EXHIBIT 1286

DTZ.001.400.0137

Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program

Darling Downs - West Moreton Health Service District - Division of Mental Health

Toowoomba, QLD

Organisation Code: 715686

Survey Date: 12 September 2011

ACHS Accreditation Status: ACCREDITED

EXHIBIT 1286
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DTZ.001.400.0138

Table of Contents

EXHIBIT 1286   DTZ.001.400.0140

About The Australian Council on Healthcare Standards

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

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

The principles upon which all ACHS programs are developed and the characteristics displayed by an improving organisation are:
• a customer focus
• strong leadership
• a culture of improving
• evidence of outcomes
• striving for best practice.
These principles can be applied to every aspect of service within an organisation.

What is Accreditation?

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

How to Use this Survey Report

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

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

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

EXHIBIT 1286   DTZ.001.400.0141

1 Surveyor Team Summary Report
2 Ratings Summary Report
3 Summary of Recommendations from the Current Survey
4 Recommendations from the Previous Survey

1   Surveyor Team Summary Report

Consists of the following:

Function Summary or Periodic Review Overview- A Function Summary/Overview provides a critical analysis for organisations to understand how they are performing and what is needed to improve. It provides an overview of performance for that Function and comments are made on activities that are performed well and indicating areas for improvement.

Criterion ratings

Each criterion is rated by the organisation and the surveyor team with one of the following ratings.

- LA
- SA
- MA
- EA
- OA

The rating levels are:

LA – Little Achievement - Organisations that achieve an LA rating will have an awareness or knowledge of responsibilities and systems that should be implemented but may have only basic systems in place. At this level compliance with legislation and policy that relates to the criterion would be expected.

SA – Some Achievement - An organisation that achieves an SA rating will have achieved all the elements of LA and will have implemented systems for the organisation's activities. At this level there is little or no monitoring of outcomes, and so efforts at continuous improvement may be limited by a lack of understanding about the effectiveness of existing systems.

MA – Marked Achievement - The label for MA has changed from "Moderate Achievement to "Marked Achievement" as the term "Moderate" did not reflect the high standard of achievement that organisations reach within the MA award level. An MA rating requires that achievement against the elements of LA and SA has been demonstrated and that efficient systems have been established for collecting relevant outcome data on processes and preferably outcomes, monitoring this information, evaluating current procedures and planning improvement in response.

EA – Extensive Achievement - To Achieve a rating of EA in EQuIP5, demonstrated achievement against the elements in LA, SA and MA must be met. In addition, response to EA elements will be reviewed and extensive achievement against the criterion statement and/or its elements is required. Organisations will be able to demonstrate extensive achievement in a criterion if they satisfy one and preferably more, of the following requirements:

- internal or external benchmarking and subsequent system improvement, and / or
- the conduct of research that relates to the particular criterion, and subsequent system improvement, and/ or
- proven, excellent outcomes in that particular criterion.

EXHIBIT 1286

DTZ.001.400.0142

OA - Outstanding Achievement - All elements of LA, SA, MA and EA must be achieved as well as a demonstration of leadership in this criterion. Leadership in a criterion does not necessarily mean that the organisation is a peer leader of performance and excellence in Australia. However, it does require an organisation to use concentrate evidence to demonstrate that it is one of the best and, more importantly, that it has taken a leadership stance in communicating its outcomes to other professionals, other organisations and/or consumers/patients, or that the organisation is being recognised and sought out for its knowledge by other professionals and organisations.

Criterion Comments -

Surveyor comments regarding individual criterion detailing issues and surveyor findings and opportunities for improvement. Comments are available for all mandatory criteria giving an indication of why the organisation is achieving at the given rating level.

Criterion Recommendations -

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular criterion. Surveyors are required to make a recommendation where an LA or SA rating has been assigned in a criterion to provide guidance and to provide an organisation with the maximum opportunity to improve. Recommendations in the survey report need to be reviewed and prioritised for prompt action and will be reviewed by the surveyor team at the next on site survey.

Risk ratings and risk comments will be included where applicable- Risk ratings are applied to recommendations especially where the criterion rating is an SA or an LA to show the level of risk associated with the particular criterion.
Risk ratings could be:

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

High Priority Recommendations (HPR) -

A High Priority Recommendation (HPR) is given to an organisation when:

> • consumer / patient care is compromised and / or
> • the safety of consumers / patients and / or staff is jeopardised.

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

2   Ratings Summary Report-

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

3   Summary of Recommendations from the Current Survey-

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular criterion.
Recommendations are structured as follows:

EXHIBIT 1286

The criterion numbering relates to the month and year of survey and the criterion number. For example recommendation number OWS 0811.2.1.1 is a recommendation from an OWS conducted in August 2011 with a criterion number of 2.1.1

4   Recommendations from Previous Survey-

This section details the recommendations from the previous onsite survey. The actions taken by the organisation and comments from the surveyor team regarding progress in relation to those recommendations are also recorded.

Survey Report

FUNCTION SUMMARY: CLINICAL

The survey team has supported the organisation's self rating of MA across twenty-one clinical criteria. The criterion 1.5.5 is Not Applicable.

The survey team found the health record to be managed well. The client medical records reviewed were appropriately stored, sectioned and mapped the care and management of the client. The medical records were routinely audited but it is unclear how areas of non-compliance were addressed and how the recommendations for improvement were noted or implemented.

Standardised Queensland State triage and assessment forms are used and there was evidence of completed and ongoing client risk assessments. The Consumer Integrated Mental Health Application (CIMHA) data base is used to record client information which enables the sharing of updated client demographics and care across all sites at any time.

There was evidence that multidisciplinary clinical reviews are conducted and client care plans updated accordingly, however, this was not consistent across all sites and improvement is needed in this area.

There was also inconsistency across teams regarding the location of the treatment/care plans and it is suggested that a standardised system of storage for these forms across the mental health service be established.

Discharge planning commences on admission and there was evidence of close links with community case managers, GPs and NGOs.

It was pleasing to note that outcome measures are routinely collected and used at all sites to guide case reviews and care planning.

The consultation liaison referral criteria at Ipswich Hospital have been reviewed. The planned mobile phone contact number to a psychiatrist providing advice and consultation for GPs is commended. It will help ensure the systems for ongoing client care are coordinated and effective.

Consent follows Queensland Health policy for involuntary patients and for ECT. There is an excellent document for permission to release information to care providers. Voluntary patients are not thought to need to consent, rather this is assumed, however there is no indication that they have received or understood the rights and responsibilities documents. In general, there is no indication that the consumer participates in care plans, either by signature or acknowledgement.

Generally, the Service has good processes in place for the safety and security of staff and consumers, for example, the use of swipe cards for staff only areas. Care is taken to ensure that consumers are not seen alone after hours in outpatient settings. The surveyors were concerned that in Evolve, (a service for disturbed adolescents who were being seen by multiple services in Ipswich), staff were seeing consumers and their families at home, often with families who were known to be abusive. The primary safety measure appeared to be the mobile phone. This was explained as necessary due to the volume of work for the number of staff available.

The Dalby Mental Health Service is a robust service effectively managing the mental health needs of the Dalby community and surrounding district. The Service has a sound working relationship with the general health service, police and ambulance services. Linkage to the Chinchilla Mental Health Service via video conferencing further ensures regional coverage and delivery of mental health services to a large rural area. Consumers can enter the Service directly or via the local hospital.

The CYMHS Team along with the Adult Team provides services across the lifespan with the ability to facilitate planned consumer transfer between these two teams. The Service maintains a strong focus on health promotion as evidenced by their preparation for Mental Health Week. The Service also has a strong linkage with, and is an active participant in, inter agency planning. The interdisciplinary mix within the teams further enhances options for consumers. There was also strong evidence that the clinical files are current and audit processes are in place to ensure sound service delivery.

The service at Kingaroy is very progressive and there is a strong commitment to consumer care. There is excellent teamwork and a commitment to quality improvement. The IT systems are well managed. The refurbished facility is very welcoming and much appreciated by staff.

There was a strong infection control and management system throughout the mental health service, with well established governance structures for reporting, monitoring and analysing data related to infection control. The proactive approach used by the Service, which includes infection rate data being tracked at a District level, ensures infection rates are kept low. In instances where infections arise they are managed via a rigorous infection control plan. There was sound evidence of consumer and staff education with respect to infection control as well as successful strategies that had been implemented at a unit level to prevent infections. All areas have designated infection control representatives who work closely with the infection control units of the general health service.

Robust frameworks are utilised in the mental health service to manage the incidents and impact of breaks in skin integrity, pressure ulcers and non surgical wounds. There was clear evidence of monitoring and reporting processes, which include audits being used to reduce the overall incidence of breaks in skin integrity. Those consumer populations considered 'at risk' are closely monitored with strategies put in place to reduce breaks in skin integrity. Queensland Health policies inform procedures and workplace instructions in the care and management of breaks in skin integrity. Targeted staff education was also identified as an adjunct to maintaining low rates of breaks in skin integrity along with the use of individualised planning for consumers which often sees the use of preventative devices.

A multifactorial approach to the minimisation of falls and falls injuries across the Service has seen an overall reduction in such events. Data related to falls and falls injuries are reported and trended to assist in identifying' at risk' consumer populations as well as designing targeted staff education around falls management. The service has identified falls portfolio holders in designated clinical areas to assist in the minimisation of falls. Consumers receive falls risk assessment upon admission and throughout their time with the service. This process has been further enhanced by the use of a validated falls risk assessment tool and the development of local falls documentation from Statewide documentation. The purchase of equipment to assist in the reduction of falls has also had a measurable positive outcome.

The mental health service has undertaken a major nutrition strategy to improve the knowledge and eating habits of consumers. This has taken the form of a complete review of the dietary needs of consumers resulting in a food management strategy that incorporates a food strategy program. Food storage, preparation and delivery has been reviewed as part of this process which has resulted in a more effective approach to nutritional management with a strong emphasis on healthy eating.

Consumer feedback surveys have informed this process also. The planning of diets along with staff and consumer education has allowed the service to provide a greater variety of food thereby avoiding repetitious menus. Interdisciplinary collaboration with dieticians has also resulted in better dietary knowledge among clinicians and more appropriate diets, especially for malnourished or obese consumers. Dietary screening tools have also been successfully introduced as part of a broader physical health assessment.

Function: Clinical   **Standard: 1.1**

Criterion: 1.1.1

Assessment ensures current and ongoing needs of the consumer / patient are identified.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.1.1

There are clear pathways into the mental health service with Child and Youth, Older Persons and Adult multidisciplinary teams providing a designated intake/triage system. Comprehensive Queensland State assessment forms are used to document the assessment of physical, cultural, psychological and social needs of the client. The suite of documents also include falls and risk assessments, care and recovery plans. A robust system is in place to provide referring agencies with feedback on the referral assessment and planned client outcomes.

An interpreter service is available to assist with the assessment process if required. The CIMHA data base records client information that is able to be updated and shared across the State. Leaflets providing information on mental illness are available at community and inpatient sites and client rights and responsibilities are included in client admission/assessment packs. Specific site booklets containing information such as unit visiting hours, suggested items needed during an admission and contact phone details are not widely available. It is suggested that site specific information booklets be developed for both the client and the families/carers.

File audits are conducted in all units. The surveyors were informed that audit results are discussed at the staff team meeting but actions to address areas of non-compliance and recommendations for improvement were not evident.

Recommendations

Criterion 1.1.1 #1

Surveyor's Comments:

At the previous survey there was a recommendation that "The allocation of specific, rather than pool, vehicles to the Ipswich Rural Community Mental Health Team be considered so that assessment tools and other requirements [including those for physical examination, such as sphygmomanometers] can be stored in the vehicles. "Although information has been sought from other Services no change has been made. The growth in services has increased the demand for vehicles and this is a cause of ongoing frustration for staff.

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

Review all options for the provision of vehicles for the Ipswich Rural Community Mental Health Team to ensure that a more effective and efficient system of vehicle allocation can be provided.

Function: Clinical	Standard: 1.1

Criterion: 1.1.2

Care is planned and delivered in collaboration with the consumer / patient, and when relevant the carer, to achieve the best possible outcomes.

Organisation's self-rating: EA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.1.2

There are systems in place to periodically review treatment/care plans across the service and, where possible, this is undertaken by a multidisciplinary team. Individual care plans are comprehensive and appropriate at most sites visited, however they are not always signed by the client which makes the client's involvement in care planning uncertain. There was no evidence of satisfaction surveys being offered to families/carers to gauge their level of satisfaction with services offered and delivered by mental health.

A complex care committee has been formed and, although in the planning stages, this will provide a multidisciplinary review for managing difficult clients and associated challenging behaviours. There is a referral system in use for allied health staff in each unit with referrals recorded in a register and signed off when received. Comprehensive daily activity programmes which provide appropriate therapeutic and recreational activities for clients were evident across all inpatient units.

It was evident that a considerable amount of consultation had occurred with clients and families at The Park and Baillie Henderson Hospital (has not yet commenced) in preparation for the relocation of clients from the Extended Treatment, Rehabilitation and Dual Diagnosis units into Community Care Units.

The Barrett Adolescent Unit continues to deliver multidisciplinary client focused programmes despite the delayed relocation of services to Redlands Hospital Campus. Evaluation and ongoing care planning was evident in what seemed to be a challenging physical environment.

The Child and Youth Mental Health Service (CYMHS) at The Plaza is to be commended for the highly motivated staff and range of programs and interventions provided for clients and their families.

It is noted this criteria was rated incorrectly by the organisation as EA. The correct rating is MA which is supported by the survey team.

Recommendations

Criterion 1.1.2 #1

Surveyor's Comments:

The previous recommendation regarding a recovery-based model of care, in its current form, has been closed and replaced by a new recommendation to better reflect the current status.

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

Make progress with a recovery-based model of care with consumer/carer participation and review the
documentation to ensure it demonstrates how this has been achieved.

Function: Clinical   **Standard: 1.1**

Criterion: 1.1.3

**Consumers / patients are informed of the consent process, and they understand and provide
consent for their health care.**

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.1.3

The surveyors noted that the Queensland Health Policy is followed. Consent for ECT and sharing of
information was excellent though consent is not required from voluntary patients.

Consumers are given an information pack on admission to the inpatient unit. There are two brochures on
rights and responsibilities.

Voluntary patients are assumed to have given consent to treatment and are not required to sign the
consent form. As a result, there is no way of checking whether the material has been read or understood.
Hence consent is not necessarily informed consent. Toowoomba do require signing of the consent from
and this process has been audited.

Involuntary admissions are covered by the Queensland Health policy and show full compliance with all
legal requirements.

The ECT documentation is comprehensive and the explanatory brochure is clear and succinct.

There is a good document for the release of information to other treatment providers, carers, researchers
and others, with clear indication as to whether consent has been given or not. This is a good initiative,
enabling carer and friends' involvement in the care of the consumer when relevant.

There is some evidence of participation of consumers in their care plans but this was not consistent. As
there was no space in the paper record for consumer signature, participation was assumed. The
electronic record (CIMHA) does not provide a section which acknowledges a carers role in the care plan
and/or his/her agreement to it.

Recommendations

Criterion 1.1.3 #1

Surveyor's Comments:

There is only sporadic evidence of consumer involvement in the care plan.

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

Develop a means of signifying the consumer's role in the development of and consent to care plans, perhaps by an entry in the electronic or paper record.

Criterion 1.1.3 #2

Surveyor's Comments:

The absence of evidence of consumer's informed consent suggests that it cannot be assumed that the consumer knows what will eventuate.

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

Develop protocols to ensure that voluntary patients have understood their rights and that this can be audited.

Function: Clinical   **Standard: 1.1**

Criterion: 1.1.4

Outcomes of clinical care are evaluated by healthcare providers and where appropriate are communicated to the consumer / patient and carer.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.1.4
Ongoing outcomes at clinical review in the inpatient services, including multidisciplinary team review, are documented in the clinical record and in the CIMHA electronic record. These are comprehensive, relevant and goal oriented. There is less evidence as to how this is imparted to the consumer, or that they have been involved in formulation or modification of the care plan.

In community centres, recording of consumer care plan reviews was variable, though there was a greater level of evidence of consumer involvement in preparation of that plan. There was, however, evidence of evaluation of service delivery and its effectiveness.

An evaluation of staff training indicated a need to improve training in basic life support and aggressive behaviour management. The evaluation also suggested the need for further training in suicide prevention. A study of seclusion levels conducted in February 2011 revealed little improvement over the past year.

This led to the formation of the Integrated Mental Health Service Seclusion and Aggression Management Group who are actively pursuing means of improving these outcomes, which is a commendable initiative.

The institution of the "Have your say about your stay" form for consumers to fill in, anonymously if desired, has provided helpful suggestions and is another good initiative to be encouraged. It is suggested that the service continue to audit clinical records to improve adherence to protocols.

Recommendations

No Recommendation

Function: Clinical   **Standard: 1.1**

Criterion: 1.1.5

Processes for clinical handover, transfer of care and discharge address the needs of the consumer / patient for ongoing care.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.1.5

Discharge and admission processes are guided by the Queensland Health Policy. Child and Youth, Adult and Older Persons intake meetings ensure referred clients who are admitted to the mental health service are allocated appropriate services and case management.

Clinical handover processes are in place in all mental health sites to ensure continuity of care for clients. Clinician and client outcome measures are routinely collected and used to guide clinical activity including discharge planning. On discharge, clients and their family/carers receive information on relevant services and support available in the community and are followed up by a community clinician within 1 - 7 days of discharge from the inpatient units. The 1 - 7 day follow up time frame is regularly reviewed and audited for compliance.

The mental health service community case managers are involved in geographical weekly inpatient clinical review discharge meetings and via tele-health for rural teams to ensure that the transfer of care from hospital to community is appropriately managed in a smooth and timely manner. The client's health care record is transferred across mental health service units to ensure continuity of care.

The community case managers attend scheduled outpatient appointments with their clients following discharge. A local discharge check list, which has recently been reviewed, is completed and audited prior to the client leaving the service. Discharge summaries are forwarded to the referring agency and filed electronically in CIMHA enabling shared information of the client's journey to all mental health staff across the State. The annual '"Consumer Perception of Care" survey provides an opportunity for clients to provide feedback on the discharge/transfer process and any recommendations for improvement.

Recommendations

No Recommendation

EXHIBIT 1286
Organisation: Darling Downs - West Moreton Health Service District - Division of Mental Health
Orgcode: 715686

DTZ.001.400.0151

Function: Clinical   **Standard: 1.1**

Criterion: 1.1.6

Systems for ongoing care of the consumer / patient are coordinated and effective.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.1.6

There are formal processes in place to provide a multidisciplinary range of services to clients in the mental health service. Such services are provided by Aboriginal and Torres Strait Islander Workers, Multicultural Coordinators, Liaison Officers, Duel Diagnosis Coordinators, Service Integration Coordinators, Consumer Consultants and GP Liaison Nurses. Clients are assigned a case manager/primary nurse on admission to the service. There is no waiting list for clients to be case managed.

Intake/triage is established in each service component to screen and prioritise care and a system is in place to provide feedback to referring agencies on the outcome of a client referral. The Consultation Liaison Service referral criteria at Ipswich Hospital has been revised and includes education to general hospital medical staff to ensure appropriate referrals for assessment/triage into mental health. Treatment/Care Plans and some Relapse Management Plans were evident in medical records audited by the surveyors but improvement is needed across all teams in completing these reviews.

The proposed dedicated telephone number and time for GPs to have access to a psychiatrist for advice and consultation for mental health clients at Ipswich is an excellent innovation and will provide coordinated and more effective client care.

All unplanned readmission data is reviewed and benchmarked to identify obstacles to continuing community care. The "Out and About" weekly group which integrates clients into community services provides not only links with NGOs but an opportunity for clients to learn new skills and gain independence.

Recommendations

No Recommendation

EXHIBIT 1286
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Orgcode: 715686

DTZ.001.400.0152

Function: Clinical   **Standard: 1.1**

Criterion: 1.1.7

The care of dying and deceased consumers / patients is managed with dignity and comfort, and family and carers are supported.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.1.7

All mental health inpatient sites have access to palliative care general hospital beds and pain management services via the appropriate hospital. Baillie Henderson Hospital (BHH) is to be congratulated for the end of life care offered to clients, many of whom are long term residents. If clients request to remain at BHH, end of life options are discussed and documented and families are offered support and unrestricted visiting.

Cultural beliefs of the client are taken into consideration. All inpatient deaths are reported to the coroner and legislated directives and policies are followed. Isolation facilities are available if needed. The Consultation Liaison Nurse and psychiatrist at The Plaza offer a consultation service, via a weekly meeting, to the Palliative Care Unit at Ipswich Hospital, which enhances the relationship between mental health and general medicine.

Recommendations

No Recommendation

EXHIBIT 1286
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Orgcode: 715686

DTZ.001.400.0153

Function: Clinical   **Standard: 1.1**

Criterion: 1.1.8

The health record ensures comprehensive and accurate information is collaboratively gathered, recorded and used in care delivery.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.1.8

Medical records systems across major and smaller clinic sites utilise the Consumer Integrated Mental Health Application (CIMHA), mental health paper based medical record and general health paper based medical record. The latter two are in the process of being integrated across the organisation. There is increased uptake of CIMHA, including by the new EVOLVE community team which uses the CIMHA electronic medical record system exclusively. The use of CIMHA during the January 2011 flood disaster as a way of contacting patients and relatives for follow up care provided a very valuable tool.

CIMHA has the ability to receive attachments of other relevant documentation such as care plans and outcome measures which enhances its effectiveness. The electronic system will decrease the amount of off-site storage currently required for the considerable volumes of medical records for the long stay and residential wards at Baillie Henderson and The Park hospitals.

The use of the Queensland Health standardised suite of documentation was wide spread with staff broadly aware that this is an evolving process. Procedures and access to information regarding these forms are available on a centralised Queensland Health website that all staff can access. The organisation developed a range of clinically appropriate documentation such as, 'long stay medication charts' for residential wards and Clozapine titration medication charts. Discharge summaries are incorporated into CIMHA as well as specific reports, for example, child psychological testing. In the case of the long term child residential ward at The Park, this means that the service receiving the consumer at discharge will have access to these documents through CIMHA.

Although medical records audits occurred in teams and were evident in an electronic format, there was evidence of inconsistent up take and the organisation could focus on ways of increasing compliance. This inconsistency may be due to non-familiarisation with CIMHA. The procedure regarding the process of review and improvement of audits of documentation did not appear to be clear.

Efforts to improve the review process, how this is documented and tracking of follow up and improvement discussions at a local level, is encouraged. Efforts to increase the uptake of CIMHA are also encouraged. There are some work groups that look at improvements but these could be more extensively used across the Service to ensure the consistency and quality of medical records.

There is a recommendation in 2.3.3 regarding a timely and progressive strategy for the full implementation of CIMHA across the Service.

Recommendations

No Recommendation

EXHIBIT 1286
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Orgcode: 715686

DTZ.001.400.0154

Function: Clinical   **Standard: 1.2**

Criterion: 1.2.1

The community has information on health services appropriate to its needs.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.2.1

There is good information for consumers, GPs and other service providers, from the single Statewide telephone number, which enables contact with the Acute Care Team (ACT) and also functions as the single point of entry to the service. There are brochures for most community services in the foyer of the Ipswich and Toowoomba services as well as the rural centres.

Access to services is good, especially at Ipswich which is located centrally, adjacent to public transport.

The ACT accepts referrals from the consumer, carers and community, including GPs. Their triage ensures that the consumer is linked to the appropriate service or agency and establishes the level of urgency.

A pilot initiative is the Indigenous Young Women's Wellbeing Program which assesses indigenous women, without labelling them as mentally disordered and has been highly successful in this endeavour.

There is good liaison between mental health, the ambulance and police services, with regular meetings between representatives of each service. Mental Health is represented by the Mental Health Intervention Coordinator. All these services provide education to each other and they have managed to cover most of the area they serve even though the mental health areas are different to the police and ambulance regions.

Recommendations

No Recommendation

EXHIBIT 1286
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DTZ.001.400.0155

Function: Clinical   **Standard: 1.2**

Criterion: 1.2.2

Access and admission / entry to the system of care is prioritised according to health care needs.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.2.2

The use of a single point of entry with the Acute Care Team (CYMHS has a separate single point of entry from Monday to Friday and after hours it is covered by ACT) facilitates effective assessment and triage, also allowing the team to be aware of bed states and availability of places in community services. The presence of ACT in the Emergency Department (ED) encourages a good relationship with ED, enables a degree of medical officer training in mental health medicine and avoids unnecessary delays. ACT also provides a consultation/liaison service to the general hospital to assess the needs and priorities for treatment or transfer.

There remain some issues with bed availability in specialist areas, which delay entry, especially to the High Security Unit, where there are a number of very long term patients. The CYMHS in Toowoomba has been required to manage the demand for community treatment by assessing consumers at presentation. Treatment is prioritised and some consumers may be placed on a waiting list for treatment. Because of the high demand it may take some months for a consumer to receive treatment.

Recommendations

No Recommendation

Function: Clinical   **Standard: 1.3**

Criterion: 1.3.1

Health care and services are appropriate and delivered in the most appropriate setting.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.3.1

The broad range of services offered covers most needs from childhood to old age, forensics, intellectual disability and traumatic brain injury in a wide variety of settings. Generally these operate well.

The survey team were impressed with the sensitive management of disabled patients at the acquired brain injury and intellectual disability units at Baillie Henderson. A recent initiative, the Community Access Service is a privately contracted service which enables many of these patients to spend time in community settings with a carer and is highly regarded by patients' families.

Community teams and services work well, coping with isolation and at times staff shortages in rural areas particularly, providing instrumental assistance in the January 2011 floods. However, it was noted that some medical records had not been updated some a considerable time.

In the Adult Inpatient Unit, a notice and documentation suggested that visiting hours are confined to one hour daily, however visiting was essentially unrestricted. The organisation should ensure that these are updated so that current information is available to visitors.

It was noted that there were no programmed activities in the High Dependency Unit (HDU) at the Toowoomba Acute Mental Health Unit and, in general, programmed activities diminished over weekends. It is suggested that the organisation review the provision of programmed activities to include coverage on weekends to ensure that consumers have relevant activities on a daily basis as a key part of their care.

A staff satisfaction survey conducted in 2009 in the HDU raised a number of features which could react on patient care. The survey has not been repeated to see if changes have improved satisfaction. There is however work in progress to address staff issues across the service and staff surveys in 2007 and 2009 showed moderate improvement in most areas, presumably reflecting on patient care.

Previous Consumer satisfaction surveys received minimal responses, making it difficult to draw conclusions. This improved in the August 2011 survey.

Recommendations

Criterion 1.3.1 #1

Surveyor's Comments:

Progress on staff satisfaction issues has been slow and spasmodic.

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

Develop longitudinal strategies to address staff and consumer issues, incorporating a recovery focused model of care.

Criterion 1.3.1 #2

Surveyor's Comments:

Clinical record entries in some areas appear not to be recorded in accordance with Policy and are not in an appropriate and consistent form as required by the Standards. A number of audits confirm that this is occurring and surveyors also noted this when reading records. Clinical record compliance varies across the Service. Regular audits are required to identify where the problems exist and strategies need to be established to remedy these problems.

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

Audit the clinical records across all Services on a regular basis, to ensure that the policy is complied with by all services.

Function: Clinical   **Standard: 1.4**

Criterion: 1.4.1

Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.4.1

The assessment process is comprehensive, enabling effective care plans to be developed which are regularly reviewed. This occurs daily in the acute wards with a weekly multidisciplinary team review ensuring attention to all aspects of the consumers' needs.

In community centres the review is as appropriate for the consumers' needs, although some files within the community did not have regular entries. The increasing use of CIMHA makes this information available across the service, which is most useful when trying to assess a new referral and to easily access past interventions.

The library situated in The Park ensures availability of current reference material both on line and paper based whenever needed. In addition, funding exists for staff to attend conferences to update current practice.

Formal consumer questionnaires have had limited response and hence are of limited value, though efforts are now being made to increase return. However, feedback from consumer companions and advocates has been useful.

Outpatient facilities at Fountain House and Ipswich were good as was the dedicated Clozapine service.

Recommendations

Criterion 1.4.1 #1

Surveyor's Comments:

The waiting area at Dalby where children and adults share the same space is inappropriate. The Service should explore options to have a segregated waiting area for children.

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

Explore ways to separate the different consumer age groups in the waiting area at Dalby.

Function: Clinical   **Standard: 1.5**

Criterion: 1.5.1
Medications are managed to ensure safe and effective consumer / patient outcomes.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.5.1

There is evidence that medication content, use and legibility are current issues that the organisation has tackled across very different care types such as community, acute and long stay. There are a number of innovations that the organisation is pursuing such as improvements to the Medication chart in all units at Baillie Henderson Hospital (BHH). These include the use of alert stickers, clinical audit schedules and standardisation of treatments charts which were evident across the survey sites. An incident management system is used to log and collate issues such as medication errors, trend data and institute practice change. This information is fed through to medication safety committees locally.

Specific auditing processes have been put in place at The Park. These occur at the end of each shift and have resulted in a dramatic reduction in medication errors. There was a review of poly-pharmacy in acute mental health unit at Toowoomba Base Hospital (TBH) with planned interventions pending. An Adult Clozapine Titration Medication chart was developed at The Park as one of four service pilot projects and this has been taken up at the TBH site.

The storage of medication is appropriate as per the legal requirement of State authorities. It was noted in many clinical areas that thermometers were missing in refrigerators that store depot medication and other temperature sensitive items such pathology specimens. New State guidelines (Queensland Health guideline for storage, transportation and handling of refrigerated medication in health facilities) describe the management of these products and the specific way in which they should be stored. The organisation did not appear to meet these new guidelines.

The location of a mental health pharmacy at BHH and the requirement for dispensing of the majority of Clozapine prescriptions from the TBH Clozapine clinic via the remote BHH site is an area of potential improvement to note. This historical arrangement has been over taken by increased Clozapine usage and patient numbers at the TBH site, which means some delays in dispensing for these patients via the BHH site.

In addition, the audit processes that include medication documentation are increasing across the District. However it is difficult to ascertain from documentation that improvements are being pursued when a variance is noted. There were, however, many examples of reported improvements such as a reduction in error rates as a result of the medication auditing.

Recommendations

Criterion 1.5.1 #1

Surveyor's Comments:

It was noted in many clinical areas that there were missing thermometers for refrigerators that store depot medication and other temperature sensitive items such as pathology specimens and that the organisation did not appear to have implemented the guidelines recently released by Queensland Health.

All refrigeration units should be reviewed and a plan developed to ensure that they meet these guidelines. The Review's recommendations should be prioritised and complied with as soon as possible.

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

Review all refrigeration units that store medication and/or pathology specimens against the new Queensland Health Guideline and ensure that the Guideline is complied with as soon as possible.

Criterion 1.5.1 #2

Surveyor's Comments:

The location of a mental health pharmacy at BHH and the requirement for dispensing of the majority of Clozapine prescriptions from the TBH Clozapine clinic via the remote BHH site requires a review. This historical arrangement has been over taken by increased Clozapine usage and patient numbers at the TBH site, which means some delays in dispensing for these patients via the more remote BHH site.

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

Review the Clozapine prescribing and dispensing processes and include consideration of the best use of limited pharmacy services to improve this process and reduce delays in delivery of Clozapine to consumers.

Function: Clinical   **Standard: 1.5**

Criterion: 1.5.2

The infection control system supports safe practice and ensures a safe environment for consumers / patients and healthcare workers.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.5.2

There was strong evidence of an infection control system throughout all mental health areas visited, with established processes for reporting infection rates. Infection rates are recorded, monitored and reported through the relevant governance structures with evidence of improvement in infection control as a result of these processes. Standard precautions are used routinely by staff in the performance of their duties. These precautions include hand hygiene, use of protective equipment, the handling and disposal of sharps, and decontamination of the physical environment.

Varicella and Noro virus outbreaks have been managed strategically, thereby decreasing the potential for spread of infection. The overall infection control strategy for the mental health service is aligned to the broader general health services within the District. An illustration of this relationship is the annual influenza vaccination program for staff and consumers along with other targeted vaccination programs where indicated, for example, programs for pertussis, hepatitis and tetanus. All clinical areas have designated infection control representatives who work with infection control coordinators in the maintenance of infection control standards. This has seen regular programs offered to all clinical areas.

Infection control rates are reported to the Mental Health Infection Control Sub Committee, where data are trended and analysed followed by focused, evidence based interventions, where indicated. This committee also monitors compliance with infection control procedures. The mental health service infection control data are forwarded to the general health service for District trending and analysis. Antibiotic usage is monitored at a clinical area level and reported through to the above committee.

The mental health service has adopted the National Hand Hygiene Initiative which contains education sessions as well as poster displays placed strategically in clinical and food preparation and serving areas. This initiative is further reinforced by January to June education sessions.

There is substantial education for staff around infection control; this takes the form of annual infection control workshops, scheduled education sessions as well as education sessions provided on an as needs basis. There is an infection control folder on the intranet, DVDs and online learning modules (CHRISP).

From January to June 2010 ninety two education sessions were delivered in the mental health service to 715 participants. In addition, education sessions around infection prevention and control are provided to consumers on an as needs or requested basis. While there is greater potential for infection in the aged and dual disability areas there was evidence of proactive strategies being used by the mental health service to minimise such potentials. The evidence collected from these areas demonstrated a reduction in infection rates over the last two years. Waste management audits as part of the same strategy have seen the development of waste management action plans.

Recommendations

No Recommendation

Function: Clinical   **Standard: 1.5**

Criterion: 1.5.3

The incidence and impact of breaks in skin integrity, pressure ulcers and other non-surgical wounds are minimised through wound prevention and management programs.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.5.3

There was strong evidence of frameworks within the mental health service and a collaborative relationship with the general health service to manage the incidence and impact of breaks in skin integrity, pressure ulcers and other non-surgical wounds. The majority of the consumer population in the mental health service are ambulatory which means a lower incidence of breaks in skin integrity compared to bed ridden consumer populations. There was clear evidence of monitoring and reporting processes around the preservation of skin integrity, particularly in those consumer populations with a higher potential for breaks in skin integrity (dual disability and aged consumers). Proactive approaches utilised by staff at an individual unit level limit the potential for breaks in skin integrity in high risk consumer populations, for example, consumers with urinary incontinence or urinary tract infections.

There was evidence of education being provided for clinical staff with regard to the preservation of skin integrity and wound management, illustrated by online training modules as well as wound management workshops. Mental health staff work closely with the general health Infection Control Unit in the management of skin integrity and report data related to this area to the Infection Control Committee via the Pressure Ulcer Sub Committee for trending and analysis.

Clear governance structures were in place for the reporting of such incidents. The service is guided by Queensland Health policy and there was evidence of these policies as well as procedures available in both hard copy and via the intranet to assist staff in the management of breaks in skin integrity, pressure ulcers and other non-surgical wounds.

The timely management of wounds has been facilitated by the emailing of wound photographs to the Infection Control Unit for advice and guidance. This process engages wound care nurses more quickly to assist with the overall management of the consumer. Data collected within the last year has shown that there has been an overall reduction in skin tear injuries in elderly consumers as well as a reduction in hospital acquired pressure injuries.

The service uses screening and assessment tools for the identification of ' at risk ' consumers when planning their care. Preventive devices are utilised by the mental health service to minimise potential breaks in skin integrity. The service has also participated in a State wide Pressure Ulcer Audit and Infection Control Surveillance Audit, thus allowing a comparison of their clinical outcomes against similar services.

Recommendations

No Recommendation

Function: Clinical   **Standard: 1.5**

Criterion: 1.5.4

The incidence of falls and fall injuries, is minimised through a falls management program.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.5.4

There was strong evidence the service had implemented a multifactorial approach to achieve an overall reduction in falls. This approach has taken the form of identification of 'at risk 'consumers, precautionary approaches in the management of identified consumers, as well as strategies to minimise the impact of falls that cannot be prevented. In these instances, staff respond to any injuries immediately. Falls and falls injury management education programs were in place for staff and consumers. Data associated with falls and falls injury are collected, reported, analysed and trended by the Falls Management Committee who also lead the falls education programs. This data is then reported and discussed at management, divisional and District safety and quality meetings and subsequently reported through to Queensland Health for the purpose of State wide bench marking. Following this process, the data is reviewed locally and recommendations implemented.

The service has a falls risk management plan which has been rolled out to clinical areas. This plan is complimented by nursing portfolio holders in identified clinical areas. For those consumers who are at risk of falling a range of protective equipment is utilised. New falls prevention guidelines are in the process of being rolled out across the service. Consumers receive falls risk assessments on admission, which are repeated throughout their time in the service to determine the most appropriate nursing interventions. There have been a range of initiatives introduced throughout the service, such as the use of a validated falls risk assessment tool, post falls management guidelines and a falls prevention care pathway, all of which have contributed to an overall reduction in falls in admitted consumers.

On admission, where indicated, falls risks are discussed with consumers and carers with potential falls prevention strategies being outlined. In an instance where a serious fall occurs it is reported via the PRIME Statewide electronic management tool and analysis is conducted in an attempt to identify causative factors and help prevent future occurrences. New equipment to prevent or reduce the occurrence of falls has been purchased in recent times as a result of these analyses.

There was also strong evidence regarding the range of falls education programs staff had attended as well as the supportive and educative relationship with the Falls Management Unit. In order to better manage falls the service has developed its own falls documentation from Statewide documentation.

Recommendations

No Recommendation

EXHIBIT 1286
Organisation: Darling Downs - West Moreton Health Service District - Division of Mental Health
Orgcode: 715686

DTZ.001.400.0163

Function: Clinical	Standard: 1.5

Criterion: 1.5.5

The system to manage sample collection, blood, blood components / blood products and patient blood management ensures safe and appropriate practice.

Organisation's self-rating: N/A   **Surveyor rating:N/A**

Overall Comment

Overall Comment   1.5.5

The surveyors confirmed that this criterion is not relevant to the Service.

Recommendations

No Recommendation

Function: Clinical	Standard: 1.5

Criterion: 1.5.6

The organisation ensures that the correct consumer / patient receives the correct procedure on the correct site.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.5.6

Electroconvulsive therapy (ECT) is performed at Toowoomba Base Hospital (TBH) and at Ipswich General Hospital (IGH) in theatre settings and at The Park in a purpose built ECT suite. These services provide outpatient, inpatient acute and maintenance treatment ECT.

At TBH, inpatients and outpatients travel from the ward to theatre and have ECT with brief recovery before coming back to the ward. The ECT is appropriately delivered and there are uniform processes that comply with State guidelines for ECT delivery.

In Ipswich, the medical and anaesthetics team commence at IGH and then move to The Park to complete the ECT list. This means that patients at The Park could often wait until mid-morning for ECT to be delivered. This is an issue that may be difficult to address giving the competing needs of the two services but may be improved with further discussion.

Research into ECT usage is occurring at The Park and continuation of this is encouraged. All sites adhere to procedures and mental health legislative requirements to provide an ECT service at their local site. There is education and training which is centralised and delivered at a regional level by the

government authority and this is complimented by local education, training and peer review processes.
The majority of senior medical staff contribute to the running of ECT services.

Recommendations

No Recommendation

Function: Clinical   **Standard: 1.5**

Criterion: 1.5.7

The organisation ensures that the nutritional needs of consumers / patients are met.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.5.7

The Service clearly demonstrated a major focus on the nutritional requirements of consumers.

Food management strategies for the service are driven by dieticians in collaboration with food service managers and clinical staff, with regular consumer food satisfaction surveys further assisting this strategy.

Menus which contain an extensive variety of healthy food with a focus on low fat and low sodium are planned well in advance to facilitate the adoption of healthy eating habits by consumers. By planning in this way, consumers are offered an extensive variety of food within the menu. Dietary planning that takes into account medical, cultural, religious, ethnic and nutritional needs of the consumer was also evident.

Liaison between dieticians, speech pathologists and other clinical staff determine the most   appropriate diet for those consumers requiring assistance with their eating, for example, texture modification. Consumers receive individual dietary assessment as part of nutritional risk screening and the overall dietary status of consumers is determined upon admission to the service. This screening is conducted with a physical health assessment which measures height, weight, waist, BMI and any changes in weight. There was ample evidence of nutrition care plans for consumers considered 'at risk' accompanied by clear service protocols for the management of such consumers.

A comprehensive review of food services, which included consumer input, has seen a change in the way in which food enters and leaves preparation areas as well as an alteration in the duties of those involved in this preparation. For example, individual cooks take responsibility for special diets. A State wide Nutrition Screening Assessment and Support policy is to be rolled out by the end of 2011; this policy will be used to further inform procedures and workplace instructions. There has been considerable staff education regarding dietary management of consumers with a focus on screening the 'at risk' population. This education is supported by educational material available for staff on the intranet.

Data regarding the dietary status of consumers is collected and reported via the intranet as well as being tabled at the Health Improvement Project meetings. This project has as its focus the objective of improving the overall dietary and nutritional status of consumers. Annual physical health audits are also a component of this project with the findings being reported locally and at the Mental Health Benchmarking Forum.

There was sound evidence of action plans that address obesity, weight and metabolic management as well as audits of individual care plans focusing on obesity and malnourishment. There was further evidence that dieticians and treating teams review the nutritional status of consumers on a regular basis to ensure nutritional care is being maintained. Consumers attend group discussions which focus on healthy eating and good nutrition. There are also cooking sessions for consumers where they select the food they wish to eat and then cook and eat it.

Recommendations

No Recommendation

Function: Clinical	Standard: 1.6

Criterion: 1.6.1

Consumers / patients, carers and the community participate in the planning, delivery and evaluation of the health service.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.6.1
Consumer Participation:
The strength of consumer participation was clearly evident across the Service. The diversity of consumer roles was very impressive and included: Consumer Consultants, Consumer Liaison Workers, Consumer Advocates, Consumer Companions, Consumer representatives, CAGs and Consumer & Carer Networks and Peer Support Workers. Some roles are soon to be re-established at Toowoomba.

The large number of activities undertaken by consumers, in various formal roles, and the MHS was equally impressive. These included membership on the Mental Health Executive by the Consumer Consultants in Toowoomba and Ipswich, which is unique within the State for these roles, the Breaking Free Concert (Toowoomba), and the establishment of a Consumer & Carer Network (Toowoomba) with funds provided the MHS, and under the auspice of a local NGO.

Other activities include: the designated consumer space at The Park, Consumer Services (The Park) which also includes "Fashion on The Park" – a clothing Op-Shop, attendance at the rural clinics' social BBQs in the West Moreton District, establishment of the CAG Group at (Ipswich), the Recovery Wall (Ipswich Acute Inpatient Unit), the Arts programme for Ipswich community consumers, development of a photograph 'gratitude' wall project for consumers and carers at Dalby, as part of 2011 Mental Health Week, the development of a Mental Health Week Bookmark which promoted mental health wellbeing, rural consumer and carer forums, participation in the State-wide Consumers' Perceptions of Care Survey and participation in the State-wide Consumer Companions evaluations.

It was noted that there was a lack of formal documentary evidence on the informal feedback provided by a variety of stakeholders to the broad range of consumer workers in the MHS.

There was a wide divergence across the whole MHS in relation to the utilisation of specific formal consumer roles. The employment of peer support workers at Toowoomba will be put into effect once the formal MOU between the MHS and a local NGO is finalised. There are a range of mechanisms which

support consumers in formal roles to receive relevant information, education and training; i.e. the peer mentoring programme, Consumer Companions' courses, peer support worker courses and others.

There are limited social activities for consumers in some of the units. Such activities assist consumers to gain skills, relieve boredom and undertake aspects of their recovery journeys.

Carer Participation:
Carer participation is still in its infancy stages throughout the services across the two Districts. The employment of Carer Co-Ordinators to support and facilitate carers' experiences of the MHS is a positive initiative. However it was noted that the two MHS employees are not, in fact, carers who have a lived experience of caring for a loved one living with mental illness. This could be seen to reduce the capacity of the MHS to gain enhanced mechanisms and feedback from carers with the lived experience of accessing and negotiating with the MHS in support of their family member.
Some highlights include: The publication of a carers' information booklet, which also provides carers with a range of contacts to support and assist them, and the Family Support orientation programme operated at The Park.

NGO Participation:
The linkages of the service with the non-government sector are strong on a range of levels throughout the service, however there are opportunities for improvement in some areas, especially NGO access to support and assistance from clinicians to assist the consumer who is becoming increasingly unwell.

One of the strengths of the service is the employment of Service Integration Co-Ordinators for each of the Districts in the service. However, it was also apparent that the success of such roles is dependent upon the personality of the actual co-ordinator rather than the structures and mechanisms which are put into place to support and enable NGO service providers to work in positive partnerships with the service.

The Agency Visit programme which is organised by the Ipswich Consumer Liaison worker is highly beneficial for NGOs to be able to promote their services to consumers and inpatient unit staff.

Recommendations

Criterion 1.6.1 #1

Surveyor's Comments:

The informal feedback given to the consumer workers should be captured and evaluated.

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

Develop mechanisms for the documentation of informal feedback given to the consumer workers for potential evaluation in the future.

Criterion 1.6.1 #2

Surveyor's Comments:

Consumer roles should be reviewed to see how they should develop for the future.

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

Undertake an independent evaluation of all the consumer roles with a view on how these roles can be progressed and developed.

Criterion 1.6.1 #3

Surveyor's Comments:

It was noted that in a number of locations consumers were bored and isolated at weekends.

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

Investigate the feasibility of consumer services providing additional weekend social activities in a range of locations to reduce the boredom and social isolation of consumers.

Criterion 1.6.1 #4

Surveyor's Comments:

The information regarding visiting hours at The Park are incorrect and this should be altered.

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

Review the details of visiting hours in the Carers' Information booklet at The Park to ensure factual information is provided to carers regarding times and days for visiting.

Criterion 1.6.1 #5

Surveyor's Comments:

The Park is a State-wide facility. The provision of video conferencing access to carers and family members would facilitate increased contact with the consumer residing at this facility.

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

Investigate the feasibility of providing videoconferencing facilities at The Park (being a State wide facility) to enable carers and family members to have increased contact with the consumer residing at this facility.

Function: Clinical   **Standard: 1.6**

Criterion: 1.6.2

Consumers / patients are informed of their rights and responsibilities.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.6.2

There are a range of mechanisms to support consumers to be informed of their rights and responsibilities. However, there was no evidence to confirm, or otherwise, that consumers understood their rights and responsibilities or whether staff assisted consumers to understand them.

It was noted that currently the State-wide Consumers Perception of Care survey is being rolled out and there has been an enormous uptake by the service to support the completion of this survey for consumers.

It was further noted that full body protection armour, which includes helmet and soft shields, is soon to be implemented for staff working in the High Security Unit at The Park. The equipment is unique at this site however the survey team could not identify any effective policies and procedures regarding how the system would be implemented, and in doing so, how consumers' rights would be protected, nor when and in what situations staff would be able to utilise such equipment.

It is suggested that all clinicians in the MHS receive education and training on Australia's international signatory obligations, under the United Nations "Declaration of the Protection of Persons with Mental Illness and the Improvement of Mental Health Care", "Universal Declaration of the Rights of Disabled Persons" and the "Universal Declaration of Human Rights". The MHS should develop effective mechanisms and requirements for clinicians, which effectively uphold these rights for mental health consumers.

The surveyors noted that QH smoke free campus policies and procedures have provision for inpatient mental health units to maintain designated smoking areas, subject to review and endorsement by relevant senior level State personnel. This matter will require constant review and management.

Recommendations

Criterion 1.6.2 #1

Surveyor's Comments:

Information on rights and responsibilities for consumers and carers should be on display and be easy to read and understand. Surveyors noted that this information was not readily displayed throughout all areas.

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

Ensure the Rights and Responsibilities posters are clearly displayed throughout the Service's facilities and the information is included in information packages and booklets.

Criterion 1.6.2 #2

Surveyor's Comments:

Consumers who have little or no carer/family support should have access to increased advocacy support when they attend mental health review tribunal hearings.

Surveyor's Recommendation: HPR:No

Work in partnership with the Consumers & Carers Advisory Forum to develop mechanisms for consumers to gain increased access to advocacy support when they attend mental health review tribunal hearings, especially consumers who have little or no carer/family support.

Criterion 1.6.2 #3

Surveyor's Comments:

There has been no survey to determine whether consumers receive or understand the rights information provided to them.

Surveyor's Recommendation: HPR:No

Survey consumers to ascertain the level of receipt, knowledge and understanding of rights information provided to them.

Function: Clinical   **Standard: 1.6**

Criterion: 1.6.3

The organisation meets the needs of consumers / patients and carers with diverse needs and from diverse backgrounds.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   1.6.3
A number of activities are being undertaken by the MHS to assist the development and implementation of a range of strategies to meet the needs of consumers and carers from diverse backgrounds. For example:

·   Specific employed positions for staff to spearhead a broad range of activities on behalf of this population group; assist and support clinicians to gain an increased understanding on the needs, issues, ideas, suggestions and concerns on how the MHS can met their needs;
·   The close liaison with the Health Service Indigenous Health Co-ordinator to assist with referrals and development of culturally sensitive programmes;
·   The new position for an Aboriginal & Torres Strait Islander Child & Youth Service Integration Co-Ordinator soon to be implemented in Toowoomba;
·   External reference group which consists of CALD, Community Leaders, Elders and the NGO sector;
·   The use of interpreters as required;
·   Education sessions across the regions to assist the level of professional involvement including medical staff;
·   Compulsory ATSI training;
·   The Journal Club at The Park;
·   Consultation and liaison services; and
·   Educating school students from a culturally and linguistically diverse background.
There are a range of activities, networking and liaising with a broad range of stakeholders to promote culturally and linguistically diverse issues with the broader health, other governmental departments and the wider community.
There was also evidence of the range of KPIs which include mandatory reporting by the MHS to Queensland Health. It is strongly suggested that the MHS reviews information provided in other languages for various population groups, to ensure that consumers and carers from as many population groups as possible receive relevant information, including rights and responsibilities, in their own language.

Recommendations

No Recommendation

FUNCTION SUMMARY: SUPPORT

The organisation has systems in place to ensure that quality improvement activities are undertaken and evaluated. There is appropriate governance of quality improvement activities via the Patient Safety and Quality Committee within mental health, aligning to the District committee to enable consistent reporting. There is also a clearly expressed commitment of management to quality improvement and evidence of quality improvement activities within the organisation's 90 day plans.

There are systems of risk management in place within the organisation. Risk management is communicated to staff during orientation and is also on the agenda of team meetings and via the consultative committee meeting processes within the organisation. Risk assessment tools such as the occupational violence risk assessment tool and the Facility/Unit Risk Assessment Tool (FURAT) are available and used within the organisation. The PRIME CI (Clinical Incident information management system) is used within the organisation to report risks.

SAC 1 and SAC 2 incidents are reviewed. Human Error and Patient Safety (HEAPS) and Root Cause Analysis (RCA) is undertaken as required. The PRIME CF is used to report on consumer feedback and is also used to identify and respond to consumer complaints or concerns, with a system to identify high priority concerns and referral to the relevant manager. Training is in place to ensure staff have an understanding of the quality improvement and risk management systems within the organisation and their use. Training in HEAPS and RCA is also undertaken.

The organisation has in place workforce planning activities in relation to redevelopment at The Park and Baillie Henderson. These activities include wide spread staff consultation and the involvement of key stakeholders such as unions and professional associations.

There are systems in place to ensure recruitment and selection takes place in accordance with the Office of Public Service Merit and Equity (OPSME) directives. These processes ensure that all staff are registered with their governing body and hold appropriate credentials. Training in the organisation's selection processes is available. A system is in place to ensure the currency of registration and credentialing within the organisation.

There is a Performance Appraisal and Development (PA&D) process in place. Staff report that where this process is used it can be very beneficial. There is some variability across the organisation in relation to completion of these PA&Ds. Systems that enable better reporting to the mental health executive on these plans, as well as some aspects of training e.g. fire safety and aggression management, would be useful enhancements to current arrangements.

There is a staff development calendar. There is evaluation of staff education and training activities that run from simple satisfaction surveys to detailed evaluation of knowledge, skills and attitudes and the subsequent impact on service delivery. The organisation has been working to improvement the quality of leadership and management through a variety of training activities. There are strong links with the University of Queensland and the University of Southern Queensland.

There is a well-attended and functioning system of staff consultative committees that are facility, discipline and District based. Here staff can raise a variety of concerns from risk to staffing levels. Managers participate in these committees in an effort to manage concerns as soon as they arise. There is an employee assistance program in place.

The organisation has extensive health promotion personnel and activities which served it well in the January 2011 flood disaster. There is a range of staff and patient focused well-being activities which are showing initial positive results.

The surveyors were impressed with the systems that were available to the Service. The Service has a very good structure for information and communication technology (ICT) which is closely linked to the State-wide structure. The State also manages business continuity, licences, standards, risk management, maintenance and virus protection functions. There are State-wide policies and procedures for the ICT system and regular internal and external audits occur to ensure that the procedures are followed. Financial and statistical reports were seen to be of a high standard. The libraries provide an excellent service for staff to assist with information for quality improvement, study and research activities.

There are established, highly regarded research activities based at The Park with additional research conducted at other major hospital locations. The increase in senior medical staff numbers and their interest in conducting research mean that this area will increase in coming years.

EXHIBIT 1286

Function: Support   **Standard: 2.1**

Criterion: 2.1.1

The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   2.1.1

Following the previous ACHS survey a recommendation was made that the Service develop a systems approach to quality improvement activities in consultation with staff and consumers and undertakes evaluation of the approach on a regular basis. The need for an organisation-wide quality improvement framework that is integrated with the District Safety and Quality Framework was accepted and actioned by the Executive.

Subsequent to this recommendation, the Service has developed a quality improvement plan that is now detailed in its Operational Plan and regularly reviewed at service and Unit level via the 90 day action plans. The surveyors received positive feedback from staff that the 90 day planning cycle was clear and that it supported teams in identifying goals and that it provided the opportunity to focus on particular projects or to kick start new quality initiatives.

The surveyors recognise that the Service has made considerable efforts to address the recommendation from the previous survey and that this has resulted in a much more robust approach to continuous quality improvement. It is hope that the Service will be able to build on these foundations to continue to develop its quality improvement and patient safety programs.

Recommendations

No Recommendation

Function: Support   **Standard: 2.1**

Criterion: 2.1.2

The integrated organisation-wide risk management framework ensures that corporate and clinical risks are identified, minimised and managed.

<u>**Organisation's self-rating: MA**</u>   **Surveyor rating:MA**

Overall Comment

Overall Comment   2.1.2

Alongside the Quality Improvement Framework, the Service has developed an Integrated Risk Management Framework which is based on the Queensland Health Integrated Risk Management Policy and Implementation Standards and is integrated with the District Risk Management Framework. Risks are reviewed by the District Patient Safety and Quality Committee. The Darling Downs West Moreton HSD Risk Reporting Process is clearly set out in the Risk Reporting Procedure.

The Integrated Risk Management Analysis Matrix is utilised to determine risk ratings and corporate, clinical and Occupational Health and Safety risks are logged onto QHRisk – the Integrated Risk Management Information System utilised across Queensland Health either on a Departmental risk register if the risk is assessed as low or medium or escalated to Division or District risk registers depending on the risk rating. Extreme risks are reported via the Executive Director of the District to the District Chief Executive Officer for immediate action.

At both Division and District level risk registers are reviewed every three months and risks that cannot be managed are escalated to the District in the case of the Division or in the case of the District to the Queensland Health Executive Management Team.

It was noted that the integrated risk management framework constituted a more robust approach to risk management across the Service and the Service is encouraged to continue the process of integrating the service risk management framework with the District risk management framework.

Recommendations

No Recommendation

Function: Support   **Standard: 2.1**

Criterion: 2.1.3

Health care incidents are managed to ensure improvements to the systems of care.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   2.1.3

The Patient Safety and Quality Framework is supported by the Patient Safety and Quality Service and designated Patient Safety Officers across the Mental Health Service. The Service utilises the Clinical Information Management Implementation System – (CIMIS) – and all incidents including near misses are reported on Prime CI.

The Procedure for Clinical Incident Management sets out the process for District application of clinical incident management. RCA is used to investigate all SAC 1 incidents and consumers are involved in RCA investigations. The Procedure flowchart sets out a triage process for determining the most appropriate tools for clinical investigation of other incidents and implementation of the open disclosure process and the appointment of open disclosure consultants.

The close working links between the Patient Safety Officers and the Quality Teams means that these teams can assist with the development of action plans to manage recommendations from clinical investigations and these action plans can be incorporated into quality improvement programs when appropriate.

Recommendations

No Recommendation

Function: Support	Standard: 2.1

Criterion: 2.1.4

Health care complaints and feedback are managed to ensure improvements to the systems of care.

Organisation's self-rating: MA   **Surveyor rating: MA**

Overall Comment

Overall Comment 2.1.4

It was noted that the consumer complaints management procedures are comprehensive. They are governed by and comply with the Queensland Health Consumer Complaints Management Policy, the Implementation Standard and the Consumer Complaints Management Model. All consumer complaints are registered on Prime Consumer feedback (Prime CF)-including consumer complaints, complaints by staff about consumer care and complaints to the Queensland Health Quality and Complaints Commission.

Quarterly reports on the number and nature of complaints and the timeframes in which complaints are resolved are provided to Queensland Health. In turn, collated complaints management reports are provided to Districts by Queensland Health to identify trends and performance across the State.

Complaints coordinators manage the complaints process, consult with the complainant about their desired outcome and keep the complainant informed of the management of the complaint. Complaints are tracked to identify trends. Compliments and Complaints feature as a standard agenda item at the Division of Mental Health Safety and Quality Committee meetings.

Compliments and complaints boxes are at the entrance to all services. Any complaints / compliments received via this mechanism are entered into the appropriate PRIME system for action and reporting.

The service is commended on the focus on consumer feedback whether positive or negative and innovative approaches such as the bouquet of flowers cards available in some units to assist consumers in giving positive feedback to staff.

Open disclosure has been implemented out across the Service, on-line training is now available for open disclosure and the service is focussing on training more mental health open disclosure consultants.

Recommendations

No Recommendation

Function: Support   **Standard: 2.2**

Criterion: 2.2.1

Workforce planning supports the organisation's current and future ability to address needs.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   2.2.1

There are systems in place to enable adequate workforce planning. The organisation is an active participant in the State wide workforce planning and advisory group. The implementation of the Queensland Mental Health Workforce plan is proceeding within the organisation. There has been the development of a workforce planning framework that considers issues of supply, demand and staff turnover.

There is evidence of the creation of workforce development committees and workforce planning days within the organisations. These have been created to support the redevelopment plans for The Park and Baillie Henderson Hospital. These committees have broad representation from within the organisation as well as unions.

The organisation was the first to trial a mental health workforce development officer position, a position that has subsequently been created in other Districts within Queensland. This position works to engage undergraduates during their placements in the District to attract them to the District to work after graduation. The officer also works to support the settlement of new staff into the District by helping them with the practical aspects of settling into a new location. The position also works with local universities to ensure that they are aware of the workforce needs in the District into the future.

The organisation is open to external review and evaluation as evidenced by a review of the mental health medical workforce which included workforce requirements and skill mix. This review has been used to inform workforce planning and service development.

Recommendations

No Recommendation

Function: Support   **Standard: 2.2**

Criterion: 2.2.2

The recruitment, selection and appointment system ensure that the skill mix and competence of staff, and mix of volunteers, meets the needs of the organisation.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   2.2.2

The organisation has a robust system in place to ensure that the recruitment and selection of staff complies with relevant requirements in the Office of Public Service Merit and Equity (OPSME) directives, QH recruitment policies, and the Industrial Relations Manual.

The organisation has a system in place that ensures medical officers hold appropriate credentials and work within their scope of practice. There is monthly reporting of currency of registration and a system of reminders for staff and managers to ensure all staff, who should be registered, are registered.

There are established orientation programs for all types of staff. This orientation occurs at both a District level and is facility specific. The orientation program has been modified as a result of feedback.

There is a HR score card that reports on a variety of recruitment and selection indicators including rates of re-advertisement as well as the proportion of appointments and unsuccessful candidates.

Although there are volunteers who provide support to the District, the mental health service has no volunteers, except for Darling Downs, and all consumer consultants and peer support workers are paid for their time.

Recommendations

No Recommendation

Function: Support **Standard: 2.2**

Criterion: 2.2.3

The continuing employment and performance development system ensures the competence of staff and volunteers.

Organisation's self-rating: MA **Surveyor rating:MA**

Overall Comment

Overall Comment   2.2.3

The organisation works to ensure that systems for clinical supervision are in place for all staff. There are training programs available for staff who provide clinical supervision.

Clinical supervision is available from clinicians both inside and outside the organisation. There are written templates available describing the expectations of supervisors and supervisees involved in clinical supervision. Interviews with allied health staff indicated that access and support for clinical supervision is part of the culture of the organisation. Work has been undertaken within the organisation to make clinical supervision available to nurses. The release of nursing staff from inpatient units has been an issue that the organisation has worked to overcome through the provision of group clinical supervision.

There is a system of performance appraisal and development agreements are in place. A system for training managers in the use of the performance appraisal and development system has been established and is being implemented across the District. The performance appraisal system is linked to the learning development needs of the staff and reports from staff indicate that this system, when used, works well to support the learning and development needs of staff.

The completion of performance appraisal and development agreements is a standing item on the team leaders' reports to mental health executive. It is currently not possible to report on completion rates of performance appraisal and development agreements for mental health.

The planned implementation of the Resource Management System (RMS) should enable reporting on these agreements for the executive and service units within the organisation and further developments in this area are encouraged.

Recommendations

No Recommendation

Function: Support   **Standard: 2.2**

Criterion: 2.2.4

The learning and development system ensures the skill and competence of staff and volunteers.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   2.2.4

There is a staff training calendar which includes orientation, basic life support and more advanced subjects such as mental health clinical outcomes, information system training and aggression management. This education program has been shaped by a number of different activities including a staff training needs analysis, in response to management concerns, service developments or reform along with the strategic direction and guidance of Queensland Health. The training offered by the organisation is responsive to issues as they arise, for example, injection technique was identified as an issue in one part of the service and the learning and development system was able to respond to this identified need with the use of a "practice bum" to ensure consistency in technique.

The training calendar is regularly reviewed to ensure it continues to meet the needs of the organisation. Education planning days occur and are timetabled into the future. The organisation hosts the Queensland Centre Mental Health Learning (QCMHL) which provides training both within the District and across the State.

The educational activities are evaluated in a number of ways. Evaluation can include simple post session satisfaction ratings. More complex evaluations such as comparing pre and post knowledge and attitude questions are aimed at demonstrating change as a result of attendance, whilst detailed evaluations aim to determine the impact of education on practice. These evaluations are used to make modifications to the education and training activities, for example the adoption of a recovery orientation to practice and the implementation of the strengths model of practice with a focus on "SMART" goal setting.

The organisation has worked at providing educational opportunities to develop the leadership skills of managers and team leaders, including how to handle conflict and better understand workplace behaviour using DISC (dominant, influential, steadiness and conscientiousness) training.

The organisation has strong links with local universities. At The Park nurses have the opportunity to complete a Masters degree through the University of Queensland along with rotation through a variety of clinical areas. There are also conjoint positions in nursing and psychology in Darling Downs with the University of Southern Queensland which provide a richer and more integrated experience for students on placement with the organisation.

Recommendations

No Recommendation

Function: Support   **Standard: 2.2**

Criterion: 2.2.5

Employee support systems and workplace relations assist the organisation to achieve its goals.

Organisation's self-rating: MA   **Surveyor rating: MA**

Overall Comment

Overall Comment   2.2.5

The organisation has worked hard to identify and respond to staff conflict. Management are open to external review and advice as well as new ideas and change to ensure staff work within a framework that is conducive to a harmonious work environment. There is system of consultative committees within the organisation at facility and District level.

The local consultative forums (LCF) work to ensure the identification and, if possible, resolution of issues as they arise. These committees deal with a range of issues from OH&S to staffing to clinical risks. If an issue is not able to be resolved at the LCF level then it is progressed to a District Consultative Forum (DCF). The DCF provides a forum for the identification and resolution of issues that may be applicable across services and are not limited to facility issues. A Nursing Workloads consultative committee has been created to ensure that specific nursing issues are dealt with by the organisation.

A special feature of these committees is the attendance of both senior and middle managers at committee meetings. Meetings are well attended and staff report that the committees work well and give them a voice within the organisation where important issues are resolved.

There is an employee assistance program in place, staff have knowledge of the program and report satisfaction with the service.

Recommendations

No Recommendation

Function: Support   **Standard: 2.3**

Criterion: 2.3.1

Health records management systems support the collection of information and meet the consumer / patient's and organisation's needs.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   2.3.1

Policies and procedures are in place to guide the storage, retrieval and management of electronic and paper records. The Queensland Health Records Management policies ensure that sound standard practices are maintained in conjunction with the State-wide electronic systems. The system allows for the timely retrieval of records when requested. Record privacy is well managed. There is a sound system in place to link electronic and paper records. Staff are gradually utilising CIMHA for community consumer health records and reducing the use of paper based records. The "EVOLVE" community team already uses the CIMHA electronic medical records systems exclusively.

All other services should be encouraged to use the electronic record only. Some staff have been reluctant to fully utilise CIMHA. However the benefits of CIMHA were realised during the January 2011 flood disaster when electronic records could be remotely accessed by staff who were unable to travel to where the paper based records were held. CIMHA is a fully integrated system and it can receive reports and attachments to enable it to provide comprehensive health record information. CIMHA can be accessed at all sites and will reduce the voluminous paper based records currently used and stored for long term consumers.

Consumers are able to access their records in accordance with the State regulations. The unique identifier is part of the State-wide mental health consumer system. This system is able to detect duplicate records and corrective action is taken if this occurs. This system also links inpatient and community consumer records by the interface between HBCIS and CIMHA.

Coding is undertaken in accordance with national standards. Internal coding audits are regularly undertaken to test compliance with the standards. External audits also take place annually and action is taken to address any issues raised in these audits. The Service also makes regular checks to ensure coding is completed in a timely manner as required by Queensland Health. Staff are trained in their responsibilities in health record management. Medical record content audits occur and action is taken to improve the record whenever necessary. The Service is considered to have met all the elements to support an MA rating.

Recommendations

No Recommendation

Function: Support   **Standard: 2.3**

Criterion: 2.3.2

Corporate records management systems support the collection of information and meet the organisation's needs.

Organisation's self-rating: SA   **Surveyor rating:MA**

Overall Comment

Overall Comment   2.3.2

The Service has a comprehensive range of corporate information. There is a range of record management systems in use across the service. A wide range of data is readily available to meet the Services' internal and external reporting needs. Ongoing improvements to the system are occurring. Key corporate information is archived and is available for retrieval when required. Records are being increasing kept in electronic form. Record retention is in line with the Queensland Health Policy. Information privacy and security are well maintained.

Internal and external audits are undertaken and recommendations are acted upon to ensure the validity of the data. Good storage systems are in place and detailed policies govern the retention and destruction of records. There is a document management system in place. There are guidelines for managing financial records. The financial and statistical reports are comprehensive and of a high standard. Financial audits occur.

There is regular staff training on information and data management. All staff expressed satisfaction with the training and support available to them. The Service rated this criterion SA. The surveyors noted that corporate records are well managed and accordingly all the elements for an MA rating were met.

Recommendations

No Recommendation

Function: Support   **Standard: 2.3**

Criterion: 2.3.3

Data and information are collected, stored and used for strategic, operational and service improvement purposes.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   2.3.3

The information management strategic plan is a State-wide plan. The surveyors noted that it was a proactive plan and the service was benefiting from the introduction of new and upgraded systems. Good training programs teach staff how to best utilise these systems in their daily work. There is a system of "super users" in each unit throughout the Service. The policies and procedures which relate to the ICT system are also State-wide.

There are also State-wide common documentation procedures. Regular internal and external audits occur to ensure that the policies and procedures are complied with. Improvements are made following a review of the audit recommendations.

A wide range of data is collected and utilised. Reporting requirements are well met. All departments receive comprehensive financial and statistical reports. The Service has formed an ICT committee. A key goal of the committee is to develop a local ICT plan which will ensure that the Service fully utilises the systems available to it and staff continue to develop higher level IT competencies.

The Service should develop an ICT operational plan covering issues at a local level. Staff have access to comprehensive library systems including a variety of external data bases for quality improvement, study and research activities. Users are able to securely access the library's electronic database from outside the hospital. A wide range of reference material is available, and the resources are well utilised. Library staff assist staff to best utilise this very good service. The Service has met all the elements for an MA rating.

Recommendations

Criterion 2.3.3 #1

Surveyor's Comments:

The Service should develop an ICT operational plan covering issues at a local level. This plan would be linked to the State-wide plan and examine ways to ensure that systems are best utilised for the benefit of the Service. This plan would enable the Service to set a time frame for the full implementation of CIMHA as well as other initiatives which need to be driven at a local level.

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

Develop an Information Management Operational Plan for Service level initiatives in conjunction with the State-wide plan.

Criterion 2.3.3 #2

Surveyor's Comments:

The ICT operational plan should examine ways to ensure that systems are best utilised for the benefit of the Service. One such issue could be the establishment of timeframes by which individual units reduce the use of paper based records and exclusively use the CIMHA electronic medical records system.

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

Utilise the Information Management Operational Plan to ensure that there is a timely and progressive strategy for the full implementation of CIMHA across the Service.

Function: Support   **Standard: 2.3**

Criterion: 2.3.4

The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   2.3.4

The Service has a good governance structure for information management which is closely linked to the State-wide structure. There are State-wide policies and procedures for the ICT system and regular internal and external audits occur to ensure that the procedures are complied with.

There are multiple State-wide systems in place for disaster recovery and to protect the system from hacking and virus attack. Staff expressed satisfaction with the support they received from the Help Desk. Licences are also held on a State-wide basis. The hardware and printers are regularly upgraded. Maintenance services are readily available and down time is minimal.

Several departments advised surveyors that they frequently had problems getting access to a computer. The ICT provision is a centralised system managed by Queensland Health. The surveyors were impressed with the systems that were available and how well they were being utilised. The systems were seen to be particularly helpful to the rural services and their consumers especially when consumers are transferred to major centres for care. The systems, and the increased use of the intranet, have improved communication throughout this large service. The Service has met all the elements for an MA rating.

Recommendations

Criterion 2.3.4 #1

Surveyor's Comments:

Several departments advised surveyors that they frequently had problems getting access to a computer. This was cited as one reason that the conversion to CIMHA was slow.

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

Review access to computers across the Service to ensure that there are sufficient computers available to staff to enable the full utilisation of CIMHA and other data systems.

Function: Support   **Standard: 2.4**

Criterion: 2.4.1

Better health and wellbeing is promoted by the organisation for consumers / patients, staff, carers and the wider community.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

> **Overall Comment   2.4.1**
> There are numerous health promotion activities taking place across the District with specific personnel involved in coordinating, delivering or supporting in this area. The Child Youth Mental Health Service provides an innovative program for indigenous women which is very well received by the community. There is ongoing input from various staff into phase 2 of the Disaster (flood) recovery. Physical health data from the high secure unit at The Park was collected with dietary staff input and consequent alteration to the sugar and salt content of ward foods.
>
> Two 'Ed-LInQ' clinicians work across a wide area and support indigenous and carer groups as well as providing mental health first aid training to various community organisations. Consumer Consultant and Indigenous Coordinator also conduct Mental health First Aid courses. There are Primary Care liaison officer positions which support General Practitioners and provide information for clinicians. Health promotion officers work with local communities and provide links to health education activities, distribution of information brochures and support of community events that promote healthy life styles and improved mental health. A multicultural mental health coordinator works with a very diverse range of community groups in the Toowoomba area and shows evidence of a broad range of activities and contacts.
>
> The Park dietician has been involved in several projects looking at the health of staff and patient groups.
>
> A 'biggest loser' program evolved from 150 out of 500 staff being involved in health checks. A consumer-completed "strengths" tools were utilised at The Park - focused on the patients' perspective of their level of wellness. A "Better work place" staff survey supports the delivery of these activities with data regarding demand for and need of health promotion activities.

Recommendations

No Recommendation

Function: Support   **Standard: 2.5**

Criterion: 2.5.1

The organisation's research program develops the body of knowledge, protects staff and consumers / patients and has processes to appropriately manage the organisational risk associated with research.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   2.5.1

Research takes place across the District in diverse ways. The Park site has a number of State wide and international groups that are contributing to significant translational studies. These research groups are linked with the Queensland Brain Institute and The Park Centre for Mental Health.

Among the projects discussed at survey were the role of Vitamin D deficiency in winter birth associated with schizophrenia and drug trials for older person's mental health looking at monoclonal antibodies for Alzheimer's disease prevention.

There is also a very broad range of skills and interests in the clinical workforce which allows research possibilities to be pursued. This is especially true in the senior medical staff workforce which has recently filled two long standing vacancies and now has an appropriate critical mass of senior medical staff.

It would be useful for the organisation to pursue links between senior medical staff across the major campus sites. This may enhance learning and grow the current culture of research and improvement to maintain momentum in this area. Utilising the existing organisation-established research resources, particularly those based at The Park, and the general hospital research resources at TBH, would enhance this effect. Strategic plans for The Park Centre for Mental Health exist.

Recommendations

No Recommendation

FUNCTION SUMMARY: CORPORATE

The overall strategic direction for the Service is set out in the Queensland Health Strategic Plan for 2010-2015. In addition, the Mental Health, Alcohol and Other Drugs Directorate of Queensland Health is responsible for setting the strategic policy direction for mental health reform in Queensland.

Consequently, the Darling Downs West Moreton Health Service District's Mental Health Operational Plan 2010 - 2011, which is the endorsed Divisional Operational Plan, needs to reflect the strategic direction set out in both overarching frameworks. This integrated operational planning was clearly evident and the Service undertook ongoing review and development of the operational plan via the 90 day planning cycle.

The service is currently moving through a period of change and transition. There is ample evidence of robust governance structures flowing down from the District to the Division and to teams and units. These governance structures are set out in the Committee Manual. However, the current restructure will require the service to review and realign a number of its existing governance processes including its existing committee structures, reporting lines and delegations schedules. Contract management is very well managed and is beneficial to the Service. Contracts are fully evaluated and action is promptly taken if there is evidence of unsatisfactory performance.

There was clear evidence that corporate and clinical policies and procedures are in place to assist the service in providing quality health care. Revision of the District Procedure and Workplace Framework has seen the development of a management implementation plan that will ensure that both corporate and clinical policies, procedures and workplace instructions are put into place. As part of this initiative a process has been developed to identify policies for review as well as policies that need rescinding.

Furthermore, this implementation process monitors compliance, particularly legislative compliance. There was sound evidence of ongoing audit processes that examine adherence to procedures and workplace instructions as they pertain to Statewide policies. All policies, procedures and workplace instructions are available via the intranet. In instances where new or complex policies are released staff education is provided to ensure understanding by both corporate and clinical staff.

There have been many internal and external audits of specialist credentialing and employment processes over the last few years that have contributed to these robust and complete processes. The growing senior medical work force is skilled, has diverse experience and is well supported by medical administration processes.

Safe Practice and Environment functions operate within a set of policies, procedures, safe operating procedures, reporting, monitoring and benchmarking, and command and control systems set by Queensland Health. All can be readily accessed by any staff member with access to a computer and the internet and intranet.

A number of "housekeeping "issues were identified - the most important being the use of plastic bag bin liners, which potentially could be used for self harm.

Systems are in place which ensure that new equipment is checked and calibrated before it is commissioned by the department which will use it, and that it is checked, calibrated and maintained on a regular basis via the CMMS system.

With respect to the migration of services from The Park to Redland, some services such as those at the Barrett Adolescent Unit have had their move delayed by 2-3 years. While considerable work has been carried out on the safety and security of the facility there was a 'run down 'environment with dark corridors and lounge furniture in need of repair.

Waste is removed by contractors who provide monthly reports on volume and segregation. Regular visual audits are carried out in wards which in turn generate in-service training and re-audits. Site Waste Management Plans are reviewed every five years. While water conservation is well addressed, methods of monitoring energy usage (carbon footprint) need further development.

External, internal and business continuity plans were significantly tested during the floods in January/February 2011. At the time of the survey the experience was still being evaluated. When this process has been completed, the organisation will have developed innovative disaster response systems and integrated plans with other services in the community. The floods severely disrupted the process of mandatory training for fire, evacuation and aggression management (and manual handling) so that compliance rates were highly variable across the organisation.

Major security risks have been identified and are well managed. Security assessments have been carried out and staff have been involved in the design of new high security facilities at The Park. There are two systems for monitoring security -The first reports on incidents to which Security staff have responded. These are monitored at a District level and by Workplace Health and Safety Committees. The second system consists of clinical reports on physical and verbal aggression on the part of consumers.

The surveyors noted instances of poor security responses to duress alarms in both the Inpatient Unit and the Older Persons Inpatient Unit at Ipswich and that duress alarms were not always worn in extended care units, such as those at Baillie Henderson Hospital. It was also noted that security officer credentials were not regularly checked after the initial appointment.

EXHIBIT 1286
Organisation: Darling Downs - West Moreton Health Service District - Division of Mental Health
Orgcode: 715686

DTZ.001.400.0190

Function: Corporate   **Standard: 3.1**

Criterion: 3.1.1

The organisation provides quality, safe health care and services through strategic and operational planning and development.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   3.1.1

The strategic and operation planning framework for the service is led by the Queensland Health Strategic Plan for 2010-2015. The Queensland Health Strategic Plan is adopted at a District level and the Service is required to develop its operational plan as an integrated part of the overall District Plan.

In addition, the Mental Health, Alcohol and Other Drugs Directorate of Queensland Health is responsible for setting the strategic policy direction for mental health reform in Queensland, leading mental health legislative policy analysis and development, and planning, funding, reviewing and redeveloping public mental health services.

As a consequence, one of the challenges for the Darling Downs West Moreton Health Service District Mental Health Operational Plan 2010 -2011 which is the endorsed Divisional Operational Plan is to be able to reflect the strategic direction set out in both overarching frameworks. The planning framework also incorporates a Clinical Services Capability Framework and a series of Models of Service covering specific programs and consumer groups.

The surveyors note that the service has been able to develop a robust and integrated operational plan and a committee structure to support implementation of this plan. However, the challenge facing the executive is the current restructure of the District which will see changes in boundaries and realignment of services and reporting lines. During this process the service will need to plan for, and manage, a range of risks such as the financial allocations for the redistributed services and most importantly the impact on staff and consumers.

Recommendations

No Recommendation

Function: Corporate   **Standard: 3.1**

Criterion: 3.1.2

Governance is assisted by formal structures and delegation practices within the organisation.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   3.1.2

The governance structure for the Service, like the Service itself, is currently moving through a period of transition. The Committee Manual sets out the Darling Downs – West Moreton Health Service District Committee structure as at 30 June 2011. As set out in the Committee Manual (March 2010) one of the first milestones for the District after the previous amalgamation was the establishment of a Governance Framework which included the realignment and reforming of the District's committee structure. At the time of the last restructure a mapping exercise was undertaken of existing committee and governance processes and committee structures were realigned.

The committee structure as set out in the Manual identifies District committees and Divisional committees and the reporting relationships between them. Standards for managing committees and other sub-committees and working groups are identified and committee responsibilities for key performance indicators are set out. It is noted that the task facing the service is to repeat this process once again and realign the governance framework and committee structure to reflect the new Districts and District boundaries and reporting lines. Likewise, delegations schedules and District Procedures which have been put in place for the Darling Downs – West Moreton Health Service District are under review.

The surveyors acknowledge that this is a challenging time for the executive, the staff and their consumers. The surveyors also recognise the commitment of the service to maintaining good consumer care during this period of major change.

Recommendations

No Recommendation

Function: Corporate   **Standard: 3.1**

Criterion: 3.1.3

Processes for credentialling and defining the scope of clinical practice support quality, safe health care.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   3.1.3

There are two main sites (TBH and IGH) where credentialing is coordinated with respect to senior medical staff. The systems at each site are uniform, robust and follow very detailed State and national legislation that has been updated in recent years. There are some issues with the length of time from recruitment through to application and credentialing checks but this is being gradually improved. Improvements include the mutual recognition of credentialing status, particularly for specialists working across multiple sites and/or interstate. This is less of an issue in Psychiatry.

It was noted that once a new staff member is appointed and commences as an employee in the organisation there is a very comprehensive orientation, support and gradual induction program with one-on-one support from administration services and colleagues. This is likely to continue a trend of high retention and recruitment success rates.

Scope of practice and credentialing for ECT is bound by regulation and supported by many processes and State run training programs. These also support training for nursing ECT coordinators and psychiatric registrars. An inspection of registrar training in June 2011 showed high levels of satisfaction and the training scheme was re-accredited.

Recommendations

No Recommendation

EXHIBIT 1286
Organisation: Darling Downs - West Moreton Health Service District - Division of Mental Health
Orgcode: 715686

DTZ.001.400.0193

Function: Corporate   **Standard: 3.1**

Criterion: 3.1.4

External service providers are managed to maximise quality, safe health care and service delivery.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   3.1.4
There are clear policies and procedures which govern the tendering, letting and managing of external contracts. Standard contracts and service agreements are used by the Service and these comply with State-wide policies. There is a register of all contracts and contract performance is regularly reviewed. The licences, insurance, standards and contract performance for each contractor are also reviewed.

There are Contractors Guidelines and contractors receive an orientation to the Hospitals. Contractors' licences and insurance policies are checked. Minor works and maintenance contracts use Public Works contracts. All contractors have a detailed site induction and they must sign in and out of the facilities. The system was seen to be working effectively and an MA rating is supported.

Recommendations

No Recommendation

Function: Corporate   **Standard: 3.1**

Criterion: 3.1.5

Documented corporate and clinical policies and procedures assist the organisation to provide quality, safe health care.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   3.1.5
There was clear evidence that corporate and clinical policies and procedures are being utilised throughout the Service to ensure the provision of quality safe health care. Revision of the District Procedure and Workplace Framework has occurred within the Service resulting in a management implementation plan which will undergo further refinement later in the year. This system has ensured implementation of, and compliance with, new or amended legislative requirements and put in place evaluation mechanisms for overall policy management. A checklist has been developed to monitor compliance with new or amended legislative requirements. This checklist also identifies changes to documents related to new or amended legislation. The information is then tabled at local team meetings to update staff and ensure they are meeting their legal responsibilities with respect to policies and procedures.

The District Clinical Standards Committee has representatives from all clinical areas on its membership and mechanisms have been developed to identify those policies and procedures that require review. There is also a mechanism whereby the committee can receive requests to review identified policies. When corporate policies are received by the service they are sent to corporate services, while clinical policies when received by the service are sent to the appropriate custodian.

There are clear processes in place for review and updating of procedures and workplace instructions, which are then reported to the District Patient Safety and Quality Committee. Statewide policy and clinical standards are also reported through to the Mental Health Patient Safety and Quality Committee. In instances where there is a deviation from the policy, liaison occurs with Statewide bodies and evidence based alternatives are negotiated.

There was evidence of ongoing audit processes that focus on adherence by the service to clinical procedures that are in accordance with State wide policies. These audits are tabled at the Mental Health Patient Safety and Quality Committee. Results of audits are also forwarded back to clinical teams in a timely manner for any adjustments that may be required. These audit results are standing agenda items in all clinical team meeting.

Staff have the capacity to develop a procedure by following a process which requires them to submit the procedure to the local standards committee, via their manager. If policies are deemed to be unviable they are taken back to the Centre for Health Care Improvement for review. All policies, procedures and workplace instructions are available on the intranet. There was clear evidence that there had been substantial review of procedures across the service within the last year, resulting in procedures and workplace instructions that are relevant to the type of services currently being delivered. There was also evidence of a schedule for reviewing policies and procedures whereby they are flagged, reviewed or rescinded. Once this occurs, the intranet data base is updated and earlier versions withdrawn.

Recommendations

No Recommendation

Function: Corporate   **Standard: 3.2**

Criterion: 3.2.1

Safety management systems ensure the safety and wellbeing of consumers / patients, staff, visitors and contractors.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   3.2.1

Safety and Workplace Injury Management in the organisation operates within a set of policies, guidelines, safe operating procedures, and reporting systems set by Queensland Health and managed through the District.

Each District site has its own trained Workplace Health and Safety Officer reporting to the site administration, the District and Queensland Health. Each site has a workplace Health and Safety Committee set up under the Queensland Occupational Health and Safety Act with managerial and elected staff representatives. Training of representatives is encouraged but is not mandatory under

Queensland legislation. Where Mental Health Services are located within hospitals they have membership of the Hospital Workplace Safety Committee. Where they are stand-alone such as BHH (Toowoomba) and The Park (Goodna) they have their own committees. Where other services are also located at Mental Health sites these have representation on the Committee although this system is still the process of development at BHH.

All staff receive Workplace Health and Safety training at orientation and there is mandatory annual training for Manual Handling, Aggression Management and Fire and Evacuation procedures.

Hazards are identified and managed through a number of mechanisms. Workplace Health and Safety Incidents are reported using an electronic system "Prime" which also requires reports on actions taken for the management of the risk. Data are collated at a Queensland Health level with major risks identified and reported back through Monthly Key Risk reports. For the organisation these are Violence and Ergonomic injuries (strains and sprains). Standard Safe Operating procedures have been developed to manage most of these risks. These include training in methods and the use of equipment to minimise manual handling injuries. Routine environmental audits of workplaces are carried out, using standardised check lists. Risk assessments, which include manual handling and aggression, are carried out on individual consumers, work places, and for home visits. Corrective action or methods of managing identified risks are included in both the audits and the assessments.

Contractors undergo orientation and receive a handbook, prepared Queensland Health. They also sign an undertaking that they will abide by the workplace safety and security requirements. Access to a site is via the site maintenance office.

Key Risk Reports, incident reports, environmental audits, risk assessments, and reports on occupational injuries are reviewed by Workplace Health and Safety Committees at the site and district level and, in turn, by the organisation's Patient Safety and Quality Committee.

All hazardous substances are recorded in the electronic Chemalert system which also provides Material Safety Data Sheets. These can be accessed electronically by the majority of staff and hard copies are kept in areas such as cleaner's rooms, where staff do not have ready computer access. There was evidence of a programme to replace hazardous substance and their safe disposal. An audit of asbestos had been carried out and there is a management plan.

There is a robust system for the management of workplace injuries and return to work. Results are monitored and success is evidenced by both the rate of return to work, and workers compensation premiums.

Radiation is confined to a small number of dental x-ray machines in dental clinics. Safety issues and licensing is covered by the District Radiation Safety Officer and safety plan.

The effectiveness of the system within the District is evaluated regularly by an external company contracted by Queensland Health. This is carried out on a site basis. Toowoomba was reviewed in 2011 and received an Organisation and Assessment Report with recommendations for improvement a few weeks before the survey.

Staff have been involved in the design of Facilities and the migration of existing services to other sites. Examples include the renovations of the Emergency Department at Toowoomba, the design of a new secure ward at The Park, and the movement of services from The Park to other facilities in Queensland.

EXHIBIT 1286
Organisation: Darling Downs - West Moreton Health Service District - Division of Mental Health
Orgcode: 715686

DTZ.001.400.0196

Recommendations

Criterion 3.2.1 #1

Surveyor's Comments:

A number of "housekeeping" hazards were noted during the survey including storage of cartons on the floor in the Inpatient unit at Ipswich due to a lack of designated storage space.

Surveyor's Recommendation: HPR:No

Ensure that supplies are not stored on the floor in any part of the Service and that staff are reminded about this important matter.

Criterion 3.2.1 #2

Surveyor's Comments:

Concern was expressed regarding the storage of sharps at Dalby. There is potential that consumers could access the storage area where these are kept.

Surveyor's Recommendation: HPR:No

Audit the sharps storage facility at Dalby to ensure access is restricted to authorised staff.

Criterion 3.2.1 #3

Surveyor's Comments:

It was noted that unperforated plastic bags are used in all facilities for the collection and storage of rubbish in patient areas. Plastic bags have been known to have been used by consumers as mechanisms for self harm. The Service should risk rate the options for the introduction of different rubbish collection bags to ensure that they cannot be used for self harm.

Surveyor's Recommendation: HPR:No

Rubbish be collected and stored in bags which cannot be used for self harm.

Function: Corporate   **Standard: 3.2**

Criterion: 3.2.2

Buildings, signage, plant, medical devices, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   3.2.2

The maintenance of buildings, plant and equipment as well as purchasing and cleaning are governed by Queensland Health policies, procedures and guidelines, which are readily available on the internet.

The electronic CMMS system contains an asset register of all plant and equipment which includes manufacturer's instructions for maintenance. From this, planned preventive maintenance is scheduled and carried out and the same system is used for ad hoc repairs and maintenance ordered electronically or by telephone by nursing or other staff.

The work is carried out by tradesmen on staff or by external contractors, all of whom have received orientation on workplace safety and security requirements. Requests are risk rated. Defects discovered from routine environmental audits are entered are recorded and electronic requests for rectification made on the CMMS system. There is a system for monitoring work carried out and outstanding on a monthly basis. The District has an asset register of all its buildings and is in the process of carrying out a condition assessment of all of its buildings, in the order of 530 some more than a century old. This expected to be completed in 2014. There are annual maintenance plans for buildings, plant and equipment, which prioritised in accordance with risk and budget constraints.

The surveyors noted out of date electrical tagging in some areas such as television rooms in the Older People's Mental Health Unit in Ipswich and in a gymnasium at BHH.

Medical equipment and supplies are purchased in accordance with Queensland Health policies and contracts. These include provision for representation on the Queensland Products Advisory Committee, complaint resolution and the correction of defects or poor quality.

District Products Officers assist with selection of equipment and consumables. Prior to a decision, items are tested by clinicians. A recent achievement has been the replacement of obsolete Imed pumps. Systems are in place which ensure that new equipment is checked and calibrated before it is commissioned by the department in which it will be used, and that it is checked, calibrated and maintained on a regular basis via the CMMS system.

The Queensland Health Biomedical Team makes six monthly visits to maintain and calibrate bio medical equipment. Routine items are maintained in patient areas on an imprest basis, with electronic scanning and automatic reordering by stores staff. Non stock items are requisitioned electronically.

Housekeeping and cleaning is carried out in accordance with Queensland Health c-Cleaning guidelines and policies. There are specifications for each area. Cleaning is carried out by in house Resident Support Officers, and evaluated regularly using a standardised auditing system. Recent improvements have included the implementation of dry steam cleaning in bathrooms which reduces the risk of slips and falls.

Signage is evaluated from consumer feedback and audit to confirm that it complies with the requirements of Queensland Health's Wayfinding guidelines.

There are formal plans for water conservation and energy saving which have involved changes to plumbing and light fittings.

Recommendations

Criterion 3.2.2 #1

Surveyor's Comments:

With respect to the migration of services from The Park to Redlands, some services such as those at the Barrett Adolescent Unit have had their move delayed by 2-3 years. While considerable work has been carried out on the safety and security, the overall environment would benefit from further modifications to the lighting and repairs to the furniture.

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

Improve the environment of the Barrett Unit e.g. dark corridors and furniture requiring repair.

Function: Corporate   **Standard: 3.2**

Criterion: 3.2.3

Waste and environmental management supports safe practice and a safe and sustainable environment.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   3.2.3

Waste and Environmental Management in the organisation operates within a nest of Queensland Health, District, and Hospital Policies, procedures and management plans covering the streaming and recycling of waste, waste removal, and water and energy conservation/reduction of carbon emissions. Waste management is included in staff orientation augmented by on line training packages. The management and disposal of waste is included in a training package for all external contractors.

Waste is removed by contractors who provide monthly reports on volume and segregation. Regular visual audits are carried out in wards which, in turn, generate in-service training and re audits. Results are reported to the Infection Control Committee. Considerable improvements have been made in the segregation, safe disposal and monitoring of kitchen waste. There was evidence of plans for reduction in the use of water and energy and their implementation through changes in plumbing and lighting systems.

Site Waste Management plans are reviewed every five years. The surveyors sighted evidence that this occurs.

Recommendations

Criterion 3.2.3 #1

Surveyor's Comments:

While waste and water usage is monitored regularly, the monitoring of carbon usage is in its early stages with the introduction of energy saving devices in some areas.

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

Develop a robust system for monitoring and reducing carbon emissions.

Function: Corporate   **Standard: 3.2**

Criterion: 3.2.4
Emergency and disaster management supports safe practice and a safe environment.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   3.2.4

Emergency and Disaster Management systems operate within Queensland legislation (Disaster Management Act), a State Wide Disaster Plan, Queensland Health Disaster Plans, a Psycho Social plan augmented with a Mental Health Recovery Plan (May 2011),and District and Site/Hospital External Disaster Plans, business continuity plans and internal emergency response plans.

Emergency responses to fire, bomb threats, violence and other such events are included in staff orientation and fire and evacuation are part of annual mandatory training. This is both face to face and on line. There is monthly training for fire wardens, and regular table top evacuation exercises are carried out in some units such as those at BHH. Fire extinguisher training is carried out using an innovative electronic system which simulates various types of fire and the extent to which the extinguisher had been successfully utilised.

There was evidence of compliance with triennial fire inspections which are carried out on all buildings by an external body. Rectification plans were in evidence.

There have been a number of simulation exercises to test the external disaster plans including Orko for floods (November 2010), Emergo (June 2011) and Phoenix for bushfires (August 2011). All have been evaluated.

External, internal and business continuity plans were tested to the utmost in the floods which occurred in January/February 2011. Ipswich, West Moreton (Grantham and Murphy's Creek), Toowoomba, Dalby and Kingaroy all experienced flooding, the destruction of houses, farms and infrastructure, and deaths. Staff members were also victims of the floods. Some mental health premises were flooded, and staff isolated but nevertheless the Mental Health emergency response worked well and included mental health first aid, preparation to receive residents of evacuated Nursing Homes, and working with other agencies with staff

flown in from other States.

At the time of the survey, the experience was still being evaluated but lessons learned included the need to have back-up systems, outside of Human Resources Department, for contacting staff, working with staff cut off from base, the importance of working in defined geographic sectors and with other agencies, and having Deputies for crucial roles. As a result of the flood, business continuity plans have been revised, and a concerted effort made to develop better disaster plans with other services (police, ambulance) and local government. When this process has been completed the organisation will have developed innovative disaster response systems and   integrated plans with other services in the community.

Recommendations

Criterion 3.2.4 #1

Surveyor's Comments:

It was noted that where the service was located on an acute hospital site, it was difficult to isolate records for compliance of mental health staff with mandatory training requirements from that of the hospital as a whole.

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

Where mental health services are part of an acute hospital, methods be devised to identify and monitor mental health compliance with mandatory training.

Criterion 3.2.4 #2

Surveyor's Comments:

The floods severely disrupted the process of mandatory training for fire, evacuation and aggression management (and manual handling) so that compliance rates were highly variable across the organisation. However the surveyors sighted plans to ensure a high level of compliance by the end of the calendar year.

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

The organisation ensures that all staff have completed mandatory training by the end of the calendar year as planned.

Function: Corporate   **Standard: 3.2**

Criterion: 3.2.5

Security management supports safe practice and a safe environment.

Organisation's self-rating: MA   **Surveyor rating:MA**

Overall Comment

Overall Comment   3.2.5

Security management operates within policies and procedures set by Queensland Health and the District, and is managed by District Corporate Services. Major security risks have been identified.

Mental Health sites have security controlled card or key access, CCTV surveillance, dual exits from rooms and fixed duress alarms. Staff wear personal alarms and risk assessments of consumers, of home visits and of work areas are conducted. Training in the management of aggressive behaviour is provided for all staff.

In the large centres (Ipswich Hospital, The Park and Toowoomba Hospital) trained security officers are in attendance with two per shift. These officers assist with mental health incidents but specific actions are guided by clinical staff. Toowoomba has security assistants as back-ups. Warwick and Dalby have security assistants, porters or cleaners with some security training, rather than security officers and links with police.

Community Services such as those used by CYMH and ACT in a shopping centre in Ipswich, and extended care facilities such as BHH have regular security patrols. Security staff have key roles in response to fire and are used to special patients.

Security assessments have been carried out and staff have been involved in the design of new high security facilities at The Park, where extensive improvements have been made, and ED renovations at Toowoomba.

An external review of security was carried out at The Park in 2009. Legal advice has been obtained as to the powers of security officers in electronic screening of staff and visitors in high security areas. Risk management procedures have been developed for the newly established EVOLVE Teams which manage children, in the community, who are subject to Care orders from the courts.

There are two systems for monitoring security. The first reports on incidents to which Security staff have responded. These are monitored at a District level and by Workplace Health and Safety Committees. The second system consists of clinical reports on physical and verbal aggression on the part of consumers.

Security issues are included in Workplace Health and Safety environmental audits. Aggression management training is carried out centrally at The Park or BHH and tailored to the needs of particular staff groups. Mental Health Clinical staff have mandatory one off five day training and annual 2 day refreshers. Difficulties were experienced in the release of staff from High Security areas to undertake this training. Training was carried out in each unit which had three effects; training became more tailored for specific need, trainers obtained more acceptance and the incidence of aggressive incidents dropped.

Recommendations

Criterion 3.2.5 #1

Surveyor's Comments:

The mandatory requirement for Queensland Health appointments of security officers is completion of a two week certificate course which has a currency of 12 months. A security officer's licence can be obtained after 12 months with a currency of 3 years. There is, however, no system for checking that a security officer's knowledge and licensing is current after initial appointment.

Surveyor's Recommendation: HPR:No

Develop a mechanism to ensure that security officers maintain their credentials and licences.

Criterion 3.2.5 #2

Surveyor's Comments:

The surveyors noted instances of poor security responses to duress alarms in both the Inpatient Unit and the Older Person's Inpatient Unit at Ipswich. As mental health staff are well trained in managing aggression, an alarm would be considered an indicator of urgency. At the time, there were two security officers responding to incidents in the Emergency Department. Ipswich, unlike Toowoomba, does not have a back-up system of security assistants.

Surveyor's Recommendation: HPR:No

Develop a system for backing up security officers in the event of multiple calls for assistance.

Criterion 3.2.5 #3

Surveyor's Comments:

It was noted that duress alarms were not worn by all staff, particularly in extended care units at BHH. The staff were aware that the duress alarms should be worn in accordance with the policy.

Surveyor's Recommendation: HPR:No

Carry out a security risk analysis of extended care units with a view to ensuring staff wear duress alarms in accordance with the Services policy.

Rating Summary

Clinical

Criterion	Organisation's self-rating	Surveyor Rating	HPR
Crit. 1.1.1	MA	MA	
Crit. 1.1.2	EA	MA	
Crit. 1.1.3	MA	MA	
Crit. 1.1.4	MA	MA	
Crit. 1.1.5	MA	MA	
Crit. 1.1.6	MA	MA	
Crit. 1.1.7	MA	MA	
Crit. 1.1.8	MA	MA	
Crit. 1.2.1	MA	MA	
Crit. 1.2.2	MA	MA	
Crit. 1.3.1	MA	MA	
Crit. 1.4.1	MA	MA	
Crit. 1.5.1	MA	MA	
Crit. 1.5.2	MA	MA	
Crit. 1.5.3	MA	MA	
Crit. 1.5.4	MA	MA	
Crit. 1.5.5	N/A	N/A	
Crit. 1.5.6	MA	MA	
Crit. 1.5.7	MA	MA	
Crit. 1.6.1	MA	MA	
Crit. 1.6.2	MA	MA	
Crit. 1.6.3	MA	MA	

Support

Criterion	Organisation's self-rating	Surveyor Rating	HPR
Crit. 2.1.1	MA	MA	
Crit. 2.1.2	MA	MA	
Crit. 2.1.3	MA	MA	
Crit. 2.1.4	MA	MA	
Crit. 2.2.1	MA	MA	
Crit. 2.2.2	MA	MA	
Crit. 2.2.3	MA	MA	
Crit. 2.2.4	MA	MA	
Crit. 2.2.5	MA	MA	
Crit. 2.3.1	MA	MA	
Crit. 2.3.2	SA	MA	
Crit. 2.3.3	MA	MA	
Crit. 2.3.4	MA	MA	
Crit. 2.4.1	MA	MA	
Crit. 2.5.1	MA	MA	

Corporate

Criterion	Organisation's self-rating	Surveyor Rating	HPR
Crit. 3.1.1	MA	MA	
Crit. 3.1.2	MA	MA	
Crit. 3.1.3	MA	MA	
Crit. 3.1.4	MA	MA	
Crit. 3.1.5	MA	MA	
Crit. 3.2.1	MA	MA	
Crit. 3.2.2	MA	MA	
Crit. 3.2.3	MA	MA	
Crit. 3.2.4	MA	MA	
Crit. 3.2.5	MA	MA	

EXHIBIT 1286
Organisation: Darling Downs - West Moreton Health Service District - Division of Mental Health
Orgcode: 715686

DTZ.001.400.0205

Recommendations from Current Survey

Function: Clinical   **Standard:1.1**

Criterion: 1.1.1
Assessment ensures current and ongoing needs of the consumer / patient are identified.

Criterion 1.1.1 #1

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

Review all options for the provision of vehicles for the Ipswich Rural Community Mental Health Team to ensure that a more effective and efficient system of vehicle allocation can be provided.

Function: Clinical   **Standard:1.1**

Criterion: 1.1.2
Care is planned and delivered in collaboration with the consumer / patient, and when relevant the carer, to achieve the best possible outcomes.

Criterion 1.1.2 #1

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

Make progress with a recovery-based model of care with consumer/carer participation and review the documentation to ensure it demonstrates how this has been achieved.

Function: Clinical   **Standard:1.1**

Criterion: 1.1.3
Consumers / patients are informed of the consent process, and they understand and provide consent for their health care.

Criterion 1.1.3 #1

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

Develop a means of signifying the consumer's role in the development of and consent to care plans, perhaps by an entry in the electronic or paper record.

EXHIBIT 1286
Organisation: Darling Downs - West Moreton Health Service District - Division of Mental Health
Orgcode: 715686

DTZ.001.400.0206

Criterion 1.1.3 #2

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

Develop protocols to ensure that voluntary patients have understood their rights and that this can be audited.

Function: Clinical   **Standard:1.3**

Criterion: 1.3.1

Health care and services are appropriate and delivered in the most appropriate setting.

Criterion 1.3.1 #1

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

Develop longitudinal strategies to address staff and consumer issues, incorporating a recovery focused model of care.

Criterion 1.3.1 #2

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

Audit the clinical records across all Services on a regular basis, to ensure that the policy is complied with by all services.

Function: Clinical   **Standard:1.4**

Criterion: 1.4.1

Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.

Criterion 1.4.1 #1

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

Explore ways to separate the different consumer age groups in the waiting area at Dalby.

Function: Clinical **Standard:1.5**

Criterion: 1.5.1

Medications are managed to ensure safe and effective consumer / patient outcomes.

Criterion 1.5.1 #1

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

Review all refrigeration units that store medication and/or pathology specimens against the new Queensland Health Guideline and ensure that the Guideline is complied with as soon as possible.

Criterion 1.5.1 #2

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

Review the Clozapine prescribing and dispensing processes and include consideration of the best use of limited pharmacy services to improve this process and reduce delays in delivery of Clozapine to consumers.

Function: Clinical **Standard:1.6**

Criterion: 1.6.1

Consumers / patients, carers and the community participate in the planning, delivery and evaluation of the health service.

Criterion 1.6.1 #1

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

Develop mechanisms for the documentation of informal feedback given to the consumer workers for potential evaluation in the future.

Criterion 1.6.1 #2

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

Undertake an independent evaluation of all the consumer roles with a view on how these roles can be progressed and developed.

Criterion 1.6.1 #3

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

Investigate the feasibility of consumer services providing additional weekend social activities in a range of locations to reduce the boredom and social isolation of consumers.

Criterion 1.6.1 #4

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

Review the details of visiting hours in the Carers' Information booklet at The Park to ensure factual information is provided to carers regarding times and days for visiting.

Criterion 1.6.1 #5

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

Investigate the feasibility of providing videoconferencing facilities at The Park (being a State wide facility) to enable carers and family members to have increased contact with the consumer residing at this facility.

Function: Clinical   **Standard:1.6**

Criterion: 1.6.2

Consumers / patients are informed of their rights and responsibilities.

Criterion 1.6.2 #1

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

Ensure the Rights and Responsibilities posters are clearly displayed throughout the Service's facilities and the information is included in information packages and booklets.

Criterion 1.6.2 #2

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

Work in partnership with the Consumers & Carers Advisory Forum to develop mechanisms for consumers to gain increased access to advocacy support when they attend mental health review tribunal hearings, especially consumers who have little or no carer/family support.

Criterion 1.6.2 #3

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

Survey consumers to ascertain the level of receipt, knowledge and understanding of rights information provided to them.

EXHIBIT 1286
Organisation: Darling Downs - West Moreton Health Service District - Division of Mental Health
Orgcode: 715686

DTZ.001.400.0209

Function: Support   **Standard:2.3**

Criterion: 2.3.3

Data and information are collected, stored and used for strategic, operational and service improvement purposes.

Criterion 2.3.3 #1

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

Develop an Information Management Operational Plan for Service level initiatives in conjunction with the State-wide plan.

Criterion 2.3.3 #2

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

Utilise the Information Management Operational Plan to ensure that there is a timely and progressive strategy for the full implementation of CIMHA across the Service.

Function: Support   **Standard:2.3**

Criterion: 2.3.4

The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).

Criterion 2.3.4 #1

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

Review access to computers across the Service to ensure that there are sufficient computers available to staff to enable the full utilisation of CIMHA and other data systems.

Function: Corporate   **Standard:3.2**

Criterion: 3.2.1

Safety management systems ensure the safety and wellbeing of consumers / patients, staff, visitors and contractors.

Criterion 3.2.1 #1

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

Ensure that supplies are not stored on the floor in any part of the Service and that staff are reminded about this important matter.

Criterion 3.2.1 #2

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

Audit the sharps storage facility at Dalby to ensure access is restricted to authorised staff.

Criterion 3.2.1 #3

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

Rubbish be collected and stored in bags which cannot be used for self harm.

Function: Corporate   **Standard:3.2**

Criterion: 3.2.2

Buildings, signage, plant, medical devices, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

Criterion 3.2.2 #1

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

Improve the environment of the Barrett Unit e.g. dark corridors and furniture requiring repair.

Function: Corporate   **Standard:3.2**

Criterion: 3.2.3

Waste and environmental management supports safe practice and a safe and sustainable environment.

Criterion 3.2.3 #1

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

Develop a robust system for monitoring and reducing carbon emissions.

Function: Corporate   **Standard:3.2**

Criterion: 3.2.4

Emergency and disaster management supports safe practice and a safe environment.

Criterion 3.2.4 #1

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

Where mental health services are part of an acute hospital, methods be devised to identify and monitor mental health compliance with mandatory training.

Criterion 3.2.4 #2

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

The organisation ensures that all staff have completed mandatory training by the end of the calendar year as planned.

Function: Corporate   **Standard:3.2**

Criterion: 3.2.5

Security management supports safe practice and a safe environment.

Criterion 3.2.5 #1

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

Develop a mechanism to ensure that security officers maintain their credentials and licences.

Criterion 3.2.5 #2

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

Develop a system for backing up security officers in the event of multiple calls for assistance.

Criterion 3.2.5 #3
Surveyor's Recommendation: **HPR:No**

Carry out a security risk analysis of extended care units with a view to ensuring staff wear duress alarms in accordance with the Services policy.

Recommendations from Previous Survey

Function:Clinical	**Standard:1.1**

Criterion: 1.1.1 Assessment ensures current and ongoing needs of the consumer / patient are identified.

Recommendation: OWS08081.1.1   **High Priority:** No

Recommendation:
Mental Health

(i) An evaluation of the mental health consultation/liaison nurse role and workload in the emergency department of the Ipswich Hospital be undertaken.
(ii) The quantity and quality of office space and computer access available to all community mental health teams be reviewed.
(iii) A review of office security and sound-proofing at South Burnett Community Mental Health be undertaken.
(iv) The allocation of specific, rather than pool, vehicles to the Ipswich Rural Community Mental Health Team be considered so that assessment tools and other requirements [including those for physical examination, such as sphygmomanometers] can be stored in the vehicles.
(v) Consumer transport needs be reviewed in order to facilitate their access to assessment and other clinical services in South Burnett.
(vi) Access to assessment and other clinical services for South Burnett consumers in the older age group be reviewed.

Action:

(i) Completed.
An evaluation for the Mental Health Clinical Liaison Nurse role has been conducted in Emergency Department (ED), Ipswich Hospital. There was an introduction of a twelve hour shift to ensure all mental health consumers are provided with timely assessment in ED and wards.

(ii)
Completed.
The quality and quantity of office space was reviewed and a physical restructure resulted. This allowed for corporate staff to be accommodated at the Health Plaza, and the accommodation of the Out Patient Mental Health staff in an adjacent area. Increased accommodation for Adult Mental Health, including office space for registrars has resulted. Computers are allocated according to QHealth policy.

(iii)
The responsibility for this building is Corporate and there are redevelopments occurring in the South Burnett area.
Mental Health refurbishment completion due 30/6/11 which provides greater security and increased functionality of both clinical and staff space.

(iv) Completed.
It is a district policy to pool rather than allocate vehicles and this remains unchanged. Information has been sought from other services to ascertain similar practices for home visits that require the use of clinical assessment tools, this recommendation is still in progress.

(v) The Team Leader (SB) attends a Kingaroy Health Related Transport Reference Groups and has tabled this issue on the agenda (4/2/09) for ongoing discussion and resolution. However, reference group disbanded (2011). Consumers encouraged to access rural transport service (ie Graham House Blue Print for the Bush) which also encourages a recovery orientated principle. The MHS works with the consumer gauge the best possible outcome.

(vi)
Completed.
A visiting psychogeriatrician has increased his services to Kingaroy from three monthly to fortnightly.
Communication has improved between Kingaroy and OPMH unit at Toowoomba regarding admissions to
that ward. A worker has been designated to Older Patient Mental Health (OPMH) in the team.

Completion Due By:

Responsibility:

Organisation Completed: No

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

i) The role of the CL nurse has been reviewed to include referral systems and referral forms.

ii) This is an ongoing issue that is not resolved and will be a recommendation in 2.3.4.

iii) The site at South Burnett Community has been refurbished.

iv) The allocation of vehicles will be a continuing recommendation as the growth of the services and case
load is not reflected in the allocation of vehicle resources.

v) Consumer transport has been reviewed-the intent of this recommendation has been addressed.

vi)Access for older age consumers has been addressed

Recommendation: OWS05081.1.1   **High Priority:** No

Recommendation:

The recruitment of the Director of Psychiatry and senior medical staff for the acute service continue to be
a priority for the service.

Action:

Consultant Workforce at establishment needs.
Recruitment of Clinical Director delayed by amalgamation - agreed to Whole of District position.
Job Description modified.
Progressed to advertisement with closing date of September 2009.
Candidate chosen and letter of offer issued, Offer was declined.
Position was unsuccessfully re-advertised.

Undertaken a review of medical services and recommendation are currently being actioned (20/7/2011)

Completion Due By:

Responsibility: DMHS

Organisation Completed: No

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

The recruitment has been completed and was successful.

Function:Clinical   **Standard:1.1**
Criterion: 1.1.2 Care is planned and delivered in collaboration with the consumer / patient, and when relevant the carer, to achieve the best possible outcomes.

Recommendation: OWS08081.1.2   **High Priority:** No

Recommendation:
Mental Health

(i) The installation of video-conferencing facilities at Goodna Community Clinic be considered, in order to support clinical care of consumers admitted to inpatient facilities [Ipswich] and to strengthen continuing professional development activities.
(ii) The seclusion room on the Aged Care Inpatient Unit be considered for conversion into a snoezelen room [or similar].
(iii) Strategies be identified to further enhance and strengthen the implementation of research outcomes of the Queensland Centre for Mental Health Research, which now has an established international reputation.

Action:
i) Under ongoing consideration, and financial prioritisation.

(ii) Complete. The Seclusion room was needed for its intended purpose, however, a mobile "sensory basket" takes place of the actual room and clients remain more settled in their own environment with these aides.

(iii) Complete. QCMHR is a statewide research unit. Responsibilities for the translation of mental health research outcomes into practice involves the development of strategies that have the potential to advance practice at all Queensland Health Mental Health facilities, not just The Park. QCMHR is currently in negotiations with the Mental Health Branch to formally amalgamate with Queensland Mental Health Statewide Education, policy, and early psychosis units to create a governance structure through which research outcomes are first translated into policy, then translated into education and training strategies to disseminate the skills needed to enact the policy, then implemented through early psychosis and similar mental health service providers. The amalgamation will be known as the Queensland Centre for Mental Health. When amalgamated, QCMHR will report directly to the Mental Health Branch and will no longer be a unit of The Park. The Service & Evaluation Unit which operates independently of QCMHR will remain at The Park and will continue to be responsible for research involving The Park and its residents, eg evaluation studies, program implementation studies.

Completion Due By: 30/1/2010

Responsibility: EDMHS

Organisation Completed: No

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

i) Video-conferencing facilities have been installed at Goodna.

ii) The seclusion room has been maintained with limited use and a 'sensory' basket is available if required.

iii) These strategies have been identified and addressed.

Recommendation: OWS05081.1.2   **High Priority:** No

Recommendation:
Mental Health

(i) The organisation move to a recovery-based model of care, with consumer/carer participation in care planning.
(ii) The Electro-Convulsive Therapy Committee recommendations be implemented, in line with the Queensland Health "Guidelines for the Administration of Electroconvulsive Therapy (ECT)" September 2006.
(iii) The criteria for admission to the acute mental health unit be reviewed, to ensure that there is no inappropriate admission of complex patients, eg those compromised by intoxication or delirium.
(iv) The use of the seclusion rooms continue to be monitored, especially the second one, until it is relocated as part of the redevelopment plan, and in accordance with the statewide and Toowoomba Acute Mental Health Unit direction to reduce seclusion and restraint.
(v) The agreed recommendations of the Seclusion and Restraint Project be implemented as soon as they are endorsed by the Safety and Quality Committee at the September 2009 meeting.
(vi) At a suitable time interval after the redevelopment has been completed, eg six months, the effectiveness of the strategies used to reduce seclusion and restraint be evaluated.

Action:

(i) Consumer Advisory Network – TD in place.
Peer Support Program in place.
Family and Carer Advisory Group formed.
Community collaborative is underway and progressed.
Issues paper developed: 'Model of Service Working Party" to establish a Centre for Recovery and Rehabilitation.
and progressed to Stage 2 - Consultation and Planning.
Recovery training planned for 2009/2010.
Consumer Participation Reference Group reconvened, and Consumer Participation plan developed and monitored.
Funding received for research project "Learning Together: Exploring the role of mental health consumers in service provision".
Participating in "Perceptions of Care" research conducted by Qld Centre for Mental Health Research.
Procedure under development "Family /Carer Participation in Mental Health Clinical Care".
Alternatives to hospitalisation in place in Ipswich and Toowoomba (2011).

(ii) Completed. New Procedure developed in line with Corporate Guidelines. Representation on Statewide ECT forum. Linked to Management processes.

(iii) Integration meeting established with Emergency Department, addressing delirium, intoxication, withdrawal etc.
Working party formed. Progress continuing.

(iv) Completed. Redevelopment completed.
Seclusion Reduction Project activities implemented.
Revised Seclusion Procedure developed in line with Statewide Guidelines.
Successful reduction in the instances of seclusion - benchmarked state wide.
Staff training in Sensory Modulation.

(v) Endorsed and implemented and progress monitored. Ongoing development. Therapeutic Milieu
Committee formed (minutes available). Development of Audit Tool.

(vi) Completed. Seclusion data reviewed and benchmarked state wide.

Completion Due By: 30/6/2010

Responsibility: EDMH

Organisation Completed: Yes

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

i) The organisation has taken steps towards a recovery based model through education and training
which needs to be documented to reflect that this has been achieved. There will be a new
recommendation made to address this.

ii) These recommendations have been implemented.

iii) Standardised forms used for assessments including appropriate screening tools.

iv) Sensory modulation rooms in use. Seclusion monitored in line with State Guidelines.

v) Implemented and monitored.

vi) Seclusion data has been monitored and evaluated. Seclusion has decreased.

Function:Clinical   **Standard:1.1**
**Criterion: 1.1.3 Consumers / patients are informed of the consent process, and they understand
and provide consent for their health care.**

Recommendation: OWS05081.1.3   **High Priority:** No

Recommendation:
Mental Health

The consumer satisfaction survey conducted in July 2007 be repeated, and this survey cover the area of
consent and consumer understanding of consent.

Action:

The Corporately developed and sponsored "Consumer Perceptions of Care" survey was conducted
across the Division between 16 August to 10 September 2010.

Completion Due By: 30/9/2010

Responsibility: Mental Health Branch

Organisation Completed: Yes

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

This audit should be repeated.

Function:Clinical   **Standard:1.1**
Criterion: 1.1.4 Outcomes of clinical care are evaluated by healthcare providers and where appropriate are communicated to the consumer / patient and carer.

Recommendation: OWS08081.1.4   **High Priority:** No

Recommendation:
Mental Health

(i) An evaluation of the extent of integration between the rehabilitation service (The Park) teams and clinical units be undertaken with the objective of identifying additional strategies to strengthen care planning and delivery.
(ii) A review of patient transport needs such that all disabled consumers are able to participate fully in rehabilitation and other treatment programs be undertaken.
(iii) Housekeeping be included in a life skills program in the Medium Secure Unit for client self esteem.
(iv) Staff attitudes in the Adult Mental Health Unit be modified by training and/or recruitment of leaders who will make changes to bring workers up to a respectful client-based, recovery model of care.
(v) Concerns expressed by clients in the Adult Mental Health Unit about boredom be reviewed and measures be put in place to address them.

Action:

(i) The Park - Rehabilitation structures are changing as part of the Redevelopment of The Park (2009-2011). Different modules will be implemented. Extended Forensic Rehabilitation to occur as part of the Clinical Team. Basis of comparison can then be undertaken. Continue to improve Rehabilitation Progress report completion rates in conjunction with care planning.

(ii) The Park - Vehicle audit undertaken. Workgroup established to develop and implement action plan from recommendations. Current fleet has capacity to transport disabled consumers. Seatbelt extensions have been purchased.

(iii) Life Skills Program is changed regularly according to assessment of client need. Housekeeping skills included in rehabilitation program when required.

(iv) Strategies have been implemented to address communication and attitudes, these include staff training and mentoring. Role Plays and scenarios were developed for individual and group learning and discussion. Programs were designed to assist in developing an appropriate personal style of communication and the development of therapeutic rapport with clients. Positive feedback from staff and the educator indicate some changes in attitudes. A planning day with CNs was conducted with an emphasis on developing their leadership and articulating above the line and below the line behaviours, exploring values and their relationship to behaviours. The CNs committed to three positive behaviours (unconditional positive regard, supportive behaviour and respectful interactions). The OT has developed a recovery folder for each client that includes information and resources that support the clients recovery journey within the ward and into the community. This is an ongoing process.

(v) A number of activities and resources have been implemented. Board games, books and diversional activities have been purchased from grants from the IH Foundation, a further submission has been made for more materials. The Lutheran Church volunteers visit fortnightly and engage in socially with consumers, the Uniting Church is also in discussion for a similar project. The NUM is attending a Non Government Organisation (NGO) forum to engage NGOs further in the unit. NGO support workers are encouraged to continue their work with the client as an inpatient.

Completion Due By:

Responsibility:

Organisation Completed: No

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

These recommendations are closed.

Recommendation: OWS05081.1.4   **High Priority:** No

Recommendation:
Mental Health

(i) The service pursue opportunities to strengthen consumer participation across all aspects of the service.
(ii) Carer support and commitment be reviewed and strategies to promote carer advocacy across the service introduced, and these include a communication strategy to all key stakeholders.

Action:

(i) and (ii)
'Learning Together' Project.
Family and Carer Advisory Group formed.
Well Ways Program - Memorandum of Understanding in place and training sessions being delivered.
Bob Bland Program - education for families and carers - Clinicians trained and first sessions planned for early September 2010.
Family and Carer Information Package developed.
Ridley and Conolly Units have introduced unit programs for families and carers.
CAN-TD involved in service development and repositioning activities and comment on Policy and Procedure.
Community Collaborative formed.
Consumer Participation Reference Group reconvened and Action Plan developed.

Completion Due By: 30/9/2010

Responsibility: EDMHS

Organisation Completed: Yes

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

This recommendation has been addressed.

Function:Clinical   **Standard:1.1**
Criterion: 1.1.5 Processes for clinical handover, transfer of care and discharge address the needs of the consumer / patient for ongoing care.

Recommendation: OWS05081.1.5   **High Priority:** No

Recommendation:

The mental health service evaluate its discharge processes to ensure that the guidelines are appropriate across the service and are being complied with.

Action:

Ongoing.
Evaluate March 2009 to ensure whole of service coverage.
Evaluation to be referred to Rural Expert Panel - Terms of Reference out for consultation.
Acute and Community Unplanned readmissions data reviewed.
Admission / Discharge checklist to be reviewed.
Working party to review admission and discharge from rural areas resulting in revision of procedures.

Completion Due By: 30/10/2010

Responsibility: Inter Hospital Transfer Steering Committee

Organisation Completed: No

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

Admission/discharge checklist has been reviewed and is audited.

Unplanned readmission data collected.

Discharge planning on admission is evident on admission across most sites.

Function:Clinical   **Standard:1.1**
Criterion: 1.1.6 Systems for ongoing care of the consumer / patient are coordinated and effective.

Recommendation: OWS05081.1.6   **High Priority:** No

Recommendation:
Mental Health

(i) The service evaluate the links established, both within the service and out to community agencies.
(ii) The service pursue the feasibility of introducing a consumer [patient] flow model, which would allow a dedicated team to chart the consumer journey, identify obstacles to smooth transitions, and investigate remedial strategies.

Action:

(i)
Completed evaluation and actions taken.

Service Integration Coordinators recruited.
Community Collaborative Groups formed.
Reference Group formed to look at clinical linkages and processes with Community agencies and Non-government agencies.

(ii)
Representative on Toowoomba Hospital Flow Committee.
Formation of Divisional Patient Flow Committee (EDMH to Chair).
Complex Care committee formed.

Completion Due By: 30/10/2010

Responsibility: EDMH

Organisation Completed: No

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

i) There is evidence this recommendation has been addressed.

ii) This has been addressed via the newly formed complex care committee and uptake of CIMHA tool across the service.

Function:Clinical   **Standard:1.2**
Criterion: 1.2.1 The community has information on health services appropriate to its needs.

Recommendation: OWS05081.2.1   **High Priority:** No

Recommendation:
Mental Health

(i) The service use an existing tool eg satisfaction survey, to evaluate the utility of the Queensland Health booklet "Understanding Schizophrenia" and obtain feedback from all key stakeholders.
(ii) Management review the resource allocation to enable Child and Youth Services to implement a comprehensive promotion and early intervention program in partnership with other community child services.
(iii) Child and Youth Services explore the benefit of developing a formal agreement with other area/district services for access to child and youth specialist beds.

Action:
(i)
Service will action results of survey when completed.

(ii)
Linked to Statewide Plan both for resourcing and Centre for PP&Early Intervention.
Developing comprehensive Model of Care to cover spectrum of care as part of development / commissioning of Adolescent Unit and Day Program.
Mental Health First Aid for adolescents.
Coping programs being rolled out.
Edlink position funded to 20009/10.

(iii)
Completed.

Refer to data regarding InterService transfers.
Adolescent Inpatient Unit and day program - will be commissioned in early 2011.

Completion Due By: 30/10/2011

Responsibility: EDMH

Organisation Completed: No

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

Recommendations closed.

Function:Clinical	Standard:1.2

Criterion: 1.2.2 Access and admission / entry to the system of care is prioritised according to health care needs.

Recommendation: OWS05081.2.2   **High Priority:** No

Recommendation:

The mental health service consider reviewing the current patient flow model to ensure it streamlines bed flow processes in both the acute and extended inpatient services, and includes the assertive community management of clients who present to the Emergency Department and are discharged home, or those who may seek early discharge from the acute inpatient unit.

Action:

Acute Care Services available.
Plans for Acute Care Team in progress. Inter team referral processes developed.
Follow up discharge from acute unit with Emergency Department.
Extended Inpatient ServicesWorking Party established to review and improve Referral and admission processes.
CYMHS Project Officer appointed.
Clinical Meetings between Community and Inpatient teams to improve Consumer flow.

Completion Due By: 30/10/2010

Responsibility: EDMH

Organisation Completed: No

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

Recommendation closed.

Function:Clinical   **Standard:1.5**
Criterion: 1.5.1 Medications are managed to ensure safe and effective consumer / patient outcomes.

Recommendation: OWS08081.5.1   **High Priority:** No

Recommendation:
Mental Health

(i) The Park Campus develop a system for monthly auditing of medication in each program area.
(ii) The Park Campus develop a system for reviewing any trends discovered from the audit and developing a plan for improving performance in identified areas.
(iii) The Park Campus review the utilisation of pharmacy time to enable clinical input at ward level.

Action:
i)
Completed.
The Park - Audit and reporting mechanisms established to address identified medication issues.
Statewide audit undertaken Nov 08 and recommendations from audit progressed. This audit will be undertaken annually.
Medication issues identified through Pharmacy Interventions Report and PRIME reports. Reports tabled at Drugs & Therapeutics Committee monthly.
Medication standards to be included in quarterly Clinical Chart Audits.

(ii)
Completed.
Flowchart developed for reporting and progressing identified medication issues.
Process of reporting includes feedback / action from and to clinical program areas and local Drugs & Therapeutics Committee.

(iii)
Completed.
Pharmacy Assistant employed to expand Webster Packs program. Pharmacists allocated to clinical teams and attend Clinical Team meetings regularly. In-service sessions have commenced in Extended Treatment and Rehabilitation (ETR) on a needs basis. Progressing in-service sessions to remainder of clinical program areas.

Completion Due By: 30/12/2009

Responsibility: District Director Pharmacy

Organisation Completed: Yes

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

There were three recommendations from the previous survey. These recommendations were substantially met.

1) Auditing of medications and reporting regularly.
There is a system of end of shift chart review by staff in inpatient units with entry of errors on the incident management system. A photocopy of errors is made and brought to the attention of the clinical team for discussion. In addition there is external periodic review of medication auditing state wide. This information

flows back through to clinical risk management meeting for their information and actions.

2) Systems review trends and flowchart for reporting with feedback action to local services and therapeutics committee.
There are a number of other steps to track this issue and will include identification of themes with the delivery of in-service education. If specific staffs are identified as high associations with errors then targeted education and performance review can take place. The medication errors are reviewed on a daily basis through incident management systems and then brought to patient safety committee.

3) Utilisation for pharmacy time to provide support to clinical settings.
The pharmacy personnel are involved in ward clinical activities and supporting education around specific issues as identified through auditing and reviews. Pharmacy is respected at drug and therapeutic as well as patient safety committees.

These 3 recommendations were substantially met and can be closed. However, there is further work to clarify the processes of district wide learning from audits and improvements that have occurred. This system wide dissemination could occur in many ways and would be most successful if clinician led and link across sites and across disciplines.

Function:Clinical   **Standard:1.6**
Criterion: 1.6.1 Consumers / patients, carers and the community participate in the planning, delivery and evaluation of the health service.

Recommendation: OWS08081.6.1   **High Priority:** No

Recommendation:

Mental Health

(i) Data collection be reviewed by consumer consultants to record outcomes, strengths and weaknesses (Rehabilitation Team at The Park) so that their service and performance can be evaluated and opportunities for improvement identified.
(ii) Consultants in the Adult Mental Health Unit be provided with training to enable them to explain adult guardian and official visitor services.

Action:

(i)
Consultation with Consumer Consultant and Rehabilitation Program Coordinators to develop strategies. Consumer Consultant and Consumer Liaison Officer to participate in Rehabilitation Coordinators meetings.

(ii)
Completed.
The recruitment of a new Consumer Consultant has recently occurred and this will be included as part of their professional development.

Completion Due By: 30/12/2010

Responsibility: EDMH

Organisation Completed: Yes

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

Recommendation closed.

Recommendation: OWS05081.6.1   **High Priority:** No

Recommendation:
Mental Health

(i) The consumer satisfaction survey conducted in 2007 be repeated, and include a broad enough dissemination and adequate feedback to enable the service to analyse strengths and weaknesses in the consumer area of the service, so that this information can be used to implement strategies to strengthen consumer participation and responsibility.
(ii) The carer participation integration plan be finalised and show progress and evaluation of actions to be completed.
(iii) A carer information package or alternative be developed in conjunction with carers, and include information on carer support and education services, mental health literacy, community support services, carer representation and advocacy processes.
(iv) The service re-visit the family response model known as SAFE, develop and implement an alternative with a family education package, and allocate a facilitator to this project.
(v) The formal agreement with CAN-TD be reviewed to ensure that this organisation is meeting the expectations of the service, and the use of performance measures be considered for any adjustments or new agreements.
(vi) Staff be surveyed, particularly in the acute services, to ascertain their understanding of the consumer and carer role in the service and their knowledge of the consumer and carer aspect of the National Standards for Mental Health Services, particularly around application of the standards.

Action:

(i)
Linked to Statewide Survey strategy.
Consumer Perceptions of Care survey Planned for 16 Aug 2010.
(ii)
Completed.
Plan endorsed by Family and Carer Advisory Group.
Progress reported quarterly.

(iii)
Booklet developed and endorsed by Family and Carer Advisory Group.
Service consultation progressing prior to publication.

(iv)
Complete.
Well Ways program – Memorandum of Understanding in place and Training being delivered.
Bob Bland program - education for Families and Carers Training being deliveried.

(v)
Complete.
Review of Memorandum of Understanding completed.
CAN - TD model to be externally evaluated prior to next accreditation in 2012.
Alternate model to be investigated for 2009 / 2010 year.

(vi)
Statewide "Perceptions of Care" research will look at issues. Recommendations made and Action Plan
developed

'Learning Together' research project will survey staff attitudes related to recovery-oriented service
provision prior to, and again several months after, trialling a number of peer specialist roles in different
components of the service.
Recovery education being provided.

Completion Due By: 30/10/2010

Responsibility: EDMH

Organisation Completed: No

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

These issues have been addressed.

Function:Clinical   **Standard:1.6**
Criterion: 1.6.2 Consumers / patients are informed of their rights and responsibilities.

Recommendation: OWS08081.6.2   **High Priority:** No

Recommendation:

Mental Health

The integrated mental health service's inpatient program policy on informing consumers/patients of their
rights and responsibilities be reviewed to include the involvement of clinical staff in this process and the
documentation of the process in the health record.

Action:
Instructions were given to staff to document their action in providing information on R&R in the Patient's
Chart. In addition the NUM introduces this topic into the ward meeting on a regular basis for discussion.
This includes an overview of the Mental Health Act, Rights and Responsibilities and includes right to
appeal. Individual nurses respond to direct enquiries from patients. At admission, clients are provided with
written material, this is confirmed with a checking time in the admission checklist. MHA information has
been displayed in the ward and it has also been displayed in the community clinics. Consumer Liaison
officer and Social Worker provides voluntary education on rights and responsibilities. Recovery folder has
information on R&R, posters are placed strategically and the brochure stand is easily accessible for
consumers and their carers.

Completion Due By: 30/6/2010

Responsibility: EDMH

Organisation Completed: Yes

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

There is a new recommendation regarding rights.

Recommendation: OWS05081.6.2   **High Priority:** No

Recommendation:

The mental health service conduct a review of the consumer consultant workforce requirements across aspects of the service, including the tasks, and consideration be given to the allocation of peer support workers and individual advocacy.

Action:
Peer Support Program in place.
Mentoring Program in place.
Research has been undertaken.
Funding to be received January - February 2010 for Consumer Companion Program.
Consumer Companion Program implemented at the Park and Ipswich.

Completion Due By: 30/10/2010

Responsibility: EDMH

Organisation Completed: Yes

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

There is a new recommendation regarding this matter.

Function:Support   **Standard:2.1**
Criterion: 2.1.1 The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.

Recommendation: OWS08082.1.1   **High Priority:** No

Recommendation:

Mental Health

A systems approach to the mental health sector quality improvement activities be developed, including the many current audits, to be applicable for a specified time frame, developed in consultation with staff and consumer staff members and evaluated for progress on a regular basis.

Action:

The Divisional operation plan serves as the overall improvement plan, Service level plans and then unit plans focus on improvements to support the divisional plan. standardised reporting is via the 90 day plans. A single and integrated audit tool has been developed for the division, this meets the needs of Mental health units and aligns with the District process. All Patient SAfety and Quality is overviewed by MHPSQ Committee

Completion Due By:

Responsibility:

Organisation Completed: No

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

Appropriate action taken.

Function:Support   **Standard:2.1**
Criterion: 2.1.2 The integrated organisation-wide risk management framework ensures that corporate and clinical risks are identified, minimised and managed.

Recommendation: OWS08082.1.3   **High Priority:** No

Recommendation:
Mental Health

(i) The requirements for client follow-up and support post-incident be reviewed and formalised.
(ii) The Peer Support Program be evaluated for effectiveness of staff participation rates as measured against its aims and objectives.
(iii) An evaluation of the rate of incident reporting, clarification of incident types and an assessment of staff understanding and use of the PRIME system be undertaken.
(iv) The current complaint management process be broadened to capture first line complaints from all sources.

Action:

(i)
Open Disclosure (QHealth). The Park - Consumer Support Program is being reviewed and revised program to be re-established within the Medium Secure Unit for a 6 month trial period.

(ii)
Completed.
Evaluation of Peer Support Program has been completed and an action plan is being developed to implement the recommendations.

(iii)
Division wide reports on prime clinical incidents are produced for the Mental Health Patient Safety and Quality Committee. These reports allow assessment of reporting rates and trends across the division and there is no apparent significant variation between like units. The incident Types and Sub types within PRIME have been altered as of December 2009, Training on these changes has been provided and any ongoing issues and feedback is captured through Patient safety rounds.

(iv)
Recommendation is incompatible with Corporate Complaint System (PRIME -CF). The Park - SERU collects and collates data from varying sources (Community Visitor reports, TP-CAG, Consumer Forums, Complaints process, Consumer Satisfaction Surveys) annually and reports disseminated to business units and relevant committees. Records of the PRIME training provided is maintained through the Patient Safety and Quality Unit.

Completion Due By: 30/2/2010

Responsibility: Service Improvement Coordinator

Organisation Completed: No

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

Queensland Health has developed a Queensland Health Standard for the Requirements for Complaints
Systems (non-consumer complaints) with which the Service complies and a Queensland Health
Complaints Management System which includes a Queensland Health Staff Reporting Concerns Portal
on QHEPS. The surveyors are satisfied that this recommendation has been implemented.

Recommendation: OWS08082.1.3   **High Priority:** No

Recommendation:
Mental Health

(i) The requirements for client follow-up and support post-incident be reviewed and formalised.
(ii) The Peer Support Program be evaluated for effectiveness of staff participation rates as measured
against its aims and objectives.
(iii) An evaluation of the rate of incident reporting, clarification of incident types and an assessment of
staff understanding and use of the PRIME system be undertaken.
(iv) The current complaint management process be broadened to capture first line complaints from all
sources.

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Queensland Health has developed a Queensland Health Standard for the Requirements for Complaints
Systems (non-consumer complaints) with which the Service complies and a Queensland Health
Complaints Management System which includes a Queensland Health Staff Reporting Concerns Portal
on QHEPS. The surveyors are satisfied that this recommendation has been implemented.

Recommendation: OWS05082.1.3   **High Priority:** No

Recommendation:
Mental Health

(i) The TDDMHS evaluate the current process for staff complaints, and ensure that there is an effective
mechanism to provide feedback to the individual and that analysis of trends is disseminated to all levels
of managers.
(ii) A mechanism be established whereby staff receive information on the process of handling staff
complaints.

Action:

(i)
Linked to District procedure.
Staff Feedback line and Complaints Email on QHEPS.
Staff education has occurred at District level.

(ii)
Complete. Linked to District Procedure on QHEPS.
Training: Informal resolution of complaints has occurred.

Completion Due By: 30/10/2010

Responsibility: EDMH

Organisation Completed: No

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

Staff complaints are well managed.

Function:Support   **Standard:2.2**
Criterion: 2.2.2 The recruitment, selection and appointment system ensure that the skill mix and competence of staff, and mix of volunteers, meets the needs of the organisation.

Recommendation: OWS08082.2.2   **High Priority:** No

Recommendation:
Mental Health

(i) The equity of access of allied health students to current under and post-graduate placements be reviewed together with the impact of any inequity on future allied health workforce recruiting.
(ii) The effectiveness and sustainability of the current preceptorship program be evaluated with a focus on its ability to support students in what is a multidisciplinary service model.

Action:

(i)
Direct outcome of EB7 was an allocation of funds to support workforce development for Allied Health. Statewide Allied Health workforce planning has been supported by the development of Clinical Education Training Unit (CETU). A model for Allied Health Clinical Education and training has been established (discipline specific expertise and training. Target groups are Undergraduates, new Graduates and supervisors of students.
Occupational Therapy - 19 FTE Statewide positions established for clinical education. West Moreton - 1 FTE clinical educator appointed and one-third of time is dedicated to mental health. KPIs include increasing student numbers and new recruits to the service in addition to achieving service skill mix requirements for staff new to the service or this field of practice. AHP Discipline Directors manage this process across the District.

(ii) The Preceptorship Program is a nursing specific QHealth Program and as such cannot be modified at service level. Allied Health provide a QHealth Supervision Program Practice supervision in Allied Mental Health (QHealth Policy G5). The Park has a facilitator for nursing at SOMH and Toowoomba has a Nurse Educator who takes this role.

Completion Due By: 30/9/2009

Responsibility: Director Clinical Services

Organisation Completed: Yes

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

The employment of specialist educators for allied health staff has helped to ensure equity of educational activities for allied health staff.

Allied health and nursing staff with clinical experience are encouraged to participate in ongoing education activities within the organisation including the preceptorship program.

Function:Support   **Standard:2.2**
Criterion: 2.2.4 The learning and development system ensures the skill and competence of staff and volunteers.

Recommendation: OWS08082.2.4   **High Priority:** No

Recommendation:

Mental Health
A review of the District Mental Health Education Service provision to all sections and disciplines of the mental health sector be undertaken and a plan of action be developed for equitable delivery of education including the resource capacity to deliver.

Action:

(i) Evaluation and review of service provision raised at District Mental Health Education Service Committee with a view to seek funding to conduct an evaluation of mental health education across the District.

Completion Due By: 30/8/2010

Responsibility: Executive Director People and Culture

Organisation Completed: No

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

An evaluation of the mental health education service has been undertaken, an action plan developed and changes are being made to ensure efficient utilisation of available resources.

Function:Corporate   **Standard:3.1**
Criterion: 3.1.1 The organisation provides quality, safe health care and services through strategic and operational planning and development.

Recommendation: OWS05083.1.1   **High Priority:** No

Recommendation:

Mental Health

The senior management team review the medical allocation to the weekly outpatient clozapine clinic to ensure that there is continuity and safe clinical practice.

Action:

Medication errors are reported in PRIME CI. These reports are tabled at the monthly Drugs & Therapeutic (D&T) Committee. The Medication Safety Sub-Committee, a sub-committee of the D&T Committee, analyses the medication errors providing recommendations which are then reported back to the D&T Committee.
The Terms of Reference for the Drugs & Therapeutic Committee have been reviewed in August 2008.

Clozapine Coordinator has completed report.
Working Group to review structure across service.
Clozapine Coordination rolled out to Western and Southern Downs areas and South West District.
Action Plan to be developed to address management of clozapine.

Completion Due By:

Responsibility:

Organisation Completed: No

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

There is a new recommendation in Criterion 1.5.1 regarding this matter.

Function:Corporate   **Standard:3.1**
Criterion: 3.1.5 Documented corporate and clinical policies and procedures assist the organisation to provide quality, safe health care.

Recommendation: OWS08083.1.5   **High Priority:** No

Recommendation:
Mental Health

The system for ensuring implementation of and compliance with new or amended legislative requirements be documented, including a mechanism for evaluation, and included in the policy management process to enable its evaluation and improvement where necessary.

Action:

Checklist is being developed to document and monitor compliance with new or amended legislative requirements. As part of the policy management process the MHS Policy / Procedure / Workplace Instruction Checklist captures changes to documents relating to new and amended legislation. Development and implementation of QHealth Policy Framework.

Completion Due By:

Responsibility:

Organisation Completed: No

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

This recommendation has been addressed.

Function:Corporate   **Standard:3.2**
Criterion: 3.2.1 Safety management systems ensure the safety and wellbeing of consumers / patients, staff, visitors and contractors.

Recommendation: OWS08083.2.1   **High Priority:** No

Recommendation:
Mental Health

(i) Thebathroom and laundry chemicals used in the Extended Treatment and Rehabilitation Unit be reviewed with a view to replacing hazardous materials with non-hazardous alternatives to enhance client safety.
(ii) Where bathroom and laundry chemicals are in use material safety data sheets be displayed at the point of use and staff and, where relevant, patients be educated in the application of the material safety data sheets.
(iii) The overall safety system be more systematically evaluated for effectiveness and improvements be made as necessary.

Action:

(i)
Completed.
All chemicals purchased for use across the facility are now environmentally friendly (non-hazardous). Training provided to staff and consumers in relation to ordering the use of chemicals. Developed information/ training guides for residents in relation to safe cleaning, steps to carry out the activity and how to use the chemicals. Laminated guides displayed in targeted locations within each ETR residence.

(ii)
Completed.
Residential Support Officers hold the Material Safety Data Sheets and information / training guides relating to the safe use of the chemicals are available in consumer's units.

(iii)
Completed.
Terms of Reference and Key Performance indicators be reviewed for OH&S Committee. Outcomes evaluated through an improved awareness of overall safety system (eg staff incident reporting, PRIME) removed in June 2009. Veranda paintwork cleaned off and repainted to seal asbestos sheets in mid 2009.

Completion Due By: 30/9/2009

Responsibility: DDCSS

Organisation Completed: Yes

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

The seclusion room in the In Patient Unit at Ipswich was sighted by the surveyors and outstanding issues have been addressed. Two renovated seclusion rooms at the Barrett Unit at The Park were also inspected.

Recommendation: OWS05083.2.1   **High Priority:** No

Recommendation:

Management ensure that the refurbishment plan for the acute mental health unit addresses the areas of concern regarding the second seclusion room.

Action:

The Refurbishment is complete and the operation of the seclusion rooms is being monitored in conjunction with all elements of the refurbishment.

Completion Due By: 30/6/2010

Responsibility: Manager Acute and Community Mental Health

Organisation Completed: Yes

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

This recommendation referred to the Park. The following actions were verified by the surveyors:

1. Chemicals in use had been reviewed and replaced with less hazardous ones. Laminated guides on the use of the chemicals were in place in Extended Treatment Rehabilitation Unit.

2. The Chemicals in use were in the Chem Alert system and Material Safety Sheets were in evidence.

3. A System of incident reporting through the Prime system was in use and environmental inspections were in place and carried out at six monthly intervals.

Function:Corporate   **Standard:3.2**
Criterion: 3.2.2 Buildings, signage, plant, medical devices, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

Recommendation: Conditional Survey0709.3.2.2   **High Priority:** No

Recommendation:

Risks to residents in the Barrett Adolescent Unit continue to be monitored and actively managed pending the relocation of the unit to Redlands Hospital.

Action:

Risks to residents in the Barret Adolescent Unit continue to be monitored and actively managed pending relocation of the unit to Redlands Hospital

Relocation of the unit and timeframe for transfer of the service is late 2011 and consumer service delivery will continue until this time. Risk Management is an important factor which has been identified as occupying a non-purpose built premises. Interim improvements have been completed to address the more urgent concerns of staff and consumers (High Acuity Area / replacement of glass with Perspex, replacement of front entrance door). Ongoing monitoring of risks occurs through: - Patient Safety Rounds (conducted quarterly) from which identified risks are managed by the appropriate departments. - A daily meeting is held with the consumers and staff and one of the meeting standing items is the identification of any physical defects within the unit or its surrounds. Any defect recognised is referred to the NUM and rectified as soon as practicable. - Unit has an OH&S Representative whose main duty is to maintain a

safe working environment. Training includes the ability to recognise potential and real risks.- Consumers have individual risk assessments to optimise their safety and these are updated after each incident and reviewed regularly with team input. While the above outlines the formal process of risk management, it is also the duty of all staff working in the area to be constantly vigilant of any potential issues and to relay this information as soon as possible to the relevant persons to enable the issue to be rectified.

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- Unit has an OH&S Representative whose main duty is to maintain a safe working environment. Training includes the ability to recognise potential and real risks.
- Consumers have individual risk assessments to optimise their safety and these are updated after each incident and reviewed regularly with team input.

While the above outlines the formal process of risk management, it is also the duty of all staff working in the area to be constantly vigilant of any potential issues and to relay this information as soon as possible to the relevant persons to enable the issue to be rectified.

Completion Due By: June 2012

Responsibility: EDMH

Organisation Completed: No

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

The Barrett Adolescent Unit is in The Park and at the time of the last survey was due for relocation to Redlands, a suburb of Brisbane, in 2011. The relocation has now been deferred to 2013/14.

A number of hazards have been identified and rectified. These include:

1. The replacement of glass windows and glass in the entrance doors with Perspex.

2. The replacement of glass mirrors with polished stainless steel ones.

3. The replacement of sliding door at the main entrance with hinged one.

Workplace Health and Safety training has been improved and the unit has its own OH&S Representative. The unit is subject to routine environmental inspections and has regular meeting with consumers and staff at which risks are discussed and rectified. Risk assessments are carried out with respect to each consumer.

Function:Corporate   **Standard:3.2**
Criterion: 3.2.3 Waste and environmental management supports safe practice and a safe and sustainable environment.

Recommendation: OWS08083.2.3   **High Priority:**

Recommendation:

(i) Waste management procedures in the mental health service be included in staff orientation packages and in-service programs.
(ii) Action plans be developed in the mental health service for implementing improvements following routine waste management audits.

Action:

(i)
Facility staff orientation program being reviewed - revising content / information. Interactive training module available on QHEPS for all staff. On-line training to be promoted through staff and unit orientation.

(ii)
Audit conducted by Waste Advisor, Southern Population Health Service January / February 2009. Action Plan developed to progress recommendations / issues. The Park Waste Management Plan is available / accessible on G:\Everyone and an Application to publish on the WMSBHSD Intranet Site. Signage for types of substances have been completed.

Completion Due By: 30/9/2009

Responsibility: DDCSS

Organisation Completed: Yes

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

This recommendation refers to the Park. Waste Management is included in orientation and on line training is offered using a Queensland Health product. Action is taken following adverse and visual audits of waste.

Function:Corporate   **Standard:3.2**
Criterion: 3.2.5 Security management supports safe practice and a safe environment.

Recommendation: OWS05083.2.5   **High Priority:** No

Recommendation:
Mental Health

(i) The management team ensure that there are sufficient numbers of personal duress alarms for all staff in the inpatient units, and a duress alarm system, including the review of policy and procedures, to ensure that staff wear the alarm and understand its use be implemented.
(ii) A review be undertaken of staff who are involved with assessing mental health clients in the Emergency Department to establish whether there is a need for these staff to wear personal duress alarms when assessing mental health clients, and this review be supported by a risk assessment.

Action:

(i)
Sufficient numbers of personal duress alarms secured and distributed.
Utilisation needs to be monitored.
Procedure reviewed and endorsed.
Service wide audit progressing.
Western Downs has hand held alarm system.
(ii)
Raise at Integration Meeting and progress.
Statewide independent Security Audit being conducted in Emergency Departments.
Will have associated recommendations.

Completion Due By: 30/10/2010

Responsibility: EDMH

Organisation Completed: No

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

This recommendation refers specifically to Toowoomba Hospital and its Emergency Department.

1. Audits of duress alarms were conducted across the whole organisation and additional alarms purchased and distributed.

2. At the time of the survey the Emergency Department was being renovated. Security and duress alarm requirements have been included in the design of the renovation.

However the surveyors noted variation in the wearing of duress alarms across the various sites of the organisation and recommendation will be made under standard 3.2.5.