN develop a more consistent organisational wide approach to requirements surrounding medical discharge summary content and that these requirements, along with general expectations regarding medical discharge summaries, be outlined to medical staff as part of their organisational orientation.

The surveyors noted that, although variable across sites, there are significant delays in medical discharge summaries in some clinical disciplines being completed and provided to appropriate health care providers. A recommendation has therefore been made in action 6.3.3 in relation to the timely completion of medical discharge summaries.

Currently, medical discharge summaries are being produced either in EPAS or OACIS software depending on the site. Surveyors were advised that discharge summaries are generally faxed to general practitioners due to lack of encryption and problems in interfacing with clinical software used by general practitioners.

The surveyors noted that CALHN identified a risk associated with delays in transcription and distribution of discharge/treatment update letters from outpatient clinics to general practitioners. Surveyors further noted that an improvement project was instituted to address this matter and that ongoing improvements have resulted.

Whilst local processes for clinical handover are reviewed in collaboration with clinical staff, surveyors could not find evidence that there is also collaboration with patients and carers. A recommendation in developmental action 6.3.2 has been made in regard to this matter. Surveyors noted that the terms of reference of the Clinical Handover Standard Committee include a consumer representative in its membership. Currently however no consumer representative has been appointed to the Committee.

The Clinical Handover Standard Committee monitors and reviews incidents related to clinical handover. No SACS one incidents were noted in the documentation provided.

Developmental Action 6.3.2 is Not Met; Core Action 6.3.3 is rated NM and subject to review at AC90.

Advanced Completion (AC) 90 Review – 30 May 2018

CALHN has reviewed medical discharge summary processes with the assistance of a multidisciplinary working party. The working party included acute and mental health representatives. Liaison with senior and junior medical staff also occurred.

The CALHN "Discharge Summaries – Separation Summaries" OWI has been reviewed and amended to better reflect current expectations in relation to medical discharge summaries. Education for medical officers has also been provided.

The most recent audit indicated that 85% of medical discharge summaries across CALHN were completed and distributed within 48 hours of discharge. Ongoing audits are scheduled.

Surveyors noted that as result of a detailed review of its medical discharge summary processes, CALHN identified issues that remain under consideration. Surveyors acknowledge that the identified issues are not within the direct control of CALHN. Surveyors support CALHN in its ongoing liaison with key partner organisations regarding these matters.

Action 6.3.3 has been re-rated to Satisfactorily Met.

Clinical handover processes

Ratings

Action	Organisation	Surveyor
6.3.3	SM	SM

Action 6.3.3 Core
Action is taken to increase the effectiveness of clinical handover

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

Surveyor Comment:

The surveyors noted that, whilst variable across sites and clinical disciplines, audits indicate that there are frequent occasions where there are delays in medical discharge summaries being completed and provided to appropriate health care providers. Interns and General Practitioner Liaison provided feedback consistent with the audit results. The most recent (January 2018) RAH audit results provided to surveyors reveal an overall positive result in relation to timeliness where a medical discharge summary has been generated for the separation. The most recent TQEH audit data provided to surveyors however shows inconsistency and at times poor compliance with medical discharge summary completion timeliness. This recommendation relates to ensuring consistency across sites and clinical disciplines in meeting medical discharge summary completion timelines in accordance with CALHN OWIs.

Advanced Completion (AC) 90 Review – 30 May 2018

CALHN has reviewed medical discharge summary processes with the assistance of a multidisciplinary working party. The working party included acute and mental health representatives. Liaison with senior and junior medical staff also occurred.

The CALHN "Discharge Summaries – Separation Summaries" OWI has been reviewed and amended to better reflect current expectations in relation to medical discharge summaries. Education for medical officers has also been provided.

The most recent audit indicated that 85% of medical discharge summaries across CALHN were completed and distributed within 48 hours of discharge. Ongoing audits are scheduled.

Surveyors noted that as result of a detailed review of its medical discharge summary processes, CALHN identified issues that remain under consideration. This includes different software being used in different sites and also software interface issues. In addition, General Practitioners are still receiving medical discharge summaries by fax. These matters do not prevent CALHN from providing timely medical discharge summaries. However, it does create inefficiencies in the production, distribution, monitoring and auditing of medical discharge summaries. Surveyors acknowledge that the identified issues are not within the direct control of CALHN. Surveyors support CALHN in its ongoing liaison with key partner organisations regarding these matters.

The action has been re-rated to SM. This action links with actions 4.12.3 and 4.12.4.

Surveyor's Recommendation:

No recommendation

The Australian Council on Healthcare Standards

2018 AC90 REPORT

Central Adelaide Local Health Network Mental Health In-Depth Review (MHIDR)

Excluding CALHN 'main survey' (see separate document)

This AC90 report contains relevant parts of the original 19-23 February 2018 Survey Report plus commentary following the AC90 Review on 30-31 May 2018

Mental Health IDR AC Onsite Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

SURVEY OVERVIEW

The Central Adelaide Local Health Network (CALHN) Mental Health Directorate (MHD) is governed by clinical policies and guidelines to establish best practice approaches across SA Health MHD and assist and support MHS clinicians in determining the appropriate health care for MHD consumers.

The clinical policy directives are mandatory requirements that are implemented across SA Health as operational practice whether short term or permanent and must be complied with no scope to deviate from the specifications within the clinical policy directives.

A clinical guideline however has flexible requirements and implementation and may be developmental or staged according to the MHD. The Clinical State-wide networks have been replaced by Transforming Health Clinical Advisory groups of which the Mental Health Clinical Network is one.

At the time of the NSQHSS Organisation-Wide Survey the MHD were operating within a difficult environment in a number of areas and caring for consumers/patients in a less than therapeutic environment. This was due to the breakdown of the duress system caused by a wiring fault resulting in the duress system not accurately relaying the location when staff are calling for assistance. Until the duress system is fully operational a security presence will remain to manage any potential risk to both patients and staff in designated areas.

The move to the Royal Adelaide Hospital (RAH) had in place a robust set of logistical, operational and strategic plans but unforeseen problems were recognised as having the possibility of occurring. A Rapid Incident Review and Response Function was in place during the period of the move using a "real time" system of analysing incidents enabling prompt action and allowing information from the Executive to be shared with the MHD in a timely fashion.

Many positive initiatives for 2018 are planned or are in place these include the patient Sexual Safety project, the proposed Connecting with People Program focused on capacity development in the general community and Interventions for Suicide Management. The development of Short Stay Units (SSU) in both the RAH and The Queen Elizabeth Hospital (TQEH) to manage the transition between the Emergency Departments and bed availability will soon be operational.

A new level of staff in the MHD Inpatient Units named the "Chaperones" has commenced to assist patients with activities of daily living and the introduction of an Infection Prevention and Control Link nurse is soon to commence.

A Strategic Mental Health Quality Improvement Indicator report provides Safety and Quality data including: New Treatment Orders, Restraint and Seclusion, ECT Treatments Challenging Behaviours, Self-Harm and Morbidity.

At the OWS the majority of the NSQHS Standards Actions were assessed as Satisfactorily Met (SM). Twenty-three (23) Actions in Standard 7 were rated Not Applicable. Action 2.2.2 was awarded an MM rating. Eight Developmental Actions were rated Not Met, and seven Core Actions (1.2.2, 1.5.2, 4.2.1, 4.6.1, 4.12.3, 4.12.4 and 6.3.3) were identified as Not Met; the Core NM actions will be reassessed at AC90 Review.

Mental Health IDR AC Onsite Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Advanced Completion (AC) 90 Review - 30-31/05/2018

The Central Adelaide Local Health Network (CALHN) Mental Health Service (MHS) have actioned all the Not Met seven Core Actions with strong evidence available to the survey team of the processes now in place by the MHS.

The primary aim of the AC90 Review was to ensure that the NSQHSS Not Met Core Actions had been addressed within the 90-day period for CALHN and for CALHN Mental Health; also, concurrently assessed at AC were the Not Met Criteria in those criteria of National Standards for Mental Health Services (NSMHS) which were not mapped to the NSQHS Standards.

Note: *This AC90 Review Report relates to CALHN Mental Health. Assessment report components should be reviewed in conjunction. Final outcomes will be included in the overall report.*

The seven Core Actions 1.2.2, 1.5.2, 4.2.1, 4.6.1, 4.12.3, 4.12.4 and 6.3.3 have all now been Satisfactorily Met.

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

Surveyor Summary

Governance and quality improvement systems

The CALHN MHD has in place a comprehensive Annual Audit Schedule 2017-2018 with a number of related audits identified against both the NSQHS and NSMHS criteria. Included are the ECT Consumer Satisfaction audits per ECT Suite, MHD Triage, Nursing Shift Handover and the Sexual Safety audit.

A seven-day Post Discharge Follow Up audit (this was the first audit conducted on seven-day follow-up in the CALHN MHD) and with some wards/units not meeting the state target rate of 60%; this is subject to a current recommendation.

The MHD workforce are aware of their delegated safety and quality roles and responsibilities with orientation education and training providing staff with the skills and information required to fulfil their roles. Annual mandatory training programs are conducted with the evidence available in the Mandatory Training and Performance Review and Development Compliance report demonstrating current compliance at 91% - February 2018.

Performance Review and Development demonstrated an overall result of all disciplines of 95%.

Advanced Completion (AC) 90 Review - 31 May 2018

Modifications have been made to the two Emergency Department (ED) seclusion rooms doors. There has been a visit by the Office of the Chief Psychiatrist (SA Health) who advised that a further modification be implemented to ensure that the PA system announcements cannot be heard in these rooms preventing a further stimulus this will be addressed. All incidents on restraint/seclusion in the ED department are to be recorded in the incident reporting system SLS and education on restraint/seclusion has been provided to the ED staff of both the Queen Elizabeth and Royal Adelaide Hospitals (power point presentation).

Continuous observation forms are now in place implemented on the 9th of May 2018 and the Mental Health Directorate Site Specific Instruction - MH Restraint has been updated.

Actions related to the previous risks identified have been completed. The CALHN ligature audit has now been extended service wide and will be conducted annually or as required.
Formal processes to escalate risk to the Executive Management Team (EMT) are now in place with a Risk Governance and Escalation flowchart introduced providing guidance to clinicians.

CALHN MHS patients now demonstrate a higher rate than the minimum state-wide Post Discharge Follow Up (PDFU) target of 60%.

The CALHN MHS PDFU audit May 2018 is now 88%. PDFU instructions -Transfer of Care (ToC) from Inpatient Services Follow Up: Seven (7) Days After has been revised. Nursing leads from each ward/unit are now identified to follow up each discharge on a weekly basis. 7 Day PDFU Eastern and Western weekly meetings have commenced.

Actions 1.2.2 and 1.5.2 have been re-rated Satisfactorily Met.

Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.2.2	SM	SM
1.5.2	SM	SM

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

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

Surveyor Comment:

The MH survey team observed a patient who was in what constitutes seclusion at the RAH. This was defined by confinement in the authorised hospital by the locked door of one of the two seclusion rooms constitutes a physical barrier preventing the patient from leaving. Discussion was held with the MH clinician and evidence was not able to be provided that the criteria applied was in accordance with an oral or written seclusion order but rather to manage the patient until a bed could be found. Two security guards were outside each of the two seclusion rooms. The second room also had a patient in it, but the door was ajar also with a second security guard sitting inside.

Advanced Completion (AC) 90 Review – 31 May 2018

Modifications have been made to the two Emergency Department (ED) seclusion rooms doors. They can now default to automatic locking if required. There has been a visit by the Office of the Chief Psychiatrist who advised that a further modification be implemented to ensure that the PA system announcements cannot be heard in these rooms preventing a further stimulus this will be addressed. All incidents on restraint/seclusion in the ED department are to be recorded in the incident reporting system SLS and education on restraint/seclusion has been provided to the ED staff of both the Queen Elizabeth and Royal Adelaide Hospitals (power point presentation). Continuous observation forms are now in place implemented on the 9th of May 2018 and the Mental Health Directorate Site Specific Instruction - MH Restraint has been updated.

Surveyor's Recommendation:

No recommendation

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

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

Surveyor Comment:

The MHD has undertaken ligature audits but were unable to provide evidence to demonstrate which recommendations from these audits had been completed. The MHD were also unable to provide satisfactory evidence that the seven-day follow-up of all MH discharged in-patients occurs, although some areas verbally described to the survey team that it does occur.

Advanced Completion (AC 90) 31 May 2018

Actions related to the previous risks identified have been completed. The CALHN ligature audit has now been extended service wide and will be conducted annually or as required.
Formal processes to escalate risk to the Executive Management Team (EMT) are now in place with a Risk Governance and Escalation flowchart introduced providing guidance to clinicians.

The seven-day follow-up of patients post discharge (PDFU). CALHN MHS patients can now demonstrate a higher rate than the minimum state wide PDFU target of 60%.

The CALHN MHS PDFU audit May 2018 is now 88%. PDFU instructions -Transfer of Care (ToC) from Inpatient Services Follow Up: Seven (7) Days After has been revised. Nursing leads from each ward/unit are now identified to follow up each discharge on a weekly basis. 7 Day PDFU Eastern and Western weekly meetings have commenced.

Surveyor's Recommendation:

No recommendation

STANDARD SUMMARY 4: MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

The LHN has three main committees to manage medication safety and quality. Drug and Therapeutics, the Medication Safety and Antimicrobial Stewardship Committees. These peak committees are supported by directorate specific committees with more local responsibility. There is an overarching framework supporting this structure. Minutes provided to the surveyors supported the ToR for these committees. Many improvement activities have been completed and are tracked within the framework. The CALHN medication safety plan demonstrates that a range of reviews and audits have been undertaken to assess some aspects of medication safety systems. The MHS relates to the CALHN structures and is in the process of redeveloping a comprehensive governance structure across MH sites to support medication safety.

As well as conducting NIMC audits, cold chain storage audits, clozapine monitoring audits, clinicians were able to describe immediate responses to MHS medication incidents that were subsequently supported by more robust structured reviews of those incidents. Evidence was provided of monitoring and actions taken to reduce medication related adverse events and incidents.

The surveyors noted the improvement activities that have been undertaken around medication management that were driven by the governance system. These include clozapine training and the development of improved LAI injection techniques to improve IM specific injection rates rather than adipose tissue injections.

The service has recently improved the specific training before doctors are approved for clozapine prescribing. Otherwise the MHS conforms to local and national requirements for medication authorisation.

Bulletins from SAH and the Office of the Chief Psychiatrist (OCP) identify medication safety themes from the state perspective that are disseminated to clinical staff.

Core action 4.2.1 was assessed as Not Met. The specific safety issues and gaps in the community services are of concern within the community i.e. the MHS service is not routinely aware of medication safety system issues within the community services. The service acknowledged that they had not reviewed completion or evaluation from the last Medication Safety Self-Assessments® (MSSA) which was a long time prior. Within the community services the teams spoke of a range of difficulties they were aware of with medication safety. Ranging from imprest stock review, prescription and dispensing issues, lack of pharmacy support, reconciliation, difficulties ensuring clarity re which service primary versus MHS were prescribing etc. The surveyors looked for evidence that the community needs had been considered and the audits and reviews were missing a broad community focus apart from some very robust specific foci for e.g. clozapine which was very good indeed. The surveyors concluded that the service needed to conduct a repeat MSSA or equivalent, that they needed to look at medication safety needs broadly, and include the community services within this broad consideration. It was understood that the MSSA was not a community tool. The MHS must complete an MSSA of the MHS and whilst considering the community MHS adopt any aspects of the MSSA or other appropriate structured tool to support a broad medication safety system assessment of the community MHS. The resultant action plans should be developed, implemented and reviewed in a timely fashion and then evaluated within the three-year cycle.

Advanced Completion (AC) 90 Review – 31 May 2018

CALHN has completed Medication Safety Self Assessments (MSSA) for its inpatient services, including mental health, using the NSW Clinical Excellence Commission MSSA tool.

Multidisciplinary teams undertook the self-assessments. Actions identified have been risk rated and documented in action plans. Action plans are being monitored through the CALHN medication safety governance structures. Surveyors noted that CALHN Pharmacy staff developed a specific MSSA tool to undertake the mental health community service self-assessment. This involved Pharmacy staff adapting and enhancing the Women's and Children's Hospital community MSSA tool to ensure its applicability to the community mental health setting. Pharmacy staff are acknowledged for their efforts.

Documentation of patient information

Documentation of medication history, reconciliation of medications, allergies and adverse drug reactions within the inpatient files for the MHS is very good. Reconciliation occurs at a high rate within 24 hours of admission and on discharge. The MHS has demonstrated a number of improvements to reduce the risk of adverse medication incidents. Within the community services it is accepted that there is a low completion rate of the Community Based Information System (CBIS) 180-day medication review. A major effort was made last year to boost completion of medication records in the community but it was not supported by an ongoing system and the rates of completion have now dropped. The lack of a robust system to maintain medication history documentation means that on admission and transfer the system relies on patient self-report supplemented by the best possible clinical documentation available. The surveyors have made a recommendation that the MHS improve its documentation of a best possible medication history systems for the community services which they believe will also improve the medication history being available at the point of care.

Advanced Completion (AC) 90 Review – 31 May 2018

The Clinical Director of the Mental Health Directorate has reinforced the need for medical staff to complete a best possible medication history for all patients. The Clinical Director has also introduced "quarantined' time for medical staff to facilitate compliance. Weekly monitoring has been established and considerable improvements are evident.

CALHN has approved a new Clinical Pharmacist position to support the community mental health team. The position has recently been filled. CALHN is also working with the Office of Chief Psychiatrist regarding potential enhancements to the functionality of the CBIS medrecs software. Surveyors support this initiative.

Continuity of medication management

Within the hospital based services that have on site pharmacists, patients and carers on discharge are provided with a list of medications and an opportunity to receive counselling regarding the prescribed medication. The surveyors note that the service has a 48-hour discharge summary completion rate of 34%. The implications of this for the medication continuity standard is that there is a low rate of provision of a comprehensive medication plan for patients who are being managed within the private system or by primary care.

Mental Health IDR AC Onsite Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Advanced Completion (AC) 90 Review – 31 May 2018

CALHN has reviewed organisation wide medical discharge summary processes with the assistance of a multidisciplinary working party. The working party included acute and mental health representatives. Liaison with senior and junior medical staff has also occurred. The review included the provision of discharge medication information which is a key component of the overall medical discharge summary. The Clinical Director of the Mental Health Directorate has issued a communique to medical staff reiterating the importance of medical discharge summaries, and has also introduced a process in which interim hard copy discharge summaries are provided on discharge from mental health inpatient units. Audits have demonstrated a substantial increase in the proportion of medical discharge summaries being completed and distributed within 48 hours of patient discharge from a mental health unit. The discharge summaries include discharge medication information. Ongoing audits are scheduled.

Actions 4.2.1, 4.6.1, 4.12.3 and 4.12.4 have been re-rated to Satisfactorily Met.

Governance and systems for medication safety

Ratings

Action	Organisation	Surveyor
4.2.1	SM	SM

Action 4.2.1 Core
The medication management system is regularly assessed

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

Surveyor Comment:

The surveyors noted that the MSSAs have not been reviewed or repeated since the last survey in 2013. The usual frequency of completion would be every three years. The service has identified that it has not yet reviewed completion of all the action items from the previous MSSA. The MHS has informally identified significant gaps in medication safety systems within the community mental health teams. The audits that have been conducted across MH regarding the management of the medication safety systems do not provide sufficient coverage to allow confidence that the MHS has systems in place to ensure the medication management system is safe. The MHS must complete an MSSA with associated action plans of the whole of the MHS including community sites as soon as possible.

Advanced Completion (AC) 90 Review – 31 May 2018

CALHN has completed Medication Safety Self Assessments (MSSA) for its inpatient services, including mental health, using the NSW Clinical Excellence Commission MSSA tool. Multidisciplinary teams undertook the self-assessments. Actions identified have been risk rated and documented in action plans. Action plans are being monitored through the CALHN medication safety governance structures.

Surveyors noted that CALHN Pharmacy staff developed a specific MSSA tool to undertake the mental health community service self-assessment. This involved Pharmacy staff adapting and enhancing the Women’s and Children’s Hospital community MSSA tool to ensure its applicability to the community mental health setting. Pharmacy staff are acknowledged for their efforts.

The action has been re-rated to SM.

Surveyor's Recommendation:

No recommendation

Documentation of patient information

Ratings

Action	Organisation	Surveyor
4.6.1	SM	SM

Action 4.6.1 Core
A best possible medication history is documented for each patient

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

Surveyor Comment:

Evidence was provided by CALHN MHS that community completion of medication history within the CBIS reviewed every 180 days was very low and had been low for some time. Within the narrative of the community notes it was unclear where one could routinely find the best possible medication history.

Advanced Completion (AC) 90 Review – 31 May 2018

The Clinical Director of the Mental Health Directorate has reinforced the need for medical staff to complete a best possible medication history for all patients. The Clinical Director has also introduced “quarantined’ time for medical staff to facilitate compliance. Weekly monitoring has been established and considerable improvements are evident.

CALHN has approved a new Clinical Pharmacist position to support the community mental health team. The position has recently been filled.

CALHN is also working with the Office of Chief Psychiatrist regarding potential enhancements to the functionality of the CBIS medrecs software. Surveyors support this initiative.

The action has been re-rated to SM.

Surveyor's Recommendation:

No recommendation

Continuity of medication management

Ratings

Action	Organisation	Surveyor
4.12.3	SM	SM
4.12.4	SM	SM

Action 4.12.3 Core
A current comprehensive list of medicines is provided to the receiving clinician during clinical handover

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

Surveyor Comment:

The surveyors noted that the discharge summary completion rate within 48 hours lies at 34%. The discharge summary is the main communication tool for medication management to primary care and secondary tier community mental health service providers.

Advanced Completion (AC) 90 Review – 31 May 2018

CALHN has reviewed organisation wide medical discharge summary processes with the assistance of a multidisciplinary working party. The working party included acute and mental health representatives. Liaison with senior and junior medical staff has also occurred. The review included the provision of discharge medication information which is a key component of the overall medical discharge summary.

The Clinical Director of the Mental Health Directorate issued a communique to medical staff reiterating the importance of medical discharge summaries. The Clinical Director has also introduced a process in which interim hard copy discharge summaries are provided on discharge from mental health inpatient units. Audits have demonstrated a substantial increase in the proportion in medical discharge summaries being completed and distributed within 48 hours of patient discharge from a mental health unit. The discharge summaries include discharge medication information. Ongoing audits are scheduled.

The action has been re-rated to SM. This action links with actions 4.12.4 and 6.3.3.

Surveyor's Recommendation:

No recommendation

Action 4.12.4 Core
Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover

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

Surveyor Comment:

The MHS is aware of the low rates of discharge summary completion and the implications for primary and secondary care providers outside of the public mental health service. However, systematic action has not been taken to address the issue.

Advanced Completion (AC) 90 Review – 31 May 2018

CALHN has reviewed organisation wide medical discharge summary processes with the assistance of a multidisciplinary working party. The working party included acute and mental health representatives. Liaison with senior and junior medical staff has also occurred. The review included the provision of discharge medication information which is a key component of the overall medical discharge summary.

Audits have demonstrated a substantial increase in the proportion of medical discharge summaries completed and distributed within 48 hours of patient discharge from a mental health unit. The discharge summaries include discharge medication information. Ongoing audits are scheduled.

The action has been re-rated to SM. This action links with actions 4.12.3 and 6.3.3.

Surveyor's Recommendation:

No recommendation

STANDARD SUMMARY 6: CLINICAL HANDOVER

Surveyor Summary

Clinical handover processes

Handover processes are based around ISBAR and are supported by patient journey boards, smart phone apps, CBIS, and the SA, CALHN and MH procedures. Handover incidents are reported and reviewed. The ISBAR format was variably applied within the handovers the surveyors observed. The service is encouraged to improve the use of the ISBAR structured format within handovers. Local care staff are involved in the auditing and review of handover. Consumer and families have not as yet been involved in reviewing handover processes. The surveyors encourage the mental health service to formally audit the handovers that occur outside of the shift to shift IP handovers. These might include medical handover for on call matters, transfers between CALHN MH services and handovers within the community mental health services. Discharge summary completion rates remain low across the service and this has been addressed in the medication criteria as well as in a recommendation in this standard.

Advanced Completion (AC) 90 Review – 31 May 2018

CALHN has reviewed medical discharge summary processes with the assistance of a multidisciplinary working party including acute and mental health representatives. Liaison with senior and junior medical staff also occurred.

The CALHN “Discharge Summaries – Separation Summaries” OWI has been reviewed and amended to better reflect current expectations in relation to medical discharge summaries. Education for medical officers has also been provided. The Clinical Director of the Mental Health Directorate issued a communique to medical staff reiterating the importance of medical discharge summaries, and has also introduced a process in which interim hard copy discharge summaries are provided on discharge from mental health inpatient units. Audits have demonstrated a substantial increase in the proportion of medical discharge summaries being completed and distributed within 48 hours of patient discharge from a mental health unit. Ongoing audits are scheduled.

Action 6.3.3 has been re-rated to SM.

Clinical handover processes

Ratings

Action	Organisation	Surveyor
6.3.3	SM	SM

Action 6.3.3 Core
Action is taken to increase the effectiveness of clinical handover

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

Surveyor Comment:

Discharge summary completion rates are low across the service and have been for some time. This is particularly an issue for clinical handover of a comprehensive clinical summary to GPs and private clinical providers as CBIS allows for handover within the public mental health system of the available clinical material.

Advanced Completion (AC) 90 Review – 31 May 2018

CALHN has reviewed medical discharge summary processes with the assistance of a multidisciplinary working party. The working party included acute and mental health representatives. Liaison with senior and junior medical staff also occurred.

The CALHN “Discharge Summaries – Separation Summaries” OWI has been reviewed and amended to better reflect current expectations in relation to medical discharge summaries. Education for medical officers has also been provided.

The Clinical Director of the Mental Health Directorate issued a communique to medical staff reiterating the importance of medical discharge summaries. The Clinical Director has also introduced a process in which interim hard copy discharge summaries are provided on discharge from mental health inpatient units. Audits have demonstrated a substantial increase in the proportion of medical discharge summaries being completed and distributed within 48 hours of patient discharge from a mental health unit. Ongoing audits are scheduled.

The action has been re-rated to SM. This action links to actions 4.12.3 and 4.12.4.

Surveyor's Recommendation:

No recommendation

Advanced Completion (NSMHS) Report for

Central Adelaide Local Health Network

31 58 94

National Standards for Mental Health Services (NSMHS) Unmapped Criteria

Excluding CALHN NSQHSS (see separate documents)

This review report contains relevant parts of the original 19-23 February 2018 NSMHS (Unmapped Criteria) assessment plus commentary following the AC90 Review on 30-31 May 2018

Note: *This Review Report relates to Mental Health Standards (Unmapped Criteria) and excludes NSQHSS which is subject to separate AC90 documentation. Assessment report components should be reviewed in conjunction. Final outcomes will be included in the overall report.*

The Australian Council on Healthcare Standards -
Based on ACHSQHC Accreditation Workbook for Mental Health Services March 2014

NSMHS (Unmapped Criteria) AC Onsite Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

National Standards for Mental Health Services (NSMHS)

In the ten National Standards for Mental Health Services (NSMHS) there are a total of 155 Criteria; when assessed concurrently with a National Safety& Quality Health Service (NSQHS) Standards accreditation survey, 87 of the NSMHS criteria (56% of the total 155) are mapped to the NSQHS Standards, and 68 NSMHS Criteria (44%) are Unmapped to the NSQHS Standards.

Mental Health Standard	MH Std 1	MH Std 2	MH Std 3	MH Std 4	MH Std 5	MH Std 6	MH Std 7	MH Std 8	MH Std 9	MH Std 10	Totals
Total Number of Criteria by MH Standard	**17 Criteria**	**13 Criteria**	**7 Criteria**	**6 Criteria**	**6 Criteria**	**18 Criteria**	**17 Criteria**	**11 Criteria**	**5 Criteria**	**10+4 +8+8 +17+ 8 =55 Criteria**	**Total 155 Criteria in 10 NSMH Standards**
NSMHS Criteria that are Mapped (M) to NSQHSS	M 14 Criteria	M10	M 6	M 1	M 0	M18	M 9	M10	M 2	M 3+ 0+1+ 3+9+ 1=17 **Criteria**	Total Mapped = 87 Criteria Mapped against the NSQHSS (out of total 155 NSMHS criteria) i.e. 56%.
NSMHS Criteria Un - mapped (U) to NSQHSS	**U 3 Criteria**	**U 3**	**U 1**	**U 5**	**U 6**	**U 0**	**U 8**	**U 1**	**U 3**	**U 7+4 +7+5 +8+7 =38**	**Total Unmapped = 68 Criteria (out of total 155 NSMHS criteria) i.e. 44% are Unmapped** against the NSQHSS.

Summary

As noted in the Executive Summary for the **Central Adelaide Local Health Network (CALHN)** NSQHSS & NSMHS survey of 19-23 February 2018, in the CALHN Mental Health Services concurrent assessment to the **National Standards for Mental Health Services (NSMHS),** eight (8) NSMHS criteria were identified as Not Met, these being NSMHS Criteria 2.2, 4.5, 5.4, 5.6, 7.2, 7.11, 10.6.1 and 10.6.8. The eight criteria rated as Not Met represent 5% of the total 155 NSMHS Criteria.
For the award of Certificate of Recognition, all NSMHS Criteria are required to be assessed as Met. Accordingly, NSMHS Criteria 2.2, 4.5, 5.4, 5.6, 7.2, 7.11, 10.6.1 and 10.6.8 were scheduled to be reviewed at the CALHN NSQHSS AC90 Review.

Advanced Completion (AC) 90 Review - 30-31 May 2018

The eight NSMHS Criteria rated as Not Met at the Central Adelaide Local Health Network (CALHN) survey in February 2018 were re-surveyed in May 2018 by two surveyors from the February 2018 survey teams.

NSMHS (Unmapped Criteria) AC Onsite Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Considerable work had been undertaken within the 90 days to address the eight NSMHS Not Met criteria. All the eight recommendations had with support from the CALHN Executive, senior staff, stakeholders, health professionals and consumers been addressed. The relevant systems were tested to ensure that the CALHN Mental Health Service (MHS) continues to address the aims of the NMHS in ensuring these standards of quality and safety are met.

NSMHS (Unmapped Criteria) AC Onsite Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

STANDARD 2 Safety

The activities and environment of the MHS are safe for consumers, carers, families, visitors, staff and its community.

Criterion 2.2

The MHS reduces and where possible eliminates the use of restraint and seclusion within all MHS settings.

Surveyor's Rating	Met

Surveyor Comments:

The Seclusion rooms in the Emergency Departments of the Royal Adelaide and Queen Elizabeth Hospitals are being used on occasions to sleep patients due to the unavailability of a MHD bed.

Advanced Completion (AC) 90 Review - 30-31 May 2018

A CALHN Emergency Service Improvement Plan has been developed. A governance group has been meeting weekly to oversee the implementation of the key improvements required and these centred on three key areas. The ED environment (inclusive of seclusion rooms) used to care for mental health patients, clinical practice processes inclusive of monitoring of patients, reporting incidents of mechanical restraint and seclusion and education of ED medical and nursing staff about the requirements of the SA Mental Health Act. Significant investment has occurred to improve the current reporting processes aimed at ensuring there is consistent monitoring of restrictive practices in ED with emphasis on improving the experience and care for patients. As recommended by the survey team the automatic locking system for the two seclusion rooms within the RAH ED have been assessed and modified. Any patient now not requiring seclusion as part of their management plan but placed in the seclusion rooms there is in place a manual locking system for those patients requiring seclusion with an automatic swipe access allowing it to be disabled as required. Two standard ED cubicles have also been “modified” to create a safer “softer” environment involving the removal of monitoring and other standardised clinical equipment not required if used to accommodate a mental health consumer. An assessment was undertaken by the Office of the Chief Psychiatrist and the CALHN Executive in conjunction with Mental Health and ED senior clinical staff.

NSMHS (Unmapped Criteria) AC Onsite Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

STANDARD 4 Diversity responsiveness

The MHS delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care.

Criterion 4.5

Staff are trained to access information and resources to provide services that are appropriate to the diverse needs of its consumers.

Surveyor's Rating	Met

Surveyor Comments:

Cultural awareness training had low attendance rates and was available for Mental Health staff until the end of 2016. No training has been available in 2017 with Aboriginal Culture learning courses to be offered in 2018.

Advanced Completion (AC) 90 Review - 30-31 May 2018

2018-A comprehensive training package and a culturally appropriate guide for working with Aboriginal mental health consumers is available to the CALHN MHS. It has a strong focus on cultural social and historical factors, consumers from rural and remote locations and the SA Health’s Recognition of Aboriginal Country Policy. Included is culturally appropriate communication and the use of translators and interpreters. A component is also around the knowledge of Aboriginal leadership and Aboriginal identified professionals within mental health The principles for effective partnerships between Aboriginal and mental health services is important for all CALHN MHS staff to understand and contribute to. Aboriginal Cultural Learning is now a once only Mandatory Training requirement for CALHN MHD staff.

NSMHS (Unmapped Criteria) AC Onsite Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

STANDARD 5 Promotion and prevention

The MHS works in partnership with its community to promote mental health and address prevention of mental health problems and / or mental illness.

Criterion 5.4

The MHS evaluates strategies, implementation plans, sustainability of partnerships and individual activities in consultation with their partners. Regular progress reports on achievements are provided to consumers, carers, other service providers and relevant stakeholders.

Surveyor's Rating	Met

Surveyor Comments:

No evidence was available to demonstrate that the MHS had strategies in place to ensure there is consistent approach in ensuring appropriate progress reports are provided to consumers, carers other service providers and relevant stakeholders.

Advanced Completion (AC) 90 Review - 30-31 May 2018

Evidence was provided of the very large number of partnerships that are in place. A summary and a list of 24 different partnerships was provided with differing levels of communication and documented reporting to each as required.

Criterion 5.6

The MHS ensures that their workforce is adequately trained in the principles of mental health promotion and prevention and their applicability to the specialised mental health service context with appropriate support provided to implement mental health promotion and prevention activities.

Surveyor's Rating	Met

Surveyor Comments:

The MHS ensure staff are provided with Mental Health promotion and prevention training and education to demonstrate that promotion and prevention activities are an important component of the direction CALHN MHS for all staff.

Advanced Completion (AC) 90 Review - 30-31 May 2018

The CALHN MHS have identified SA Health MH courses available with MH Promotion and Prevention embedded in these courses. Completed in April 2018 was the review of the state MH Courses and the SA Health training calendar. Ongoing is the updating of the summary of current additional staff training opportunities and the identification of partnerships with training organisations, Many staff receive training on the principles of MH Promotion and Prevention within their discipline specific undergraduate and post graduate courses Both the MH Nursing university courses and the training provided by SA Psychiatry Branch Training in association with the RANZCP includes a number of significant of sessions relevant to the provision of MH Promotion and Prevention.

NSMHS (Unmapped Criteria) AC Onsite Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

STANDARD 7 Carers

The MHS recognises, respects, values and supports the importance of carers to the wellbeing, treatment, and recovery of people with a mental illness.

Criterion 7.2

The MHS implements and maintains ongoing engagement with carers as partners in the delivery of care as soon as possible in all episodes of care.

Surveyor's Rating	Met

Surveyor Comments:

Carers identified that they do not feel engaged in the delivery of care for the consumer - this is further evidenced in the care plan. In conversation with the survey team it was noted that not all consumers were aware that they could have carer involvement and a number stated they did have a family member actively supporting them.

Advanced Completion (AC) 90 Review - 30-31 May 2018

The CALHN MHS have reviewed the 2015 Mental Health Care Plans and ULYSSES Agreements written by consumers and carers for consumers and carers. Whenever possible Care Plans with the consent of the consumer will ensure the carer is involved either when the initial Care Plan is formulated, at the 91 day review or if a review is required prior to this.

Criterion 7.11

The MHS actively encourages routine identification of carers in the development of relapse prevention plans.

Surveyor's Rating	Met

Surveyor Comments:

It has been identified that carers are not actively engaged in the development of consumer relapse prevention plans.

Advanced Completion (AC) 90 Review - 30-31 May 2018

Carer input and feed-back to clinicians can be provided at any time with the consumers consent in the development of their relapse prevention plans.

STANDARD 10 Delivery of Care

The MHS assists consumers to exit the service and ensures re-entry according to the consumer's needs.

Criterion 10.6.1

The MHS ensures that on exiting the service the consumer has access to services that promote recovery and aim to minimise psychiatric disability and prevent relapse.

Surveyor's Rating	Met

Surveyor Comments:

Prior to a consumer/patient exiting the service the treating clinical teams liaise with the consumer's General Practitioner, existing supports and the Non-Government Sector (NGO) to provide ongoing support to prevent relapse and to manage their disability. Case reviews are documented in CBIS detailing the exit plan and the relevant contacts.

Advanced Completion (AC) 90 Review - 30-31 May 2018

The CALHN MHS are experiencing different information systems across the Inpatient and Community Services. These include CBIS, EPAS paper medical records/case notes.
A directive has been sent by the Clinical Director, Mental Health Directorate to all Psychiatrists within the MHS to complete discharge summaries on all consumers within the designated timelines ensuring that receiving clinicians of all patients either exiting the service or referred to different parts of the MHS have access to current clinical information enabling good patient management.

Criterion 10.6.8

The MHS, in conjunction with the treating clinician, has a procedure for appropriate follow-up of all consumers within 7 days after discharge from inpatient care wherever possible, and has a follow-up procedure for those consumers who do not keep the planned follow-up arrangements.

Surveyor's Rating	Met

Surveyor Comments:

The first audit conducted of Transfer of Care from CALHN MHD inpatient services without adequate follow-up from some MHD wards/units demonstrated further improvement is required. Patients leaving hospital after an admission for an episode of mental illness have heightened vulnerability and without adequate follow-up may relapse or require re-admission.

Advanced Completion (AC) 90 Review - 30-31 May 2018

The action around this recommendation has been implemented. The state target is 60%. The recent inpatient audit conducted in May 2018 seven-day follow-up is 88% The timeframes and monitoring of this risk is to continue fortnightly with the risk now controlled. A revision has occurred of the OWI Transfer of Care from Inpatient Services Follow Up: Seven days after the Quality Manager of the MHS is liaising regarding CBIS collection of 7-day PDFU data. The Nursing Leads from each ward/unit have been identified to follow up each discharge every week ensuring a single point of accountability. Reviews are occurring of the other Local Health Networks compliance rates via state-wide data reports as a benchmarking exercise.

NSMHS (Unmapped Criteria) AC Onsite Survey

Organisation: Central Adelaide Local Health Network
Orgcode: 315894

Rating Summary

STANDARD 1	
1.9	Met
1.15	Met
1.17	Met
STANDARD 2	
2.1	Met
2.2	Met
2.5	Met
STANDARD 3	
3.4	Met
STANDARD 4	
4.1	Met
4.2	Met
4.4	Met
4.5	Met
4.6	Met
STANDARD 5	
5.1	Met
5.2	Met
5.3	Met
5.4	Met
5.5	Met
5.6	Met
STANDARD 7	
7.1	Met
7.2	Met
7.3	Met
7.6	Met
7.8	Met
7.9	Met
7.11	Met
7.13	Met

NSMHS (Unmapped Criteria) AC Onsite Survey

Organisation: Central Adelaide Local Health Network
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STANDARD 8	
8.2	Met
STANDARD 9	
9.1	Met
9.2	Met
9.5	Met
STANDARD 10	
STANDARD 10.1	
10.1.1	Met
10.1.3	Met
10.1.4	Met
10.1.5	Met
10.1.7	Met
10.1.9	Met
10.1.10	Met
STANDARD 10.2	
10.2.1	Met
10.2.2	Met
10.2.3	Met
10.2.4	Met
STANDARD 10.3	
10.3.1	Met
10.3.2	Met
10.3.3	Met
10.3.4	Met
10.3.5	Met
10.3.7	Met
10.3.8	Met
STANDARD 10.4	
10.4.2	Met
10.4.4	Met
10.4.6	Met
10.4.7	Met
10.4.8	Met

NSMHS (Unmapped Criteria) AC Onsite Survey

Organisation: Central Adelaide Local Health Network
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STANDARD 10.5	
10.5.4	Met
10.5.5	Met
10.5.12	Met
10.5.13	Met
10.5.14	Met
10.5.15	Met
10.5.16	Met
10.5.17	Met
STANDARD 10.6	
10.6.1	Met
10.6.2	Met
10.6.3	Met
10.6.5	Met
10.6.6	Met
10.6.7	Met
10.6.8	Met