Patient Journey

The "Report of the Site Options paper for the Development of the Barrett Adolescent Centre" identified a number of issues related to the patient journey of clients admitted to BAC. These included:

- The need for acute medical management at a local general hospital at regular intervals;
- Occasional need for more intensive acute psychiatric care;
- The need for intensive discharge planning at point of referral;
- Integration of BAC with services at the local community of origin;
- Partial hospitalisation as a method of transition from BAC to community management;
- The remoteness of referring services, making the above patients difficult to manage;
- Out of home care for increasingly older adolescents and young people who cannot return to their family of origin;
- Transitioning to suitable adult mental health services if the adolescent requires long term treatment and has reached an age where this transition is necessary.

The management or the difficulties in managing these issues has created some significant problems for BAC. The reviewers were advised that:

- Admissions to BAC are increasingly severe and complex;
- There is a perception that BAC has a limited choice over whom it accepts;
- There are referrals on from the CAMHS Acute Units if there is no obvious community placement option and that BAC becomes a treatment option of "last resort";
- A number of clients who are accepted are homeless;
- A number of clients are referred from very remote parts of Queensland – often by NGOs with little local CAMHS type support.

The concept of continuity of care is based around the notion of seamless transitions between treatment episodes, and this does not appear to be the case at BAC.

While some of these issues will be addressed when the unit is relocated to a site adjacent to an acute hospital, there appear to be significant problems with all of: referral to the unit, waiting time to admission for accepted patients, length of stay, and discharge planning and discharge placement.

The BAC has 15 inpatient beds gazetted for use of adolescents with challenging mental health problems requiring medium to long term treatment. At the time of the visit, there were 9 inpatients. The nursing staff on duty were unable to clarify how the remaining beds were being utilised. [One of the clinical nurses performs the role of Clinical Liaison Officer, coordinating the intake activities of the service. The clinical liaison nurse informed the reviewing team that BAC has developed exclusion criteria that include: conduct disorder, predatory behaviour, criminal behaviour, aggression, substance misuse and moderate-severe intellectual impairment.]

An obvious indicator of this constellation of problems is the increasing age of the clients. At the time of the review, one third of the inpatients (3 out of 9) were over the age of 18 years. Those 3 individuals had admission dates of November 2007, August 2006 and April 2005, meaning length of stay for them was approaching 2, 3 and 4 years respectively.

Thus, consumers are not necessarily discharged at 18 years of age and there appears to be a lack of clearly understood or communicated process to transition these young people to adult services.

An assertively managed approach to admission and discharge will need to be adopted by BAC wherever it is located. The following recommendations can define the parameters of this approach.

***Recommendations*:**

1. *That advice be provided to referring agencies about the nature of the services offered by BAC.*
2. *That clear inclusion and exclusion criteria be formulated.*
3. *That referral forms for referring agencies be updated.*
4. *That service level agreements, Memoranda of Understanding or shared protocols be used as the basis of agreement for the transfer or sharing of care between BAC and other units. These would include but not be restricted to:*
5. *Agreements with local Acute Hospitals for assistance in the management of the physical sequelae of self harm.*
6. *Agreements with local Acute Hospitals for assistance in the management of the physical complications of eating disorders.*
7. *Agreements with local Acute Mental Health Facilities for assistance in the management of acute and extreme behavioural disturbances.*
8. *Agreements with local Acute Mental Health Facilities with regard to the transition of older adolescents from care at BAC to care in Adult Mental Health Services.*
9. *That responsibility for accepting admissions and managing discharges be clearly articulated in the Unit policies and that this include the position(s) responsible for the decision making.*
10. *That the length of admission, and planned discharge date, for prospective admissions, be agreed upon by referrer and BAC staff prior to admission.*
11. *That there is firm agreement, prior to admission, about which service will have an ongoing role in the patient's management upon discharge (failure to agree on this will result in the patient not being admitted to BAC).*
12. *That homelessness in the absence of an identified and agreed upon strategy for accommodation at discharge be an exclusion criteria for admission to BAC.*
13. *That the concept of step up/step down facilities and halfway houses, possibly managed by NGOs, be explored as methods of transitioning clients back to the community, especially those clients who will require out of home care.*
14. *That a target for Length of Stay be set for BAC – this can be aspirational, but should be no more than 12 months. Any client that exceeds this target on*

clinical grounds should be identified and intensively managed to find alternative clinical placement including, for older clients, placement with Adult Mental Health Services.

15. *That planning towards and documentation regarding a patient's discharge should be undertaken throughout the admission.*
16. *That regular (eg twice yearly) meetings of BAC staff with key referring agencies occur to improve the referral, treatment and discharge processes.*
17. *That data regarding referrals, wait times, lengths of admission etc be reviewed regularly and in different forums (eg at meetings of senior BAC staff and Park Hospital and Qld Mental Health)*

Treatment evaluation

There appears to have been negligible evaluation of treatments delivered by BAC.

Recommendations:

1. *Routine use of standardised outcome measures.*
2. *Additional (specific) measures be used for the specific disorders managed by the unit (eg depression rating scales for those patients with depression etc).*
3. *Regular use of patient and parent/carer satisfaction surveys.*
4. *Affiliation with an academic unit to facilitate treatment evaluation.*
5. *Introduction of a regular meeting to specifically address the process of outcome measurement at BAC and the (outcome) results obtained for patients.*

Clinical leadership

One of the major problems of BAC relates to leadership and leadership structure. While several staff (e.g. psychiatrist, NUM, liaison nurse, senior allied staff) have considerable experience, there does not appear to be a clear Executive structure nor forum for the Executive to meet. In relation to nursing, while nursing staff reported

that they weer all were very supportive of the relatively newly appointed Nurse Unit Manager, it was apparent that the Clinical Nurses were underutilised in their potential capacity as clinical leaders. It was not clear if regular nursing staff meetings were conducted, and the reporting lines were vague.

Similarly, it was unclear whether the Nurse Unit Manager and the Dirccto attended regular meetings in their roles as providing the leadership group at BAC.

Recommendations:

1. *Appointment of an Executive whose members have clear roles and responsibilities*
2. *Clear delegation and succession planning (for example, when the Director, NUM, liaison nurse etc go on leave, others are appointed to act in these roles – this also provides career development opportunities for various staff).*
3. *The Director should implement professional development seminars for all the staff and these should reflect the practice of other service providers. Examples of new and innovative therapies, presented by people external to BAC, should be included.*
4. *BAC should provide a regular (eg quarterly) report to Park Hospital and State mental health about its programs and use of both tested and innovative approaches.*
5. *The Nurse Unit Manager may benefit from adopting strategies to encourage the Clinical Nurse group to take on more leadership roles and functions. This would firmly establish reporting lines and support the Nurse Unit Manager in the everyday functioning of BAC.*

Staffing profiles (nursing)

BAC consists of a large multidisciplinary team; as with most inpatient services, the nursing establishment make up the bulk of this team. BAC currently maintains a nursing establishment of 23.9 FTE. Six nurses are rostered on each shift on

weekdays. The nurses work continuously in 8 hour shifts. The nursing team is led by the Nurse Unit Manager and 4 Clinical Nurses, one of which holds an Intake/Community Liaison position.

As in all nursing teams, there are varying levels of clinical skill and experience amongst the individuals. At BAC, there are a number of staff who have been working there for many years and some staff who are relatively new to Child and Youth Mental Health (CYMH). Consultations with nursing staff present on the day of the visit suggested that there were no nurses who had experience with another CYMH service outside BAC. This indicates the team may be disadvantaged by a lack of current exposure to contemporary nursing practice within the CYMH speciality.

While all nursing staff reported being very supportive of the relatively newly appointed Nurse Unit Manager, it was apparent that the Clinical Nurses were underutilised in their potential capacity as clinical leaders. It was not clear if regular nursing staff meetings were conducted and the reporting lines were vague.

Recommendations:

1. *More robust interactions between nursing staff of BAC and other CYMH services should be facilitated; one way to address this may be found in secondment activity negotiated between services.*
2. *The Nurse Unit Manager may benefit from adopting strategies to encourage the Clinical Nurse group to take on more leadership roles and functions. This would firmly establish reporting lines and support the Nurse Unit Manager in the everyday functioning of BAC.*

Nursing Staff Training and Education

Individual consultations with nursing staff during the visit identified a general desire for more educational/training opportunities, specifically in adolescent mental health.

There appeared to some issue with the budget limiting nursing staff access to their professional development funds to pay for development activities.

The previous BAC review conducted by McDermott et al in 2003 recommended more training and education for staff on adolescent issues. It is clear from discussions with nursing staff that this education is still somewhat haphazard and limited.

Clinical supervision structures are problematic. The whole team attends group supervision with a specialist clinical supervisor, who is also a member of the team. Additionally, nursing staff identified a need for more clinical supervision.

Recommendations:

1. *The use of professional development funds by nursing staff should not be compromised by budgetary constraints. The provision of the money to undertake development activities is an award condition.*
2. *Nursing staff would benefit from regular and relevant in-service, and a program or calendar of such in-service could be developed and then facilitated through rostering. There appears to be generous blocks of time that could be regularly quarantined for staff development during the time the young people are attending school.*
3. *Structures for group clinical supervision should be reviewed and strengthened by sourcing a clinical supervisor not currently working at BAC.*

Finally, while staff may understandably be unsettled by the prospect of significant changes as recommended in this report, the proposed rebuilding of the facility at a new location constitutes an unprecedented opportunity to reflect on BAC's purpose, mission, systems and work practices. With a motivated leadership team employing good change management skills, BAC and key stakeholders can seize this chance to review the service and maintain BAC's commendably long record of service provision to young people in Queensland.

Final Report of the 2009 Review of Barrett Adolescent Unit

Recommendation		Comments & proposed actions	
1.	**Governance**		
1.1	The State & hospital should give a clear determination of the role and function of BAC.	▪ Draft Model of Service Delivery developed ▪ Currently under consideration at the Statewide Child and Youth Steering Committee ▪ Review existing documentation ▪ Consult Mental Health Implementation Team regarding confirmation of role and function for Extended Adolescent Inpatient Service ▪ Identified role and function to be incorporated into future planning as a component of the relocation of the service to Redlands Hospital.	▪ Finalised ▪ Ongoing ▪ Finalised 2008 ▪ Finalised 2008 ▪ Ongoing review 2011 Role and function articulated within the Clinical Services Capability Framework v3 2011 (Level 6, non-acute inpatient service, Child and Youth Mental Health)
1.2	This information (about role and function) needs to be disseminated in written form to all stakeholders.	▪ Whilst awaiting finalising actions from 1.1, revisit current documents in relation to operation of Barrett Adolescent Centre ▪ Assess alignment with directions contained in report ▪ Modify/strengthen and redistribute as indicated.	▪ Ongoing as part of continuing quality processes ▪ AETRC MOSD has been endorsed by the SWCYAG ▪ Information package forwarded out to referrers
1.3	The role and function should be operationalised and a reporting	▪ Establish review mechanisms including patient profiling in line with	▪ The AETRC MOSD profiles the patients who are likely to benefit from

Recommendation		Comments & proposed actions	
	framework developed such that the unit is shown to be fulfilling its function.	outcomes from 1.2 & 1.3.	admission to the BAC ▪ The AETRC MOSD provides for a referral panel including senior clinicians from the Children's Health District and the Metro South Health district on the referral panels and the six month review panel. This has yet to come into operation due to time pressures on staff from these Districts.
1.4	A procedure is developed to provide a framework governing the credentialing and defining the scope of clinical practice of practitioners at BAC.	▪ As appropriate. ▪ Review existing processes. ▪ Establish baseline/existing staff.	▪ Approved Role Descriptions are in place for all staff. ▪ All clinical staff registered maintain current registration with the appropriate registration authority, and maintain professional standards as per their professional discipline requirements. ▪ Medical credentialing in place ▪ Non-mandatory credentialing available to other clinical staff in line with professional discipline framework.
1.5	An integrated risk management approach is introduced into all aspects of BAC functioning, ensuring it is evidence based and aligned with a broader Hospital, Area and State Risk Management approach.	▪ Review existing procedures and mechanisms, such as WH&S, PRIME CI, PRIME CF, Patient Safety Rounds, Clinical Review, Root Cause Analysis, Clinical Risk Management etc. ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ In use as per The Park Processes

Recommendation		Comments & proposed actions	
1.6	All incidents (including "near miss" events) should be reported and documented and regularly reviewed in a broad staff forum to identify problems and improve client safety.	▪ As above.	▪ Achieved. All incidents are reported and documented. Reviewed in a number of forums, eg specifically convened critical incident forums, case conferences and intensive case workups.
1.7	Regular file audits be undertaken to ensure the medical record is capturing all appropriate patient centred data and to identify areas and indicators for improvement.	▪ Strengthen clinical record audit procedure/proforma. ▪ Incorporate results into quality improvement.	▪ Clinical record audit procedure in line with The Park process.
1.8	All policies should be reviewed as to their appropriateness and rewritten or updated to reflect desired practice.	▪ Utilise existing process for procedure review and development to align with future directions	▪ As per Clinical Steering Committee and Park established processes.
1.9	A system for managing, responding to and analysing complaints to be introduced to improve community and client satisfaction with BAC.	▪ Review existing procedures & mechanisms. ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ In line with Park and Q Health processes, clients can also access Community Visitor, CAG and Children's Commission.
1.10	Performance review processes are established or enhanced to assist clinicians maintain best practice and improve patient care.	▪ Review existing HR practices, PADs ▪ Explore alternate options for professional supervision ▪ Assess alignment ▪ Establish/re-establish/strengthen existing.	▪ Achieved. Line Manager process for all BAC clinical staff PADs. ▪ All clinical staff receive clinical supervision regularly.
1.11	Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.	▪ Review existing procedures and mechanisms, such as Individual Case Workups, Clinical Review, HEAPS, Root Cause Analysis, Assess	▪ Clinical audits assigned to RN portfolios. ▪ BAC is implementing the use of CIMHA/POS entries/reports which can

Recommendation		Comments & proposed actions	
		alignment ▪ Explore alternate options for the inclusion of external review/input ▪ Establish/re-establish/strengthen existing.	facilitate auditing /monitoring of case reviews, OIS reviews, and alerts. (This has since become a pilot for The Park).Clinical audits are forwarded to the Nurse Unit Manager who reviews and makes recommendations which are then forwarded to the relevant persons/committees. ▪ CIMHA processes are presented at the CIMHA reference group where improvements are identified and acted upon.
1.12	Clinical handover should be refined and implemented; its nature will be dependent on the integrated model of care adopted, but it should involve all relevant clinical staff and provide nursing staff, in particular, with the opportunity to comment on consumers that they have had direct care responsibilities for on a particular shift.	▪ Review existing handover processes, policies, procedures. ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ Specific times are established for nursing handover and multidisciplinary team meetings, including case conferences, intensive case workups, and morning meetings with consumers. There are specific formats for each of these meetings and are recorded on meeting specific documentation eg consumers morning meeting book, case conference review sheet, care planning documents. ▪ Nursing handover is a well established routine consisting of the review of the ward report book and communication diary to identify prioritisation of care planning. Input is by all nursing staff.
2.	**Clinical Model**		
2.1	A model of care should be	▪ Review existing client assessment	▪ The AETRC MOSD developed and

Recommendation		Comments & proposed actions	
	formulated, based on the currently available evidence and the nature of clients presenting to the service.	and treatment planning.	endorsed by the SWCYMHAG in August 2010 ▪ Clinical Services Capability Framework v3 2011 (Level 6, non-acute inpatient service, Child and Youth Mental Health)
2.2	The recommendations made previously (2003) to close the program for several days to undertake a review and development of a model of care is reiterated.	▪ Not possible given nature of service. ▪ Review other approaches to facilitate this activity.	
2.3	The increase in risk associated with unstructured time is noted and that structured interventions are considered for these periods.	▪ Review Structured Day Program	▪ Reports from [PRIME] have been reviewed and have shown a trend for behavioural incidents that does not support the statement that unstructured time results in increased risk. One of the more significant aspects of adolescent development requires the ability to manage leisure time, eg unstructured time is developmentally appropriate, however, this is always with staff assistance and supervision if required.
2.4	If BAC is seen as a Therapeutic Community utilising a Milieu approach, that this approach is formalised, key activities identified and documented, and appropriate	▪ To be considered in line with the outcomes of recommendations 1.1 & 1.2	▪ BAC is not a therapeutic community. ▪ BAC utilises the Recovery Model ▪ Clinical Services Capability Framework v3 2011 (Level 6, non-acute inpatient service, Child and

Recommendation		Comments & proposed actions	
	training and supervision for staff provided.		Youth Mental Health) ▪ Key activities of the unit already in existence are identified in the AETRC MOSD
2.5	Adventure Therapy may continue but, if so, this would be seen as a component part of an overall therapeutic approach.	▪ As above	▪ The therapeutic approach is outlined in the AETRC MOSD.
2.6	Interventions other than continuous observation be introduced, that are suitable for maintaining the safety of consumers and others when consumers present with severe behavioural disturbance.	▪ Review existing interventions such as HDU, Structured Day Program and Individual Contracts ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ The statewide group that investigated seclusion and restraint in Adolescent inpatient units in Queensland, and which Barrett participated in, noted that the use of continuous observations significantly reduced the need for seclusion. Barrett was commended for its low seclusion rates considering the difficult nature of its clientele. Since the completion of the High Acuity Area it has been noted that disruptive behaviour can be more easily confined and afford more dignity to the patients and staff.
2.7	The different presentations to the service and variety of disorders encountered will require a range of tailored treatments and, consequently, individual treatment plans should be developed and documented in the medical record and an appropriate range of	▪ As per recommendation 2.1 and 2.6	▪ CIMHA used for all Intensive Case Workup's.

Recommendation		Comments & proposed actions	
	evidence based interventions should be utilised to meet the individual needs of an increasingly complex group of clients.		
2.8	Staff require adequate training and clinical supervision to ensure the new treatments are delivered optimally and that they are modified as new evidence becomes available.	▪ As per recommendation 1.10	▪ Training needs identified as part of the development of the new unit and appropriate resources allocated.
2.9	Individual treatment contracts should be developed with patients and parents/carers. The contract should stipulate the expectation of participation in BAC programmes by clients/parents/carers and the consequences for non participation.	▪ As per recommendation 2.6	▪ Clients are included in the care planning negotiations as part of the Intensive Case Workup process. Consumers sign off on their plans in conjunction with their care co-ordinators.
3.	**Nursing Models of Care**		
3.1	Consideration should be given to changing to a Patient Allocation Model or a Team Nursing Model, or a combination of both (the Combination Patient Allocation & Team Model). The strengths of each model are outlined in Queensland Health Nursing Model of Care – Toolkit for Nurses (2003, pp6-7).	▪ Review existing model ▪ Explore alternative models. ▪ Implement agreed model	▪ The nursing model of care in BAC is and always has been Primary nursing with elements of Case Management. ▪ The Toolkit for Nurses 2003 lists strengths and weaknesses of each nursing model and upon review by the Barrett nursing team it was identified that the current model in use was the most suitable. The weaknesses of the Primary nursing model according to the Toolkit are more than adequately addressed by the Barrett nursing team.
4.	**Patient Journey**		

Recommendation		Comments & proposed actions	
4.1	Advice be provided to referring agencies about the nature of the services offered by BAC.	▪ Review and update existing service brochures ▪ Review existing referral and intake processes ▪ Implement agreed processes	▪ Service brochure for referrers was established and separate ones for DChS. Referral processes have continued to be reviewed and adjusted based on review of admissions and changes in referral trends.
4.2	Clear inclusion and exclusion criteria be formulated.	▪ Review existing criteria ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ Previous criteria exist but not always adhered to due to elements of other referring services. ▪ The MHD has instructed that exclusion criteria not be included in the latest version of MOSD's. ▪ The Clinical Services Capability Framework v3 2011 (Level 6, non-acute inpatient service, Child and Youth Mental Health) provides a service description outlining details of who the service is provided for.
4.3	Referral forms for referring agencies be updated.	▪ As per recommendation 4.1	▪ CN/CL now utilises CIMHA for referral information.
4.4	Service level agreements, Memoranda of Understanding or shared protocols be used as the basis of agreement for the transfer or sharing of care between BAC and other units. These would include but not be restricted to: - Agreements with local Acute	▪ Review existing background documents. ▪ Partnership agreements be developed in accordance with Service Model & State Directions. ▪ Review MOS (Statewide).	▪ Ipswich Hospital CL Park patient transfer protocol developed. ▪ Management of physical complication of ED's managed at Ipswich Hospital, PA Hospital or Mater. ▪ Arrangements now in place with acute mental health facilities at PAH to assist with management of acute

Recommendation		Comments & proposed actions	
	Hospitals for assistance in the management of the physical sequelae of self harm. - Agreements with local Acute Hospitals for assistance in the management of the physical complications of eating disorders. - Agreements with local Acute Mental Health Facilities for assistance in the management of acute and extreme behavioural disturbances. - Agreements with local Acute Mental Health Facilities with regard to the transition of older adolescents from care at BAC to care in Adult Mental Health Services.		behavioural disturbances and for transition processes of older clients.
4.5	Responsibility for accepting admissions and managing discharges be clearly articulated in the Unit policies and that this include the position(s) responsible for the decision making.	▪ Incorporated into referral.	▪ As per BAC clinical pathway.
4.6	The length of admission, and planned discharge date, for prospective admissions, be agreed upon by referrer and BAC staff prior to admission.	▪ Incorporate into referral and pre admission process.	▪ Treatment process often impact on these aspirational plans. However discharge planning is incorporated as a core component into each clinical review.
4.7	There is firm agreement, prior to	▪ Review existing continuity of	▪ We have continued involvement of the

Recommendation		Comments & proposed actions	
	admission, about which service will have an ongoing role in the patient's management upon discharge (failure to agree on this will result in the patient not being admitted to BAC).	care/involvement protocols included in referral form. ▪ Assess alignment ▪ Establish/re-establish/strengthen	referring team at Intensive Case Workups and prior to discharge as recorded as a group POS in CIMHA.
4.8	Homelessness in the absence of an identified and agreed upon strategy for accommodation at discharge be an exclusion criteria for admission to BAC.	▪ This recommendation is contrary to the 4th National Mental Health Plan. The only appropriate exclusion criteria should be based on the inability to benefit from admission and the likelihood of detriment to the welfare of other young people.	▪ Continue to liaise with the Department of Communities regarding the provision of step down and supported accommodation for adolescents with severe and complex mental illness in line with the 4th National Mental Health Plan
4.9	The concept of step up/step down facilities and halfway houses, possibly managed by NGOs, be explored as methods of transitioning clients back to the community, especially those clients who will require out of home care.	▪ Supported. ▪ Requires Statewide support and commitment. ▪ Partnership agreements.	▪ NGO services are accessed as part of transition programs when required. ▪ Continue to liaise with the Department of Communities regarding the provision of step down and supported accommodation for adolescents with severe and complex mental illness in line with the 4th National Mental Health Plan
4.10	A target for Length of Stay be set for BAC – this can be aspirational, but should be no more than 12 months. Any client that exceeds this target on clinical grounds should be identified and intensively managed to find alternative clinical placement including, for older clients, placement with Adult Mental Health	▪ To be included as component of recommendations 4.1, 4.2, 4.3, 4.5, 4.6, 4.7.	▪ Currently every case review makes every effort to include the referring agency and other relevant agencies as part of the review. This provides opportunity for a detailed review of treatment within the Centre, as well as the capacity of the community to manage aspects of the young person's or family's care and begin

Recommendation		Comments & proposed actions	
	Services.		the transition process. ▪ The AETRC MOSD includes the additional requirement for review by senior staff from the Children's and Metro South Health Districts if admission continues beyond six months. Because of time demands on staff, this has yet to be set in operation.
4.11	Planning towards and documentation regarding a patient's discharge should be undertaken throughout the admission.	▪ Review existing processes such as Clinical Care Review Meeting, Clinical Audit ▪ Assess alignment ▪ Establish/re-establish/strengthen	▪ Incorporated into the Intensive Case Workup process.
4.12	Regular (eg twice yearly) meetings of BAC staff with key referring agencies occur to improve the referral, treatment and discharge processes.	▪ Explore establishment of referral network	▪ As part of the Qld Children's Health Services District CYMHS Key Skills training program site visits to Barrett occur several times a year. An overview of Barrett's function and services are presented to the participants who represent key referring agencies. This important process has been in place for several years. ▪ We also include the community service providers at Intensive Case Reviews.
4.13	Data regarding referrals, wait times, lengths of admission etc be		▪ All referral data reviewed in regular reports by CNCL and at weekly

Recommendation		Comments & proposed actions	
	reviewed regularly and in different forums (eg at meetings of senior BAC staff and Park Hospital and Qld Mental Health.		intensive case workups –This data is entered into CIMHA and regular monthly reports are sent by District MHISSO to Director of Clinical Services at the Park.
5.0	**Treatment Evaluation**		
5.1	Routine use of standardise outcome measures.	▪ Review existing use of outcome measure in clinical care and treatment planning ▪ Review existing use of outcome measures in program evaluation ▪ Establish/re-establish/strengthen	▪ Outcomes are collected during Intensive Case Reviews, on admission and on discharge. Recent changes have included the use of the Teacher SDQ by BAC School.
5.2	Additional (specific) measures be used for the specific disorders managed by the unit (eg. depression rating scales for those patients with depression etc).	▪ As above ▪ Explore options for Benchmarking with like services.	▪ Disorder specific scales are routinely used e.g. RADS 2, RACMAS-2, AARS, EDI depending on specific indications for specific disorders
5.3	Regular use of patient and parent/carer satisfaction surveys.	▪ Review existing ▪ Establish/re-establish/strengthen	▪ BAC's carer surveys are in line with The Park processes.
5.4	Affiliation with an academic unit to facilitate treatment evaluation.	▪ Explore options for affiliation	▪ Close links with UQ developed in allied health areas.
5.5	Introduction of a regular meeting to specifically address the process of outcome measurement at BAC and the (outcome) results obtained for	▪ Workgroup to be established in relation to recommendations 5.1, 5.2 to consider ongoing regular process	▪ Work Improvements Group has been established. Minutes of these groups go to the Service Improvement Co-ordinator at the Park and to all BAC

Recommendation		Comments & proposed actions	
	patients.		staff.
6.0	**Clinical Leadership**		
6.1	Appointment of an Executive whose members have clear roles and responsibilities.	▪ Review existing structures.	▪ The Barrett Adolescent Centre Management Committee comprises: - Dr Trevor Sadler - Clinical Director - Risto Ala-Outinen - Nurse Unit Manager - Kevin Rodgers - School Principal - Kim Hoang - Occupational and Leisure Therapist ▪ The roles of these members are clearly defined as are the responsibilities as defined in the role descriptions of these members.
6.2	Clear delegation and succession planning (for example, when the Director, NUM, Liaison Nurse etc go on leave, others are appointed to act in these roles – this also provides career development opportunities for various staff).	▪ Within HR practices.	▪ One of the priorities of the relocation of Barrett to Redlands Hospital has been the intention to give learning opportunities to those staff who have indicated they will be moving with the service. This has resulted in higher duties being undertaken by these staff. ▪ Relevant courses are given priority.
6.3	The Director should implement professional development seminars for all the staff and these should	▪ BAU management team to review existing ▪ Assess alignment.	▪ Achieved. ▪ Regular inservices provided on Family Therapy, Multisensory therapy, art

Recommendation		Comments & proposed actions	
	reflect the practice of other service providers. Examples of new and innovative therapies, presented by people external to BAC, should be included.	▪ Establish/re-establish/strengthen existing.	therapy, sandplay therapy. The Director notifies all BAC staff of seminars, workshops and courses relevant to BAC service. Seminars have been run and another is in the planning process for early 2011.
6.4	BAC should provide a regular (eg. quarterly) report to Park Hospital and State Mental Health about its programs and use of both tested and innovative approaches.	▪ Review existing processes ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ Regular reporting is provided via Nurse Unit Manager's attendance at CSC, CRMC, Park management Committees. ▪ The Clinical Director attends the State-wide Child and Youth Mental Health Advisory Group. ▪ The CN/CL attends the Care Planning Committee.
6.5	The Nurse Unit Manager may benefit from adopting strategies to encourage the clinical nurse group to take on more leadership roles and functions. This would firmly establish reporting lines and support the Nurse Unit Manager in the everyday functioning of BAC.	▪ Explore options for specialist portfolio roles for CNs	▪ Specialist portfolio roles for the CN group and the RN's have been developed. ▪ CN's are encouraged to perform higher duties where available. ▪ CN's attend the Case Conference and Intensive Case Workup each week.
7.0	**Staffing Profiles (Nursing)**		
7.1	More robust interactions between nursing staff of BAC and other CYMH Services should be	▪ Network of C&Y Psychiatrists and staff within District.	▪ Secondment not feasible at this time. Interactions between BAC and CYMHS services well developed.

Recommendation		Comments & proposed actions	
	facilitated; one way to address this may be found in secondment activity negotiated between services.		
7.2	The Nurse Unit Manager may benefit from adopting strategies to encourage the Clinical Nurse group to take on more leadership roles and functions. This would firmly establish reporting lines and support the Nurse Unit Manager in the everyday functioning of BAC.	As per recommendation 6.5	▪ Specialist portfolio roles adopted by CN's. ▪ Line Manager responsibilities allocated to CN's.
8.0	**Nursing Staff Training & Education**		
8.1	The role of professional development funds by nursing staff should not be compromised by budgetary constraints. The provision of the money to undertake development activities is an award condition.	▪ Noted ▪ Professional development funds utilisation has been reviewed and BAU nursing staff have been well represented ▪ Revised EB arrangements now in place.	▪ Nursing staff regularly access Professional Development leave - funds are now part of the award conditions.
8.2	Nursing staff would benefit from regular and relevant in-service, and a program or calendar of such in-service could be developed and then facilitated through rostering. There appears to be generous blocks of time that could be regularly quarantined for staff development	▪ Align with recommendation 6.3 - Access to Professional Development activities.	▪ Regular inservices provided on Unit and via The Park School of Mental Health education program. ▪ Journal Club established

Recommendation		Comments & proposed actions	
	during the time the young people are attending school.		
8.3	Structures for group clinical supervision should be reviewed and strengthened by sourcing a clinical supervisor not currently working at BAC.	▪ Review existing clinical supervision model ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ Clinical supervision is available on ward and throughout the facility. At the time of the review the percentage of staff receiving clinical supervision was approx. 60% including 100% for medical and allied health staff. Nursing percentage has fallen since the dedicated clinical supervisor has resigned. Efforts have been made within BAC with input from the previous A/DON P Beavis to access clinical supervision for nursing staff. Currently the Park has provided a list of clinical supervisors and the number of nursing staff accessing clinical supervision is increasing.

Minister's Office RecFind No:	
Department RecFind No:	**BR050182**
Division/District:	**MD09**
File Ref No:	

Briefing Note

The Honourable Geoff Wilson MP
Minister for Health

Requested by: Chief Executive Officer, Darling Downs - West Moreton Health Service District **Date requested: 22 May 2011** **Action required by:**

Action required
For approval | With correspondence
For meeting | For Information

Other attachments for Ministerial consideration
Speaking points | Ministerial Statement
Draft media release | Question on Notice
Cabinet related document

SUBJECT: Update and Finalisation - External Review Report of Barrett Adolescent Unit

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Proposal
That the Minister:

Note the contents of this brief in relation to external review report of the Barrett Adolescent Unit.

Urgency

1. Routine.

Background

2. The Barrett Adolescent Unit provides mental health inpatient rehabilitation services (15 beds) for young people aged between 13 and 17 years who require extended inpatient care and treatment for a mental illness. The Unit provides a statewide service and referrals are received from mental health services throughout Queensland.

3. In January 2009, an external review of the Barrett Adolescent Unit was commissioned to examine reported consumer clinical incidents and make recommendations regarding the safe care of consumers of the Barrett Adolescent Unit. This included measures to:
    a. manage the mix and acuity of consumers attending the Unit;
    b. ensure that arrangements for transferring care are timely and safe;
    c. enhance the capacity of the Unit to safely manage high levels of behavioural disturbance;
    d. review the progress, appropriateness and models of care; and
    e. ensure the appropriate handover of care, including to and from other medical services.

4. The final report from this review was received by the District on 29 September 2009 (Attachment 1).

5. The reviewers considered previous review reports, concerns raised by external parties, details of particular clinical incidents and also conducted meetings with key stakeholders and staff.

Minister's Office RecFind No:	
Department RecFind No:	**BR050182**
Division/District:	**MD09**
File Ref No:	

6. A total of 55 recommendations were made under the domains of Governance, Clinical Model, Nursing Model of Care, Patient Journey, Treatment Evaluation, Clinical Leadership, Nurse Staffing Profiles and Nursing Staff Training and Education.

7. The final report and recommendations were released to staff within the Unit, along with an action plan for addressing the issues raised in the recommendations.

8. Staff within the Barrett Adolescent Unit have undertaken a range of actions to address the issues and these are contained in the final action plan report (Attachment 2).

9. It is proposed that the report and recommendations have been actioned and that this matter is now finalised.

Key issues

10. The recommendations arising from the 2009 Review of the Barrett Adolescent Unit have been substantially actioned.

11. The outstanding recommendations (detailed below) are contingent upon the completion of the Statewide Model of Service for the Adolescent Extended Treatment and Rehabilitation Inpatient Service, via the Mental Health Alcohol and Other Drugs Directorate and associated relocation to Redlands Hospital. These recommendations will continue to be progressed via usual business processes:

    a. a model of care should be formulated, based on the currently available evidence and the nature of clients presenting to the service; and

    b. identified role and function to be incorporated into future planning as a component of the relocation of the service to the Redlands Hospital.

Consultation

12. Not applicable.

Financial implications

13. There are no financial implications.

Legal implications

14. There are no legal implications.

Elected representative

15. Not applicable.

Remedial action

16. No remedial action is required.

Attachments

17. Attachment 1 – Barrett Adolescent Review (2009)

    Attachment 2 – Final Action Plan Report of the 2009 Review of the Barrett Adolescent Unit

Minister's Office RecFind No:	
Department RecFind No:	**BR050182**
Division/District:	**MD09**
File Ref No:	

Recommendation
That the Minister

Note the contents of this brief in relation to external review report of the Barrett Adolescent Unit.

APPROVED/NOT APPROVED **NOTED** **NOTED**

GEOFF WILSON
Minister for Health

Principal Advisor

Senior Policy Advisor/
Policy Advisor

/ / / / / /

Minister's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)	Endorsed by:
Katrina Mathies	Shirley Wigan	Pam Lane	Dr Tony O'Connell Acting Director-General
Director, Mental Health Services	Executive Director Mental Health	District Chief Executive Officer	
Darling Downs – West Moreton Health Service District	Darling Downs – West Moreton Health Service District	Darling Downs – West Moreton Health Service District	
14 June 2011	14 June 2011	14 June 2011 21 June 2011	/ /

Last reviewed: 25/3/2008

THE AUSTRALIAN COUNCIL ON HEALTHCARE STANDARDS

Advanced Completion within 60 days Survey Form

(TO BE COMPLETED BY THE OWS/PR/Alignment SURVEY COORDINATOR)

Organisation: **West Moreton South Burnett Health Service District** **Org. Code: 715130**

In my view, this organisation will be able to progress the required improvements to convert the rating assigned to an MA *[Moderate Achievement]* rating, within the specified 60-day timeframe. I have explained this option to the designated principal of the organisation, including the requirement by the organisation to notify the ACHS of the intent to pursue this path.

Please Note:
The scope of this Advanced Completion Review is strictly limited to a maximum of 4 criteria to be reviewed.

OWS/PR/Alignment Survey Coordinator: Date:

Deborah Wilmoth 26.8.08
[Please print]

Signature:

As this process depends on a strict 60-day timeframe, please ensure that this form is forwarded to the respective ACHS Customer Services Manager, electronically within 7 days after the Survey.

We thank you for your co-operation in anticipation.

AC60 Survey Coordinator: Contact phone no:

Deborah Wilmoth
[Please print]

Important Note

The Surveyor Comments and Recommendations that follow will appear within the final Survey Report in their current format.

[TO BE COMPLETED BY THE SURVEY COORDINATOR]

COMMENTS & RECOMMENDATION/S FROM OWS OR PR SURVEY

Standard: 1.1	**Criterion: 1.1.8**
Organisation's Self-Rating: MA	Surveyor Rating: SA
High Priority Recommendation:	Yes ☐ No XX

Surveyor Comment

This criterion is to ensure that medical records are maintained appropriately and that the information kept within them is comprehensive and accurate. The organisation needs to have processes in place that ensure that this comprehensiveness and accuracy is occurring. Without accurate and comprehensive information, there is the risk that the organisation will not be able to provide appropriate care. In terms of The Park, the organisation has no systematic auditing process to help determine that medical record content is sufficiently detailed to allow care delivery to be tracked, monitored and evaluated.

The Mental Health Service does not have a robust system in place to ensure that all programs within its service area are effectively managing medical record content. This places the organisation at some risk for adverse outcome related to this criterion. There is a moderate risk to the organisation if there is not a change to its monitoring of medical records.

Surveyor Recommendation:

Stage 1 (AC60)

1. (Park Campus) Develop a system for reporting results of clinical record audit to clinical teams.

2. (Park Campus) Develop a system for reviewing any trends discovered from the clinical record audit and develop a plan for improving performance in identified areas.

3. (All mental health programs) Implement audit of quality of clinical notes for each clinical discipline.

Stage 2 (by August 2009)

1. Evaluate effectiveness of clinical record audit process implemented above.

2. Audit completed by West Moreton South Burnett Health Service District to ensure all mental health services have a clinical record audit system in place and operational

---

[TO BE COMPLETED BY THE ORGANISATION]

AC 60 ACTION TAKEN BY ORGANISATION TO ADDRESS RECOMMENDATION:

Completion Due By: **Responsibility:**

AC 60 SURVEY REPORT

[TO BE COMPLETED BY THE AC60 SURVEY COORDINATOR]

Surveyor new rating:

Surveyor's Comments on Criterion:

Surveyor's New Recommendation/s
HPR (Yes/No)

[TO BE COMPLETED BY THE SURVEY COORDINATOR]

COMMENTS & RECOMMENDATION/S FROM OWS OR PR SURVEY

Standard: 1.5	**Criterion: 1.5.1**
Organisation's Self-Rating: MA	Surveyor Rating: SA
High Priority Recommendation:	Yes ☐ No XX

Surveyor Comment
This criterion is to ensure that medication practices are in place to ensure safe and effective practice. In terms of The Park, the organisation has no systematic auditing process to help determine if medication is managed safely and effectively. An audit of medications in the service is generally conducted only once a year. Additionally, the pharmacists on campus have little time to provide clinical pharmacy services on the ward – such as attending ward rounds or providing education to consumers or their carers.

There is a moderate risk to patients in the absence of a robust audit of medication management.

Surveyor Recommendation:

Stage 1 (AC60)

1. (Park Campus) Develop a system for monthly auditing of medication in each program area.

2. (Park Campus) Develop a system for reviewing any trends discovered from the audit and develop a plan for improving performance in identified areas.

3. (Park Campus) Review utilisation of pharmacy time to enable clinical input at ward level.

Stage 2 (August 2009)

3. Evaluate effectiveness of the medication audit process implemented above.

4. Audit completed by the Health Service District to ensure all Park mental health services have a medication audit system in place and operational.

[TO BE COMPLETED BY THE ORGANISATION]

AC 60 ACTION TAKEN BY ORGANISATION TO ADDRESS RECOMMENDATION:

Completion Due By: **Responsibility:**

[TO BE COMPLETED BY THE SURVEY COORDINATOR]

COMMENTS & RECOMMENDATION/S FROM OWS OR PR SURVEY

Standard:	**Criterion:**
Organisation's Self-Rating:	Surveyor Rating:
High Priority Recommendation:	Yes ☐ No ☐

Surveyor Comment

Surveyor Recommendation:

[TO BE COMPLETED BY THE SURVEY COORDINATOR]

COMMENTS & RECOMMENDATION/S FROM OWS OR PR SURVEY

Standard: Support	**Criterion: 2.1.2**
Organisation's Self-Rating: MA	Surveyor Rating: SA
High Priority Recommendation:	No

Surveyor Comment

Staff across the West Morton South Burnett Health Service District mental health sector are aware of their responsibilities for managing risk and do so through communication and consultation. The risk management policy is District wide, Executive endorsed, addresses clinical and corporate risks and is available to staff electronically. The policy is based on the Hunter Valley framework and is detailed and in parts specific about processes.

The current risk management framework identifies risk, analyses, evaluates and addresses risks, but there is a lack of evidence of site specific monitoring, review on a regular basis and communication of reassessment to the relevant site staff, committees and persons responsible as articulated in the policy *West Moreton South Burnett Health Service District Clinical Governance Operational Plan* and the *Risk Management Plan*. The risk register is centrally managed and again, access or full engagement by site-specific staff are not demonstrated.

There are specific committees for clinical risk management, but the evidence of effective functioning or impact of the committees was not demonstrated. The corporate risk management system is inclusive of all sites but the interface between sites and the District process is not clearly demonstrated as providing effective bottom-up and top-down communication and follow-up.

The many audits, both clinical and corporate, completed across the sites are compliance directed and there was little evidence of a collective approach to the coordination of, purpose of and outcomes that improved safety or quality. Staff did report that they could initiate an action related to risk, had some control over response to an identified risk, but were unsure of who in the risk management framework held overall responsibility for any incident follow-up.

The recommendations for RCAs and HEAPS (local investigations) are recorded in PRIME and do come to the Patient Safety Committee, however there is not a demonstrated control over the actioning, timeframes and outcomes from them, with little if any detail recorded in minutes and an inability of staff, either directly involved or management, to articulate what were the outcomes of many of the HEAPS/RCA recommendations. A system for the tracking of recommendation progress was not established.

There is an explainable reliance on the central Patient Safety process for monitoring, but the effectiveness of the interface of District with IMHS, Kingaroy, Goodna and The Park was not established.

Trending and reporting of incident data occurs and is reported to staff but there was, again, an "ad hoc" approach to engaging staff in understanding or using the aggregate data to improve care.

The following issues were notable:

The home visiting safety policy - *Home Visiting in the Community – PROWMSB20080258,* for mental health service community staff does not provide a formal requirement for completion or formal recording of home visiting risks for individual clients. There is an "ad hoc" approach by some teams to utilising the alert process to inform colleagues of identified risks. The policy is also not inclusive enough, for example, the recording of staff exposure to cigarette smoke/dogs.

The risk associated with this recommendation is rated as unlikely with moderate consequences as the components of an appropriate risk management system are in place and the concerns surround the effective integration of the system.

Surveyor Recommendation:

1. Mental Health - An audit of the current control of and tracking of the progress of the recommendations from RCAs and HEAPS be undertaken. The focus should be on ownership by site staff and leaders as well as the District system with the development of an identified pathway of open, two way communication.
2. Mental Health - A formal and inclusive home visiting risk assessment process be put in place and evaluated.

[TO BE COMPLETED BY THE ORGANISATION]

AC 60 ACTION TAKEN BY ORGANISATION TO ADDRESS RECOMMENDATION:

Completion Due By: **Responsibility:**

AC 60 SURVEY REPORT

[TO BE COMPLETED BY THE AC 60 SURVEY COORDINATOR]

Recomm. Completed: Y / N

Surveyor's Comments for recommendation:

Surveyor new rating :

Surveyor's Comments for Standard or Criterion:

New Surveyor's Recommendation/s

HPR (Yes/No)

[TO BE COMPLETED BY THE SURVEY COORDINATOR]

COMMENTS & RECOMMENDATION/S FROM OWS OR PR SURVEY

Standard: Corporate	**Criterion: 3.1.3**
Organisation's Self-Rating: MA	Surveyor Rating: SA
High Priority Recommendation:	Yes

Surveyor Comment

The Surveyors noted that there are rigorous processes in each professional discipline in WMSBHSD to ensure credentialing and currency of registration with the respective registration authority.

Allied Health

There are rigorous processes to check credentialling and registration at time of appointment. It is noted that there is no registration authority for some craft groups (eg Social Work) and that membership of the professional association is non-mandatory.

It was noted that in some allied health disciplines checks of registration were not being done until some days after registration renewal date on 1 July. It was also noted that in some allied health disciplines the responsibility for credentialling was a shared responsibility between the service manager and Director, and in others the responsibility rested with either the Director or service manager. It is suggested that responsibility for credentialling of allied health staff is standardised, and responsibility is assigned to the Director of the respective allied health discipline, and that checking of registration renewal occurs prior to 30 June each year.

Nursing

The Surveyors noted that nursing administration has implemented rigorous processes around appointments and initial credentialing, and that there are systems for monitoring registration, education and competencies.

Junior and Senior Medical Staff

There are robust processes to check credentials and registration with Qld Medical Board, using the Qld Medical Board public access register. It was noted that evidence of current registration was missing from the files of two junior medical staff which was not in accordance with the District policy (untitled). It is suggested that an internal audit process of personnel files is introduced in Medical Administration to ensure evidence of currency of registration of junior medical staff.

The Survey Team noted that the District has implemented a policy /procedure 'Credentials and Clinical Privileges for Medical Practitioners' and has a system for credentialling and clinical privileging of medical practitioners (other than junior medical staff), which is facility-specific and relates to the Service Capability Framework of the facility and/or health service. The Surveyors noted however that there is currently no policy/procedure or system for defining the scope of clinical practice for medical practitioners, in particular for proceduralists, which defines those procedures which the consultant can or cannot perform.

The Surveyors noted that there is no system or policy/procedure for credentialling and defining the scope of clinical practice of registrar or senior medical officer staff, with the exception of obstetric and gynaecology registrars where there is a robust process for credentialling and competency assessment of obstetric and gynaecology registrars to conduct unsupervised after-hours LUSCS. The clinical leadership of the Director Obstetrics and Gynaecology and the high level of consultant engagement in this process, and the commitment to providing after-hours

supervision for registrars and junior medical staff is to be commended.

The Survey Team recommends that a process of credentialling and defining scope of clinical practice for registrar and senior medical officers is implemented as a priority for all registrars and senior medical officers who are performing interventional procedures. This will provide a framework for managing requests from registrars to perform procedures, as with the recent request by a surgical registrar to perform a laparoscopic appendicectomy.

The Survey Team notes that there is a District policy 'Introduction of New Equipment or Consumables for Surgical Services' however there is no policy or system for the safe introduction of new interventions/services. The Surveyors recommend that a policy and system for the safe introduction of new interventions/services is implemented as a priority, and that the scope of clinical practice of a clinician is reviewed prior to new services or interventions being introduced. The implementation of this system will provide a framework to appropriately manage applications from clinicians to perform new procedures, as with the recent request by a consultant to perform laparoscopic banding.

It is noted that there is a performance appraisal and development framework for consultant medical staff, however few consultant staff have completed performance appraisals. This system of performance monitoring needs to be linked to the system of credentialling and defining scope of clinical practice, in order that a consultant's scope of clinical practice can be varied where indicated.

The Surveyors noted that there is no policy or system for performance management of junior medical staff, and that management of poorly performing junior medical staff has been identified as a key risk for the organisation.

The Survey Team notes that there is currently no process of formal communication to key stakeholders of the clinical privileges and scope of clinical practice of medical staff including consultant, GP-VMO, registrar and senior medical officers. As a consequence, these staff are required to contact individual staff including the Executive Director Medical Services and Directors of Business Units to provide this information. It is recommended that a communication strategy be implemented which enables key stakeholders to have direct access to this information.

The Surveyors noted that at Kingaroy there has been a long-standing medical workforce shortage of anaesthetist and obstetrician consultant staff, and that currently a GP-VMO who has clinical privileges as a generalist obstetrician and anaesthetist is rostered to concurrently cover two rosters and provide after-hours cover as both the on-call anaesthetist and obstetrician. It is the understanding of the Surveyors that the GP-VMO only performs epidural anaesthesia and not general anaesthesia in this situation. The Surveyors note that the District conducted an internal review of maternity services at Kingaroy in May 2007, and that a result of this review several risk management strategies have been implemented including screening of high risk pregnancies and transfer to higher level care, whilst concerted endeavours have been made to recruit additional obstetric and anaesthetist staff. The surveyors understand that a new consultant anaesthetist is expected to be appointed in 8-12 weeks and that the GP-VMO will then only cover the after-hours obstetric roster.

Surveyor Recommendation:

Stage 1 (AC60)

1. Implement a system for defining, monitoring and communicating the scope of clinical

practice for all consultant, GP-VMO, registrars and senior medical officers in the District, which specifically includes medical staff working in the Park Centre for Mental Health and registrars performing electro-convulsive therapy procedures.
2. Implement a system of performance management for consultant and GP-VMO medical staff, which is linked to the system of credentialling and defining scope of clinical practice, and ensures that all consultant and GP-VMO medical staff have an annual performance appraisal.
3. Implement a system of performance management for junior medical staff, which is linked to the system of credentialling and defining scope of clinical practice.
4. Develop a policy and implement a system for the safe introduction of new interventions, which includes review of a clinician's scope of clinical practice prior to the introduction of new interventions.
5. Implement the systems developed in response to recommendations 1 and 2 in at least two clinical services and develop an action plan for their implementation across the whole District.

Stage 2 (by August 2009)

1. Demonstrate that the scope of clinical practice and performance management systems developed in Stage 1 have been implemented across the whole District.

[TO BE COMPLETED BY THE ORGANISATION]

AC 60 ACTION TAKEN BY ORGANISATION TO ADDRESS RECOMMENDATION:

Completion Due By: **Responsibility:**

AC 60 SURVEY REPORT

[TO BE COMPLETED BY THE AC 60 SURVEY COORDINATOR]

Recomm. Completed: Y / N

Surveyor's Comments for recommendation:

Surveyor new rating :

Surveyor's Comments for Standard or Criterion:

New Surveyor's Recommendation/s
HPR (Yes/No)

COMMENTS & RECOMMENDATION/S FROM OWS OR PR SURVEY

Standard: Corporate	**Criterion: 3.2.2**
Organisation's Self-Rating: MA	Surveyor Rating: SA
High Priority Recommendation:	Yes ■ No ☐

Surveyor Comment

Part of the intent of this criterion is to ensure that all buildings (and utilities) owned or used by a healthcare organisation are managed and operated to support a safe health environment. The criterion addresses in a broader sense, how the organisation maximises the safety, comfort and needs of the community it serves. The focus of this AC60 recommendation and the accompanying subservient recommendations is the Barrett Adolescent Centre (BAC) located within The Park – Centre for Mental Health. Many of the patients admitted to the BAC have extensive histories of recurrent, severe self harm and suicidal behaviours often associated with abuse and trauma. As a state wide service and the only facility capable of providing care for this high acuity group of patients the BAC does not have a choice about the mix of patients they admit. The surveyors noted that as the redevelopment of The Park site progressed, BAC lost access to other buildings eg nearby auditorium, high dependency unit and medical centre for the management of patients with eating disorders. This compounded the problems and placed greater strain on the patient accommodation, notably the ward environment.

The level of risk associated with the BAC patient accommodation and treatment areas has been identified over a long period of time with reviews conducted in 2003-2004 and in 2006. In addition internal reviews have been instigated following various critical incidents over the period from 2003 to the present time. Evidence in BAC and hospital records demonstrates an increasing level of incidents often associated with serious outcomes for both patients and staff. This has lead to a high level reliance on continuous observation as a patient safety strategy. Recommendations to address the associated staffing issues are included under criterion 2.1.2 in the IDR survey report.

Whilst there has been a decision to rebuild the facility the timeframe for this to occur remains unclear and is reported as not likely to occur for another two or three years.

The current situation needs to be addressed immediately with interim measures to address and mitigate the risks associated with:

1. Requirement for containment - for high acuity patients and to provide for protection from self harm or harm to others;
2. Accommodating physically fit seriously ill adolescents in a non purpose built environment which it has been agreed in various reports, is entirely unsuitable to their needs.

A further comprehensive review was conducted in March 2007 and a range of improvements recommended to enable the unit to continue to provide a safe patient and staff environment pending the capital works program to re build the facility. This report reiterated the findings of

previous reports and could provide a useful basis for addressing the immediate risk issues.

The surveyors assessed the risk as in the extreme category (i.e.likelihood – almost certain and consequences high) based on the history of incidents, near misses and RCA investigations, discussions with clinicians working in the unit and observation of the area first hand by surveyors from both the IDR and OWS teams. The rating was subsequently reduced to SA and an HPR recommendation assigned.

Surveyor Recommendation:

Stage 1 (AC60)

1. Obtain written confirmation of approval (with necessary budget allocation) to immediately make the necessary environmental modifications to BAC to reduce risk to acceptable levels and improve patient and staff safety;
2. Provide documented evidence of approved plans and work schedule for the environmental modifications with designated time frames for completion.

Stage 2 (August 2009)

1. The immediate works identified in Stage 1 to reduce risk to acceptable levels be completed.
2. The rebuilding of the BAC be expedited to enable care and services to be provided for adolescent patients in a purpose built facility which facilitates a safe health environment and maximises the safety, comfort and needs of the community.

[TO BE COMPLETED BY THE ORGANISATION]

AC 60 ACTION TAKEN BY ORGANISATION TO ADDRESS RECOMMENDATION:

Completion Due By: **Responsibility:**

AC 60 SURVEY REPORT

[TO BE COMPLETED BY THE AC 60 SURVEY COORDINATOR]

Surveyor new rating :

Surveyor's Comments on Criterion:

Surveyor's New Recommendation/s
HPR (Yes/No)

[TO BE COMPLETED BY THE SURVEY COORDINATOR]

COMMENTS & RECOMMENDATION/S FROM OWS OR PR SURVEY

Standard: Corporate	**Criterion: 3.2.4**
Organisation's Self-Rating: MA	Surveyor Rating: SA
High Priority Recommendation:	Yes ☐ No X☐

Surveyor Comment

The organisation provided evidence of full fire inspections of Esk, The Park, Boonah, Laidley, Kingaroy, Wondai, Nanango, Cherbourg and Murgon facilities. Action plans have been developed and identified works have been completed, or are progressing towards completion. Inspections and action plans of those facilities have been developed within the current EQuIP cycle. At the time of survey a fire inspection was underway at Ipswich Hospital and was due for completion in the coming months. There was no evidence of planned fire inspections for Oral Health facilities at Collingwood Park or Sacred Heart facilities.

The lack of evidence that Ipswich Hospital and Collingwood and Sacred Heart Dental Clinic have had a full fire inspection places patients, visitors and staff in an at risk situation in those facilities and risk is rated as high.

Surveyor Recommendation:

1. **Ipswich fire inspection be completed and that there be a documented plan to implement the recommendations from that fire inspection.**

2. **Oral Health facilities at Collingwood Park and Sacred Heart undertake a full fire inspection by an authorised external provider and that there be a documented plan to implement the recommendations of those fire inspections.**

[TO BE COMPLETED BY THE ORGANISATION]

AC 60 ACTION TAKEN BY ORGANISATION TO ADDRESS RECOMMENDATION:

Completion Due By: **Responsibility:**

AC 60 SURVEY REPORT

[TO BE COMPLETED BY THE AC60 SURVEY COORDINATOR]

Surveyor new rating:

Surveyor's Comments on Criterion:

Surveyor's New Recommendation/s
HPR (Yes/No)

AC60 FUNCTION SUMMARY

ACHS IDR Mental Health Survey Recommendations Action Plan – West Moreton South Burnett Health Service District

Criteria 1.1.2 – Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.

Recommendation	Action	Progress	Responsible Officer / Committee	By When	Completion Date
(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 ***(TP)*** ***Self Assessment Feedback 2009*** *Amalgamation of services related to Mental Health Education and to research under discussion*	QCMHR is a State-wide research unit. As such its 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 State-wide 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 and Evaluation Unit (SERU) which operates independently of QCMHR will remain at The Park, and will continue to be responsible for research involving The Park and its residents e.g. evaluation studies, program implementation studies.		District Director, MHS / Director QCMHR		

Criteria 1.1.4 – Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.					
Recommendation	**Action**	**Progress**	**Responsible Officer / Committee**	**By When**	**Completion Date**
(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 ***(TP)*** ***Self Assessment Feedback 2009*** *Redevelopment of the rehabilitation service (The Park) occurring, and this will include the investigation of different models of care.*	Review of the Rehabilitation Team as part of the staffing profile review for the Redevelopment of the facility 2009-2011.	▪ 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.	Director of Clinical Services / Project Officer, Redevelopment / Rehabilitation Services Coordinator		
(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 ***(TP)*** ***Self Assessment Feedback 2009*** *Recommendations from an audit and action plan in progress*	Vehicle audit undertaken and Recommendations implemented. Redevelopment program over next 2 years may impact on fleet capacity.	▪ The Park - Vehicle audit completed. Workgroup established to develop and implement action plan from recommendations. ▪ Current fleet has capacity to transport disabled consumers. ▪ Seatbelt extensions have been purchased.	Service Manager / Rehabilitation Services Coordinator		

(iii) Housekeeping be included in a life skills program in the Medium Secure Unit for client self esteem ***(TP)*** ***Self Assessment Feedback 2009*** *Recommendation Met*	Life Skills Program is changed regularly according to assessment of client need	▪ Housekeeping skills included in rehabilitation program when required.	Rehabilitation Services Coordinator / MS Rehabilitation Program Coordinator		

Criteria 1.1.8 – The health record ensures comprehensive and accurate information is recorded and used in care delivery.					
Recommendation	**Action**	**Progress**	**Responsible Officer / Committee**	**By When**	**Completion Date**
Mental Health **Stage 1 (AC-60)** (i) **The Park** Campus develop a system for reporting the results of clinical record audits to clinical teams.	Review established audit processes & tools. Develop a system for reporting findings / recommendations. ***Recommendations completed & closed.***	• Audit processes & tools reviewed & a linking system is in place for collection of data. (Revised Audit Tool and Audit Report Spreadsheet.) • Reporting findings / recommendations system developed and formalised for the following clinical chart audits: - HIM – Area Admin Officer Clinical Chart Audit. Compliance looks at the administrative components of the medical record - Clinical Programs Clinical Chart Audit. To ensure clinicians, by discipline, comply with facility policy and professional standards regarding clinical charts. - Clinical Initiatives – Care Plan Audit. Compliance measures the Individual Care Plan in the Medical Record - Medical Services – Limited Community Treatment Audit. Compliance with MHA 2000 and other legislation & standards. *(Documentation includes audit tool, flowchart, audit report and action plans)*	Director of Clinical Services / Clinical Records Committee	December 08	December 08
(ii) **The Park** Campus develop a system for reviewing any trends discovered from the clinical record audit and a plan be developed for improving performance in identified areas.	Develop process for reporting and review of identified trends from audit reports. Communication / feedback processes to be incorporated in process. ***Recommendations completed & closed***	• Flowchart developed which incorporates each clinical chart audit. Process links audit tools and outlines the process for reviewing any trends or patterns identified in the findings of each audit. • Communication / feedback flow process included in flowchart.	Director of Clinical Services / Clinical Records Committee	December 08	December 08

EXHIBIT 75

WMS.9000.0003.00556

Recommendation	Action	Progress	Responsible Officer / Committee	By When	Completion Date
(iii) All mental health programs implement an audit of the quality of clinical notes for each clinical discipline	Review Audit Tools & reports to include the quality of clinical notes for each clinical discipline. ***Recommendations completed & closed***	• An audit of the quality of clinical notes has been implemented in the audit tool and report contains action plan for each discipline. *(Evidence through flowchart, findings and audit summary report for each clinical chart audit)*	Director of Clinical Services / Clinical Records Committee	December 08	December 08
Stage 2 (by July 2009) (i) The effectiveness of the clinical record audit process implemented be evaluated.	Evaluation of clinical record audit. ***Recommendations completed & closed***	· Evaluation undertaken bv SERU - Clinical audit and effectiveness project: Assessing changes in practice and staff attitudes (Jun 09) · Evaluation to be completed by Dec 09	Director of Clinical Services / Service Improvement Coordinator / SERU	July 09	Jul 09
(ii) West Moreton Health District complete an audit to ensure that all mental health services have a clinical record audit system in place and operational	Develop audit tool and undertake audit of clinical record audit process. ***Recommendations completed & closed***		Director Patient Safety & Quality Unit / Health Information Management	June 09	July 09
Criteria 1.5.1 – Medications are managed to ensure safe and effective practice.					
Recommendation	**Action**	**Progress**	**Responsible Officer / Committee**	**By When**	**Completion Date**

EXHIBIT 75

WMS.9000.0003.00557

(i) **The Park** Campus develop a system for monthly auditing of medication in each program area. ***Self Assessment Feedback 2009*** *Medication audit conducted annually. Identified issues with medications are followed up, and through, appropriate Committees.*	Develop audit process / system.	▪ 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. ▪ ***New medication chart introducted October 2009. Evaluation performed by SERU in January 2010.*** ▪ ***Recommendations to be looked at by D&T Sub-Committee.*** ▪ Medication issues identified through Pharmacy Interventions Report and PRIME reports. Reports tabled at Drugs & Therapeutics Committee monthly. ▪ ***Tabling of i-Pharmacy interventions at D&T meetings to be discussed in conjunction with PRIME reports.*** ▪ Medication standards to be included in quarterly Clinical Chart Audits	Director of Pharmacy / Drugs & Therapeutics Committee	**Apr 10**	**Jan 10** **Sep 08**
(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. ***Self Assessment Feedback 2009*** *System in place that includes identification, improvements and feedback*	Develop flowchart to include process and feedback mechanisms.	▪ 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 ▪ ***Process being reviewed***	Director of Clinical Services / Director of Pharmacy / Drugs & Therapeutics Committee		

(iii) **The Park** Campus review the utilisation of pharmacy time to enable clinical input at ward level. ***Self Assessment Feedback 2009*** *Pharmacy input at ward level has been implemented with the employment of Pharmacy Assistants who have relieved pharmacists of appropriate duties.*		▪ Pharmacy Assistant employed to expand Webster Packs program. ▪ ***Webster Pack program has been expanded.*** ▪ 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. ***Individual patient counselling sessions have commenced.***	Director of Clinical Services / Director of Pharmacy / Drugs & Therapeutics Committee		**Oct 08** **Nov 08**
Criteria 1.6.1 – Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service.					
Recommendation	**Action**	**Progress**	**Responsible Officer / Committee**	**By When**	**Completion Date**
(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 ***Self Assessment Feedback 2009*** *Consultation occurring to develop strategies*		▪ Consultation with Consumer Consultant and Rehabilitation Program Coordinators to develop strategies. ▪ Consumer Consultant and Consumer Liaison Officer to participate in Rehabilitation Coordinators meetings.	Rehabilitation Services Coordinator / Consumer Consultant		
Criteria 2.1.1 – Consumers / patients are informed of their rights and responsibilities.					
Recommendation	**Action**	**Progress**	**Responsible Officer / Committee**	**By When**	**Completion Date**

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 ***(MHS)*** ***Self Assessment Feedback 2009*** *Quality register now in place. Streamlining of data collection occurring.*	Develop Quality Activity Register and process including evaluation / audit of process throughout the EQuIP cycle. Implementation of process to include in-service sessions.	· Quality Activity Register and process developed and implemented. Evaluation of process to be developed and undertaken July 2010. The Park - Collection of data over 12 month period (July 08 to June 09) from varying sources (Consumer Forums, Community Visitor Reports, TP-CAG, Consumer Satisfaction Surveys, Complaints process) has been collated and a report to be available by end of Sep 09. Process to be developed to streamline the collection of data to generate annual reports for distribution to business units and relevant committees.	Service Improvement Coordinator (The Park) / Service Innovation & Development Team Leader (IMHS)		
Criteria 2.1.2 – The integrated organisation-wide risk management policy and system ensure that clinical and corporate risks are identified, minimised and managed.					
Recommendation	**Action**	**Progress**	**Responsible Officer / Committee**	**By When**	**Completion Date**
Stage 1 (AC-60) (i) An audit of the current control and tracking of the progress of the recommendations from root cause analysis and HEAPS be undertaken in the mental health service, and the focus be on ownership by site staff and leaders as well as the District system with the development of an identified pathway of open, two-way communication ***(MHS)***	Audit undertaken and process for progressing recommendations from reviews (RCA / HEAPS) be developed. Process to include feedback mechanisms (two-way communication) ***Recommendation completed and closed.***	• Audit completed in relation to monitoring & progress of RCA & HEAPS recommendations. Audit identified deficits in the process. • Process revised and includes: - Flowchart includes defined sequence of events & reporting processes and improved flow of communication - Electronic & paper checklist implemented to monitor progress of each recommendation for completion and closure of incident - feedback mechanisms to clinical teams revised • Appointment of MH Patient Safety Officer	MH Patient Safety & Quality Committee / MH PSO	December 08	December 08
(ii) A formal and inclusive home visiting risk	Review *Home Visiting in the Community* policy and develop audit tool to evaluate	• Policy reviewed and revised version endorsed by 14 Nov 08.	Service Innovation & Development	December 08	December 08

EXHIBIT 75

WMS.9000.0003.00560

assessment process be put in place in the mental health service and evaluated ***(MHS)***	***Recommendation completed and closed.***	• Risk Assessment tool reviewed to include environmental risks (cigarette smoke / dogs / weapons). • Audit tool developed to evaluate policy	Team Leader		
Stage 2 Conditional Survey team to confirm that the changes have been sustained	District develop and collect some relevant performance indicators to demonstrate the effectiveness and sustainability of the changes ***Recommendation completed and closed.***	· The District has a Clinical Governance Operational Plan which defines the governance structure, systems and processes for the District. Stage 1 AC60 items for this defined area have been completed. Stage 2 AC60 progress for this item includes completion of the home visiting risk assessment tool audit and development of the performance indicators on the RCA and HEAPS analysis recommendations. These performance indicators are to be tabled at the Patient Safety and Quality Council in late June 2009.	Director Patient Safety & Quality Unit	July 09	July 09
Criteria 2.1.3 – Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.					
Recommendation	**Action**	**Progress**	**Responsible Officer / Committee**	**By When**	**Completion Date**
(i) The requirements for client follow-up and support post-incident be reviewed and formalised ***(MHS)*** ***Self Assessment Feedback 2009*** *Consumer Support program being reviewed.*	Open Disclosure (QHealth) Rolling out pilot of Consumer Support Program in Medium Secure	▪ 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.	Clinical Risk Management Committee / Senior Psychologist / Consumer Consultant		
(ii) The Peer Support Program be evaluated for effectiveness of staff participation rates as measured against its aims and objectives ***(TP)*** ***Self Assessment Feedback 2009*** *Evaluation conducted.* *Action plan in place.*	Evaluation of program and implementation of recommendations. Review policy and training program. Inservice sessions to promote program	▪ Evaluation of Peer Support Program has been completed and an action plan is being developed to implement the recommendations.	Service Improvement Coordinator / Senior Psychologist / SERU		

EXHIBIT 75

WMS.9000.0003.00561

(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 ***(MHS)*** ***Self Assessment Feedback 2009*** *Work in progress.*		▪ A one month review will be carried out across the services to monitor incident reporting against actual reporting. ▪ A survey tool / questionnaire is being developed for assessment of staff knowledge. ▪ Evaluation Sheet developed for staff attending PRIME Training.	MH Patient Safety Officer / SERU		
(iv) The current complaint management process be broadened to capture first line complaints from all sources ***(MHS)*** ***Self Assessment Feedback 2009*** *Recommendations not in line with mandated QHealth Corporate Complaints System (PRIME-CF).*	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.	Service Improvement Coordinator / Service Innovation & Development Team Leader		
Criteria 2.2.2 – ***The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation***.					
Recommendation	**Action**	**Progress**	**Responsible Officer / Committee**	**By When**	**Completion Date**
(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 ***(MHS)*** ***Self Assessment Feedback 2009*** *The allied health discipline is well supported in access arrangements for students.*	District – AHP Workforce development in place (Statewide)	▪ 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	Director Clinical Services / Allied Health Seniors		

		FTE clinical educator appointed ***to 30 Jun 10 with possibility of funding being recurrent after this date***. One-third of time is dedicated to mental health. ***Focus is to support students, new graduates and supervisors of students. Position is managed via CETU which is now under ClinEdQ.*** ▪ 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.			
(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 ***(MHS)*** ***Self Assessment Feedback 2009*** *The recommendation does not align with QHealth policy and program. The Preceptorship Program is aimed specifically for nurses. Other disciplines are supported by other arrangements.*		▪ 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). ▪ ***No further progress.***	Nursing Executive / Allied Health Seniors		
Criteria 2.2.4 – ***The learning and development system ensures the skill and competence of staff and volunteers***.					
Recommendation	**Action**	**Progress**	**Responsible Officer / Committee**	**By When**	**Completion Date**
The District Mental Health Education Service undertake a review of service provision to all sections and disciplines of the mental health sector, develop a plan of action for the delivery of	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	· 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.	Director DMHES / Nursing Director Education		

equitable education, and the District review the Mental Health Education Service's resource capacity to deliver ***(MHS)*** ***Self Assessment Feedback 2009*** *Funding is being sought to review the Mental Health Education Service.*					
Criteria 3.1.5 – ***Documented corporate and clinical policies assist the organisation to provide quality care****.*					
Recommendation	**Action**	**Progress**	**Responsible Officer / Committee**	**By When**	**Completion Date**
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 ***(MHS)*** ***Self Assessment Feedback 2009*** *Checklist being developed.*	Policy review process includes review of policies when effected by legislation. The process includes a process for endorsement of changes. Development of QHealth Policy Framework and implementation.	▪ 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.	District Director Mental Health Services / Director Clinical Services (The Park / IMHS)		
Criteria 3.2.1 – ***Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors****.*					
Recommendation	**Action**	**Progress**	**Responsible Officer / Committee**	**By When**	**Completion Date**
(i) The bathroom 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 ***(TP)***		▪ 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.	Service Manager / Manager Hotel Services	March 2009	April 2009

Self Assessment Feedback 2009 *Non hazardous chemicals now used for cleaning*		· Laminated guides displayed in targeted locations within each ETR resident.			
(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 ***(TP)*** ***Self Assessment Feedback 2009*** *Residential Support Officers responsible for holding the Material Safety Data Sheets*		▪ 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.	Workplace Health & Safety Officer / Business Unit Nursing Directors		
(iii) The overall safety system be more systematically evaluated for effectiveness and ensure that improvements are made as necessary ***(TP)*** ***Self Assessment Feedback 2009*** *Occupational Health and Safety Committee reviewed the terms of reference and performance indicators.*		▪ 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.	Workplace Health & Safety Officer / Service Manager		
Criteria 3.2.2 – ***Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.***					
Stage 1 (AC-60) (i) Written confirmation of approval be obtained (with necessary budget allocation) to immediately make the necessary environmental modifications to the Barrett	Progress environmental modifications to BAU	Written approval with appropriate budget allocation has been obtained for modifications. Modification progress: - Removal & replacement of glass with Perspex in identified areas completed - Front door entrance – scope of work developed. Door replaced with aluminium	Service Manager / BEMS	December 08	December 08

Adolescent Unit to reduce risk to acceptable levels and improve patient and staff safety.	***Recommendation Completed & Closed***	frame and toughened glass - HDU – plans drawn up and progressing through building approval process. Associated plans drafted in relation to under slab, sewerage & drainage services and ducted airconditioning. Finalised plans will be submitted to Project Services.			
(ii) Documented evidence of approved plans and work schedule for the environmental modifications be provided, with designated timeframes for completion	Collation of documented evidence of plans and designated timeframes for completion ***Recommendation Completed & Closed***	• Building & Engineering Maintenance Services maintain the documented plans and work schedules for the modifications. • Timeframe for completion is Apr/May 09 • Scope of Work outlines the requirements / specifications of the work and the timeframes for work to be completed.	Service Manager / BEMS	Apr / May 09	
Stage 2 (July 2009) (i) The immediate works identified in Stage 1 to reduce risk to acceptable levels be completed.	***Recommendation Completed & Closed***	▪ Written approval with appropriate budget allocation has been obtained for modifications. Modification progress includes: : removal & replacement of glass with Perspex in identified areas is completed : front door entrance – door has been replaced(aluminium frame and toughened glass) - completed : HDU – associated plans drafted in relation to under slab, sewerage & drainage services and ducted air conditioning plans drawn up. Finalised plans submitted to private certifier for approval.	District Director MHS / Service Manager / BEMS Chief Executive Officer / District Director MHS	December 08 July 09	December 08 August 09
(ii) The rebuilding of the Barrett Adolescent Unit be expedited to enable care and services to be provided for adolescent patients in a purpose-built facility which facilitates a safe health environment and maximises the safety, comfort and needs of the community ***(TP)***	Final decision on the redevelopment of the unit is signed off and the unit will be relocated to Redlands. A new User Group is being established to progress the relocation and redevelopment of the unit ***Recommendation Completed & Closed***	▪ Building & Engineering Maintenance Services maintain the documented plans and work schedules for the modifications. Scope of work outlines the requirements / specifications of the work and the timeframes for work to be completed. Once plan approval has been received, construction will begin with an estimated time of construction of 6 weeks			
Risks to residents in the Barrett Adolescent Unit	Relocation of the unit and timeframe for transfer of the service is late 2011 and	▪ Ongoing monitoring of risks occurs through:			

continue to be monitored and actively managed pending the relocation of the unit to Redlands Hospital ***Self Assessment Feedback 2009*** *The unit is due to remain in use until late 2011 so ongoing risk identification and management is a high priority, and ongoing.*	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).	- 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.			
*Criteria 3.2.3 — **Waste and Environmental management supports safe practice and a safe environment.***					
(ii) Waste management procedures in the mental health service be included in staff orientation packages and in-service programs ***Self Assessment Feedback 2009*** *Orientation program under review*	Revise information provided in Staff Orientation manual. Training / Inservice sessions	· 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.	District Operational Services Manager / Service Manager (The Park) / Nursing Director, Education		
(iii) Actions plans be developed in the mental	The Park Waste Management Operational Handling Guidelines.	· Audit conducted by Waste Advisor, Southern Population Health Service	District Operational Services Manager /		

health service for implementing improvements following routine waste management audits ***Self Assessment Feedback 2009*** *Action plan in place since audit.*	Waste management audit conducted and implementation of recommendations	(Jan/Feb 09) · Action Plan developed to progress recommendations / issues. · The Park Waste management Plan available /accessible on G:\Everyone and application to publish on WMSBHSD Intranet Site. · Signage for types of substances have been completed.	Service Manager (The Park)		

EXHIBIT 75

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WEST MORETON SOUTH BURNETT HEALTH SERVICE DISTRICT

BARRETT ADOLESCENT CENTRE WORK PROGRAM

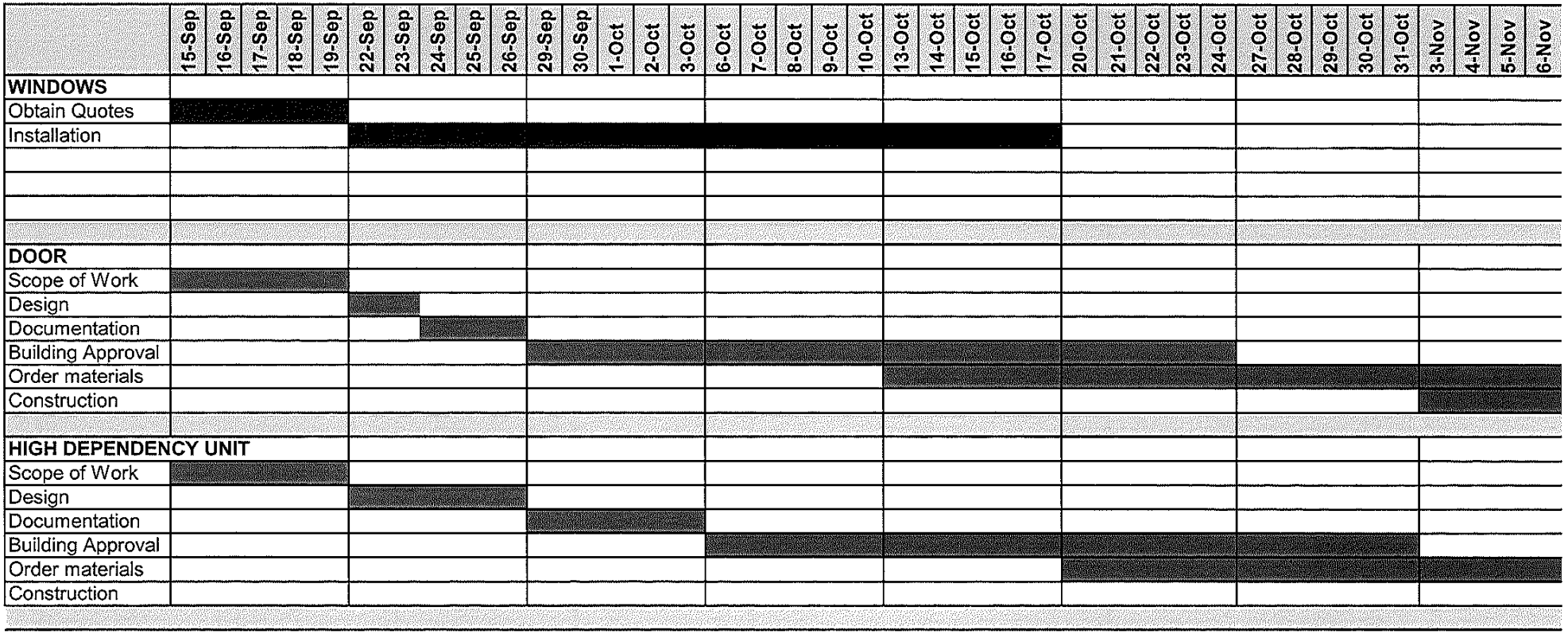

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EXHIBIT 75

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CERTIS building certification

CERTIS Pty Ltd

[redacted]

Thursday, 30 April 2009

The Park, Centre for Mental Health
Locked Bag 500
Richlands QLD 4077

Attention: Michael Thompson

FEE PROPOSAL FOR BUILDING CODE CERTIFICATION
Quote 10012: The Park Centre for Mental Health Wacol

Thank you for the opportunity to submit a fee proposal for building certification services for the proposed development at The Park, Centre for Mental Health in Wacol. We understand the work involves converting a portion of the existing Barrett D Block, into a High Dependency Unit which will contain two single bedrooms, a lounge area and ensuite.

FEE SUMMARY

Building Code Certification	$	1,200.00
Inspection Fee	$	350.00
GST	$	155.00
Local Govt Archive Fee	$	150.00
Total lump sum	**$**	**1,855.00**

This offer is made to The Park, Centre for Mental Health who we understand will be our client upon acceptance of this proposal. CERTIS will receive instructions from Michael Thompson.

Accompanying this proposal is our "Engagement Form". It contains the minimum information needed to commence an application. Upon accepting our fee proposal, please complete, sign and return the engagement form.

Hourly Rates

Principal Building Certifier	$220 p/h
Senior Building Certifier	$200 p/h
Building Certifier	$185 p/h
Assistant Building Certifier	$160 p/h

SERVICES OFFERED

- Review the project for compliance with the Building Code of Australia (BCA) in accordance with the deemed-to-satisfy (DTS) provisions.
- Determine the non-compliance matters and prepare a (DTS) preliminary assessment report.
- Respond to BCA interpretation requests from architects and services consultants.
- Lodge the engagement notice with the local authority as required under the Integrated Planning Act. (If required)
- Issue the Decision Notice for the Building Approval.
- Lodgement of the approved plans with the local authority.
- Carry out one final inspection upon completion of the building works, to ensure compliance with the approved plans.
- Prepare the certificate of classification for the building.
- Lodge copies of the documents and certificate of classification documents with the local authority.

All additional inspections will be charged at $200 p/h.

The scope of work is limited to the floor area being altered and Fire Services approvals are in place for the existing facility

EXCLUSIONS

Unless identified in the Services Offered, the fee does not include:

1. Time taken by CERTIS to obtain approvals or documentation from statutory authorities. These include and are not limited to: Town Planning advice; Health and Food Act; Work Cover and Occupational Health and Safety advice; Specialist dangerous and hazardous goods requirements; Heritage; Acoustics; Utilities consents; NatHERS or BERS energy assessments; Lodging plumbing applications.
2. Payment of statutory fees required by any Act or Regulation. Statutory fees required to be paid, to achieve Development Permit (Building) include by may not be limited to: **a)** QFRS application fee to assess the Special Fire Services.
3. Assessment of the building for compliance with The Disability Discrimination Act 1992 (Commonwealth), and Anti-Discrimination Act 1991 (Queensland).
4. Responses to or issue of notices and local authority queries.
5. Assessment, acceptance and certification of alternative solutions, or concessional approvals under the Standard Building regulation.
6. Assessment of the building for compliance with the BCA's Section J (Energy Efficiency). It is anticipated that independent consultants will be engaged to carry out the assessment and certification for this section.

SUMMARY

CERTIS is committed to providing you with timely and responsive certification services for your project. We look forward to working on this project with you. If you wish to discuss this proposal in more detail, please do not hesitate to contact Prabha Ponniah on 07 3144 4600.

Regards,

Nicole Hutton
On behalf of Prabha Ponniah
Principal Building Certifier

CERTIS building certification

CERTIS Pty Ltd

ENGAGEMENT FORM

APPLICANT / CONTACT:

Company: **The Park, Centre for Mental Health** Representative: **Michael Thompson**

Address: **Locked Bag 500**

Richlands QLD 4077

Telephone: Email:

ADDRESS INVOICE TO:

Company: ..... Representative: .....

Address: .....

Telephone: ..... Email:

OWNER / TENANT / LESSEE:

Company: ..... Representative: .....

Address: .....

Telephone: ..... Email:

PROJECT DETAILS:

Project description/proposed use:.....

Project Address: .....

Lot: ..... RP: ..... Site area:.....

Total Value of Building Work:.....

ENGAGEMENT AGREEMENT

Provisions of services as per quote number **10012** dated **30/04/09** as per agreed fee for Professional Certifying services as indicated on the fee proposal.

CERTIS is authorised under the Integrated Planning Act 1997 (Qld) (IPA) to undertake the work of a private certifier in relation to development applications requiring assessment under the Integrated Development Assessment Systems against the Standard Building Regulations.

It is agreed:

1. Payment is due in accordance with CERTIS Terms and Conditions.
2. This Agreement constitutes the engagement in writing required under IPA (Section 5.3.9).
3. CERTIS is authorised by the owner/applicant to sign forms & documents to facilitate statutory requirements.

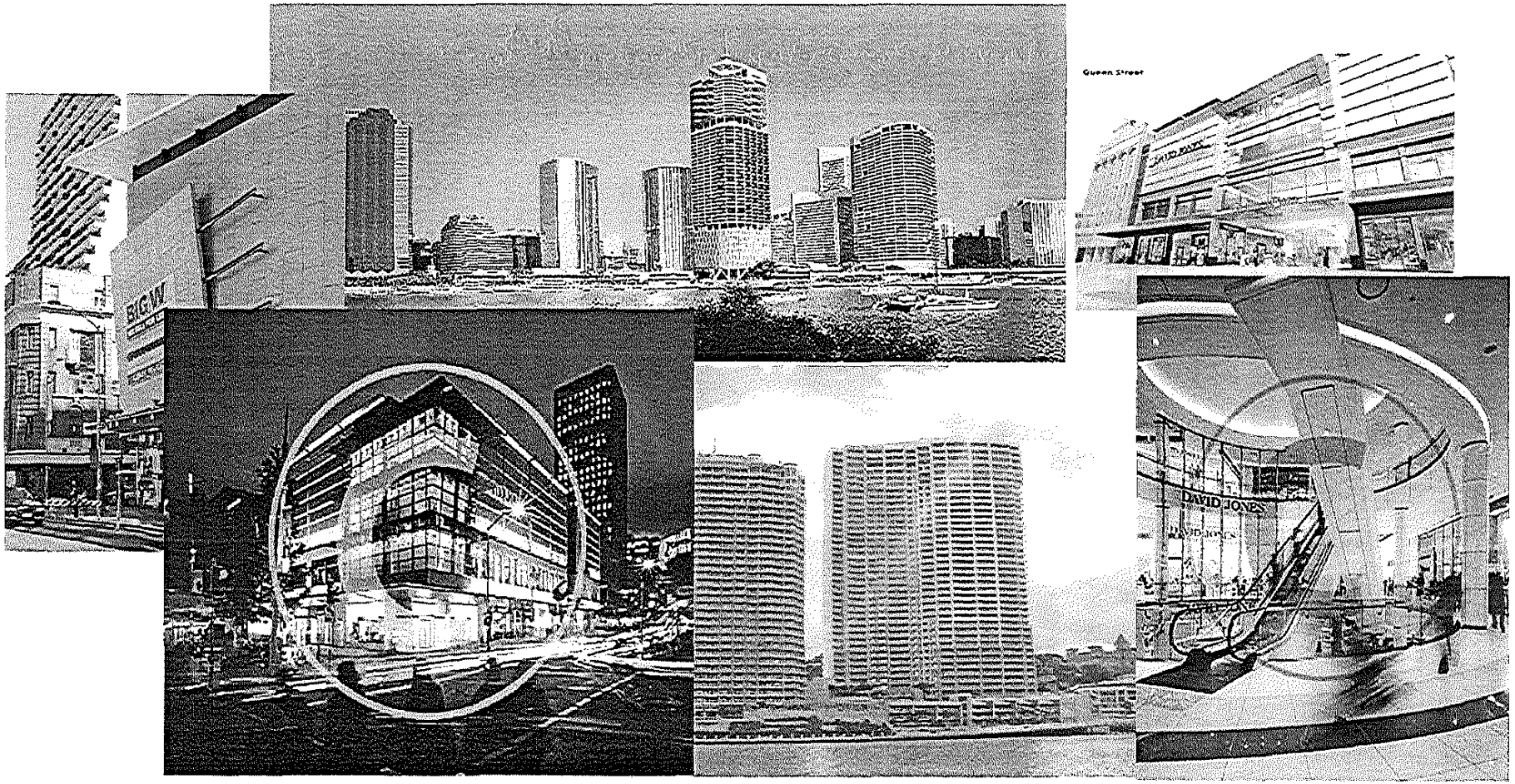
SIGNED by or on behalf of the Owner
(As the owner or authorised representative) .....

Print name of signatory .....

ACN number if a company .....

CERTIS
building certification

Company Profile & Capability Statement



Introduction

CERTIS is one of Australia's construction industry's preferred building certifiers with an established and growing client base in Queensland, Northern New South Wales and ACT.

CERTIS' respected reputation in the industry has been built on years of consistently delivering high value, practical building solutions which maintain essential fire and life safety standards for building end users but offer substantial project and life cycle cost savings for its clients.

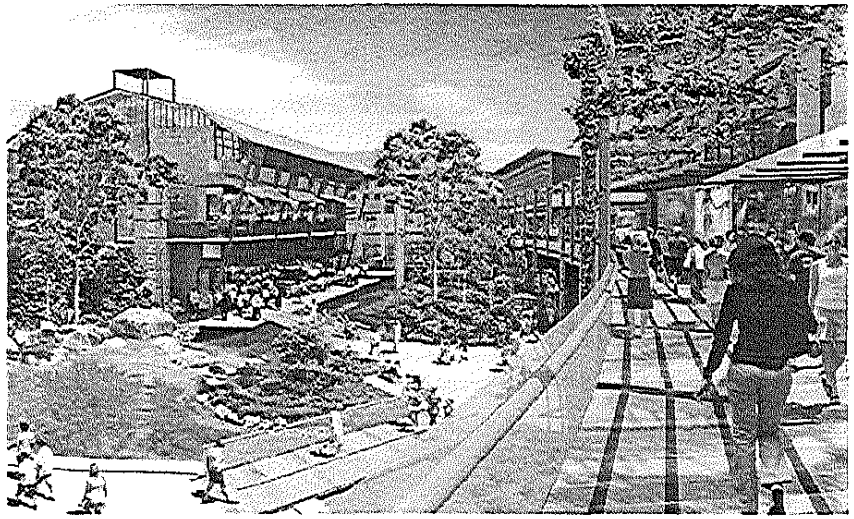
All of CERTIS' work comes from "word-of-mouth" referral, with 80 per cent being repeat business. We are known for getting the job done and removing any unnecessary bureaucratic steps along the way.

This solid reputation is substantiated on a daily basis by some of the most experienced and respected certifiers in the business. They are heavy-thinkers, with fire engineering qualifications, who really know how to devise the most cost effective solution, while ensuring all safety standards are met

Who are we?

Our Organisational values reflect:

- Loyalty to staff and the Company
- Excellence of Customer service, exceeding expectations
- Solution focussed to provide economical options for our clients
- Commitment to professional standards and a safe built environment
- Working together as a team
- Respect for our staff and the people that work with us.



Our Services

CERTIS works on a range of projects from Commercial, Retail, Apartment and Industrial sectors and delivers the following services:

Building certification

- Concept design advice
- Assessment of design documentation against the BCA
- Issuing of building approvals
- Inspection of building work under construction
- Fire Safety Advice

Performance based design solutions

- Alternative design certification
- Peer review of alternative design solutions
- Performance Based Design Solutions
- Fire Engineered Solutions
- Building Certification
- Tenancy Fit-out Certification
- Compliance inspections

DDA Access Services

- Building Audit to DDA and AS1428 suite of standards
- Review of New Building Applications
- Review in line with the Draft disability standards on access to premises

Fire safety consultancy

- Fire safety reports on existing and proposed buildings
- Due diligence reports

Essential Services Audits

- Assessment of existing essential services
- Certificate of Fitness
- Audit inspections and certification

Appeal submissions

- Preparation of submission for building tribunal appeals
- Appeal attendance

CERTIS' current capacity

CERTIS at this time has four offices. Our head office is located in Brisbane, and we have another on the Gold Coast, Cairns and Canberra. We primarily carry out extensive work throughout Queensland, NSW and ACT.

Seven of our Technical staff hold senior Qualifications with significant experience, which allows them to be nationally accredited at the unrestricted Building Certifier level. Another fifteen staff are accredited at the Assistant Building surveying level. This level of technical skills provides CERTIS with a significant flexibility in allocating resources across the region as workloads typically peak and trough.

CERTIS enhancing capability

CERTIS has embarked on a number of Business Strategies to improve its delivery of Building Certification Services to industry.

Three of these Strategies are of particular importance.

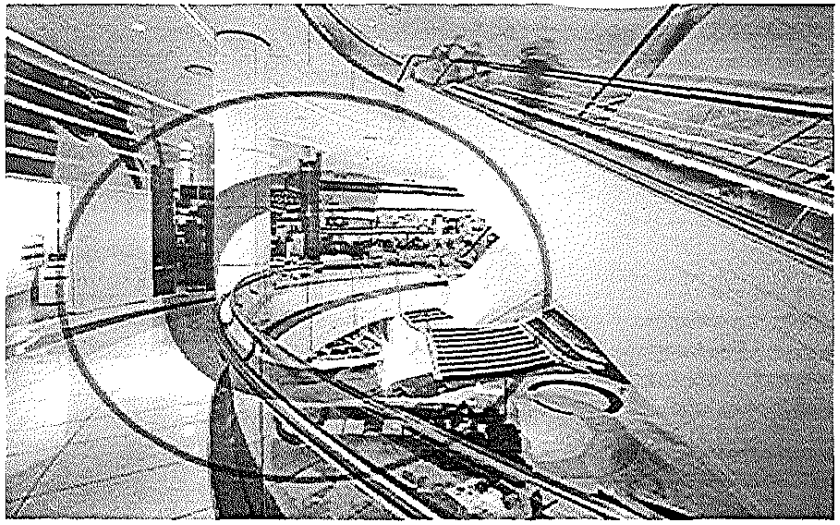
1 Increasing our Professional Capacity

CERTIS has recently; successfully attracted several highly qualified and experienced professionals to join us. All hold degree qualifications as a minimum and most have additional experience in one of the many specialist areas of certification eg Fire Engineering, Disability Access or Energy Efficiency.

Each of these new staff were selected on their ability to meet CERTIS' high expectations of being proactive in offering performance based solutions to solve client building compliance issues.

These additional professional staff will grow CERTIS to a position of being one of the leading Building Certification companies in Australia.

This means greater capacity to respond quickly and with the appropriate level of skills to your specific project.



2 Preliminary & Concept Design Consultancy Services

Despite good evidence to show that the earlier you engage our Certification Services the more ability we have to offer significant cost savings in terms of compliance strategies, we infrequently get engaged early enough to make a substantial difference.

This is a possible reflection of the old Local Authority process which required designs to be fully developed before the Council would view the plans.

CERTIS sees this as a major market deficiency and are seeking to partner with key designers to effect an industry change in this area. By early engagement CERTIS can offer options to designers to reduce the costs of compliance or to maximise building efficiencies to ensure clients benefit from better profit margins on their projects. Positive partnerships that can provide this value added service will attract the discerning client.

CERTIS has the capability to offer pre-design and concept design consultant services. This is a growing and important aspect of the CERTIS service offering.

3 Using Smart Systems

CERTIS has recently introduced a new iteration of its highly successful database system which is to be complemented by a remodelled and enhanced internet site. The combination of these two systems will enable a significantly enhanced capability in the e-commerce technological environment.

This means we have and will continually improve the capability to communicate and deliver our services completely electronically. It will also mean that we can elect to set up secure websites for our regular clients to provide proactive information on their projects as well as giving them the benefit of advice on the most recent advances in certification options and technical standards.

Our systems deliver a capacity to work across States and Regions and to access and use information from many digital data sources quickly and accurately.

What Our Clients say

"CERTIS has earned our loyalty by giving consistently good service"

"CERTIS always add value to my projects"

"CERTIS helped us maximise our commercial return"

CERTIS Project Experience

Aged Care Developments

Varsity Lakes Retirement Village	Varsity Lakes, QLD
Sunnymeade Aged Care Facility	Caboolture, QLD
Aveo Albany Creek Stage 8 & 9	Albany Creek, QLD
Clayfield Forest Place	Clayfield, QLD
Brookland Village Stage 4	Brookland, QLD
Cleveland Forrest Place Stage 1 – 4	Cleveland, QLD

Apartments

The Aurora	Brisbane, QLD
Cutters Landing	Brisbane, QLD
Marine Parade	Redcliffe, QLD
River City	Brisbane, QLD
Solito Apartments	Carindale, QLD
Saltwater Santi	Townsville, QLD
Mariners Peninsula	Townsville, QLD
MacArthur Chambers	Brisbane, QLD
Casino Towers	Brisbane, QLD
Port of Airlie	Airlie Beach, QLD

Commercial Developments

French Quarter Commercial Tower 3	Brisbane, QLD
Newstead Riverpark Energex Building	Newstead, QLD
SW1	Brisbane, QLD
Icon Place	Brisbane, QLD
Flinders Street	Townsville, QLD
175 Eagle Street	Brisbane, QLD
MacArthur Tower	Brisbane, QLD

Community Centres

Brisbane Convention & Exhibition Centre	Brisbane, QLD
Caboolture Central	Caboolture, QLD
North Lakes Community Centre	Mango Hill, QLD
Caboolture Community Campus	Caboolture, QLD
Tennyson Centre	Tennyson, QLD
Mackay Convention Centre	Mackay, QLD
Kelvin Grove Urban Village Community Hub	Kelvin Grove, QLD

Government Developments

Queensland Police Academy 2012	Brisbane, QLD
ASLAV, Gallipoli Barracks	Enogerra, QLD
Amberley Air Force Base	Amberley, QLD
Australian Government Department of Defence	Brisbane, QLD
Bulimba Barracks	Bulimba, QLD

Infrastructure

INB2 – Roma Street Bus Station	Brisbane, QLD
INB1 – King George Square Bus Station	Brisbane, QLD
North South Bypass Tunnel	Brisbane, QLD
Northern Busway Alliance – Royal Brisbane Hospital	Brisbane, QLD
Northern Busway	Brisbane, QLD
Airport Link	Brisbane, QLD
Southern Regional Water Pipeline	Brisbane, QLD
Darling Downs Power Station	Darling Downs, QLD
Braemar Power Station	Dalby, QLD
Brunswick Street Rail Station	Brisbane, QLD
Richlands Railway Station Stage 1	Richlands, QLD

CERTIS Project Experience

Mixed Use Developments

Vision	Brisbane, QLD
Milton Railway Station Redevelopment	Brisbane, QLD
Amalgamated Mill Site Redevelopment	Albion, QLD
Trilogy Tower	Brisbane, QLD
Eagle Street Pier	Brisbane, QLD
Soleil	Brisbane, QLD
Riparian Plaza	Brisbane, QLD
Soul	Gold Coast, QLD

Residential Developments

Brookwater Townhouse & Housing	Brookwater, QLD
Dutton Park Residential	Dutton Park, QLD
Affordable Housing	Spring Hill, QLD

School Developments

State Government Walkways project – 42 schools	North Brisbane, QLD
State Government Walkways project – 28 schools	Logan-Beaudesert QLD
State Government Walkways project – 31 schools	Toowoomba/Darling Downs, QLD
St Eugene College Stage 1 & 2	Burpengary, QLD
Brisbane Girls Grammar School	Brisbane, QLD
Ipswich Girls Grammar School	Ipswich, QLD
Our Lady of Lourdes Primary School Stages 3-6	Sunnybank, QLD
Bulimba State School	Bulimba, QLD
St Stephens Primary School Stage 2-4	Algester, QLD
Guardian Angels Primary School Stage 3-5	Wynnum, QLD
Narangba Valley School	Narangba, QLd
School of Arts Relocation	Windsor, QLD
Toowoomba Grammar School	Toowoomba, QLD
Geebung State School	Geebung, QLD

Shopping Centres

Stockland Townsville Shopping Centre	Townsville, QLD
Stockland Cairns Shopping Centre	Cairns, QLD
Queens Plaza	Brisbane, QLD
Orion Shopping Centre Stage 1 & 2	Springfield, QLD
Westfield Chermside Shopping Centre	Chermside, QLD
Westfield Carindale Shopping Centre	Carindale, QLD
Pacific Fair Redevelopment	Broadbeach, QLD
Westfield Helensvale	Helensvale, QLD
Clifford Gardens Shopping Centre	Toowoomba, QLD
Westfield North Lakes	Mango Hill, QLD

University & Educational Developments

South Bank Institute of TAFE	South Bank, QLD
Translational Research Institute	Brisbane, QLD
QIMR Smart State Medical Research Centre	Brisbane, QLD
UQ/CSIRO Molecular Science Laboratory	Brisbane, QLD
UQ Gatton School of Veterinary Science	Gatton, QLD
UQ, Queensland Brain Institute	Brisbane, QLD
Institute of Health & Biomedical Innovation	Brisbane, QLD
QUT Creative Industries Precinct	Brisbane, QLD

Warehouse Developments

Woolworths Distribution Centre	Larapinta, QLD
Laminex Warehouse	Murarrie, QLD
Queensland Tissue Products	Brisbane, QLD
Stramit Warehouse	Brisbane, QLD
Visypet Warehouse Extension	Heathwood,QLD
Linfox	Virginia, QLD
Reverse Corp & Tritel	Milton, QLD

Contact and Further Details

Brisbane Head Office	Gold Coast Office	Cairns Office	Canberra Office
CERTIS Pty Ltd	CERTIS Gold Coast Pty Ltd	CERTIS (NQ) Pty Ltd	CERTIS (ACT) Pty Ltd

Email

Web http://www.certis.com.au/

Managing Director
Paul Mackie

Principal Building Surveyor
Prabha Ponniah

Date: 8th May 2009
Our Ref: FP0184

Coordinator Projects and New Work
Building Engineering and Maintenance Services
The Park, Centre for Mental Health
Locked Bag 500
RICHLANDS QLD 4076

Attention: Michael Thompson

Dear Michael

RE: FEE PROPOSAL FOR BUILDING CODE CERTIFICATION OF INTERNAL WORKS BARRETT D ADOLESCENT UNIT – THE PARK, CENTRE FOR MENTAL HEALTH - WACOL

Thank you for the opportunity to provide you with a fee proposal for Private Certification on the proposed building works on the above project.

PROPOSAL
Our fee for the above service is **$ 3,890.00** ***(Three Thousand Eight Hundred & Ninety Dollars)*** **+ GST**. This fee proposal has been prepared on the basis of the details provided and is for the services set out below.

This fee is broken into the following components: -

Approval Stage	$ 2,590.00
Inspection Stage	$ 1,300.00

SCOPE OF WORKS
We envisage our scope of works to be as follows:

Approval Stage

- Attend a Site Consultants Meeting
- Provide Advice relating to the Building Code of Australia and Relevant State Legislation
- Make lodgement and liaise with Fire Service (State Authority)
- Assess the Minor Alternative Building Solution and issue a "Notice of Reasons"
- Assess the Development Application for Building Work under the BCA and various State Legislation
- Issue a Development Approval and Decision Notice for Building Works
- Lodge the development permit for building works with the Relevant Authority

Inspection Stage

- Carry out a Final Inspection in conjunction with the Fire Service at completion of the work
- Assess construction/installation certificates from contractors and consultants for compliance
- Issue a Certificate of Classification
- Lodge inspection documents with the Local Authority

TT Building Surveyors Pty Ltd
ABN : 53 133 441 380

PO Box 24
ROYAL BRISBANE HOSPITAL
QLD 4029

W: www.tt-bs.com.au

ADDITIONAL FEE INFORMATION
The following hourly rates apply where additional services are required: -

- Additional site and/or design team meetings $ 190/hr + GST
- Additional advice during construction $ 190/hr + GST

EXCLUSIONS
The following items, unless specifically mentioned in the above scope of works, are not included in this fee proposal:

- All other statutory fees including payment of the Q-Leave Levy, various State Building Industry Levies, the Fire Service assessment fee, etc.
- Footing, Slab and Frame inspections, which are to be carried out by a suitably qualified competent person accepted by the Building Certifier.
- Co-ordination of other statutory approvals including plumbing approvals, health approvals, etc.
- Undertaking a Town Planning compliance check
- Assessment of the proposal against the Disability Discrimination Act 1992 (Commonwealth) & the Anti-Discrimination Act 1991(Qld)
- Undertaking assessment and approval of Fire Engineered Alternative Building Solutions
- "Minor" ABS – is defined as variations not requiring Fire Engineering or additional referral advice/consideration of a third party
- Undertaking enforcement action required under State legislation.
- Additional meetings and inspections not accounted for in the scope of works (including re-inspections for defective works)

PAYMENT TERMS
The Approval Stage and Inspection Stage will be invoiced at commencement of that work for payment within 14 days, unless agreed otherwise.

Any additional services/consultancy advice, above that nominated in the scope of works, will be invoiced at completion of that work for payment within 14 days, unless agreed otherwise.

CURRENCY OF FEE PROPOSAL
Please note that this fee proposal will remain current for a period of 3 months from the date of issue. Any accepted fee proposals that are not completed within 2 years maybe subject to variation for the outstanding components. Where an application is withdrawn or lapses, a refund may be considered, based on the amount of time expended on the application.

ACCEPTANCE
To accept this fee proposal and engage TT Building Surveyors Pty Ltd (TTBS) as your private certifier/building surveyor please complete, sign and return the engagement and acceptance section below.

SUMMARY
TTBS are committed to providing a superior level of customer service at a competitive price. Our aim is to provide an efficient service with the highest level of involvement and a proactive approach. Should you have any queries with any of the above please do not hesitate to contact the writer at the above address.

Yours faithfully

Shawn Brosnan
TT Building Surveyors Pty Ltd

✂----------

ENGAGEMENT & ACCEPTANCE

I have checked the above details and confirm the scope of works as correct. I accept the fee proposal and hereby engage TT Building Surveyors Pty Ltd as the private certifier for the development in accordance with the Integrated Planning Act 1997 Chapter 5 Part 3.

Name in full: ..... Position: .....

Signature: ..... Date: .....

Ref No: FP0184 Amount: $ 3,890.00 + GST

PHILIP CHUN

BUILDING CODE

Our Ref: Q5175

30 March 2009

Coordinator Projects & New Works
The Park Centre for Mental Health
West Moreton South Burnett Health Services District

Attn: Michael Thompson

Dear Michael,

Re: Fee Submission – The Park Centre for Mental Health, Wacol

Thank you for the opportunity to provide a fee proposal for the Building Certification of the proposed minor modifications to a ward for The Park Centre for Mental Health located at 89 Grindle Road, Wacol.

This submission has been prepared in accordance with the permitted functions of a Private Certifier as prescribed in Chapter 4, Part 2, Division 2 of the Queensland Building Act 1975. Philip Chun's role is to facilitate issue of the Development Permit (Building) and Certificate of Classification and advise the project team on all aspects of building regulation control.

BUILDING DESCRIPTION

For the purpose of the Building Code of Australia the proposed building work is considered to be a tenancy fitout within an existing building.

This fee submission assumes the intention is the design will comply with the Deemed-to-Satisfy provisions of the Building Code of Australia.

SCOPE OF WORK

1. Assess project documentation against the Deemed-to-Satisfy provisions of BCA and the provision of timely regulatory advise.

2. Attendance at consultants meeting (x1 max).
3. Issue of the Development Permit (Building).
4. Final Inspection of the completed building works.
5. Issue of the Certificate of Classification.

FEE FOR BUILDING SURVEYING SERVICES

The fee proposed for the project is based on the information provided assuming issue of the Certificate of Classification 12 months from the date of this submission. The fee (excluding GST) for Building Certification Services is described below:

Review documentation and provide BCA compliance advice	2730
Attend meetings (x1 maximum)	390
Issue Development Permit (Building) (x1 stage maximum)	1430
Advice during construction	Hourly rate
Attendance at site meetings	Hourly rate
Final inspection (x1 maximum)	520
Collate inspection certificates from consultants and contractors	390
Issue Certificate of Classification	520
The fee (excluding GST)for Building Certification Services is	**$5,980**

Due to the limited building works proposed, this submission has been prepared on the basis an application to the Queensland Fire and Rescue Service for assessment of Special Fire Services is not required.

ADDITIONAL SERVICES

Once the scope of works relating to these areas is defined, additional services may be negotiated for a fixed fee or be charged at an hourly charge of:

Role	Hourly Rate
Director / Accredited Certifier	$220.00
Building Certifier	$180.00
Cadet Building Certifier	$130.00

EXCLUSIONS

1. Fees exclude the Goods and Services Tax.
2. Unless identified in the Scope of Work, Philip Chun's time to obtain documentation or approvals from authorities, is excluded from this fee proposal. These include and are not limited to:
   - Town planning advice.
   - Work cover and occupational health and safety advice.
   - Specialist dangerous and hazardous goods requirements.
   - Health and Food Act.
   - Heritage.
   - Acoustics.
   - Utilities Consents.
   - Part J of BCA energy assessments.
   - Lodging plumbing applications

3. Payment of fees required by any Act or Regulation is excluded from this fee proposal. Fees required to be to achieve Development Permit (Building) include but may not be limited to:
   - The Brisbane City Council fee to archive the Development Permit (Building).

4. This fee submission assumes an engineer will be responsible for the design, inspection and certification of any structural elements of the proposed works.

5. Assessment of the building for compliance with The Disability Discrimination Act 1992 (Commonwealth) and Anti-Discrimination Act 1991 (Queensland).

6. Assess alternative solutions against the performance requirements of the BCA and ensure consultant's documentation is consistent with the outcomes required by the fire safety engineering report.

7. Printing costs for paper sizes larger than A3 are excluded from this fee submission.

CONDITIONS

1. Payment must be made at the time of appointment.

2. This proposal is valid for a period of 3 months from the date of issue. However, our involvement with the project may commence immediately on our appointment being accepted in writing.

3. Unless advised in writing at the time of appointment, invoices will be charged to the addressee of this letter.

4. Section 141 the Queensland Building Act 1975 requires the engagement of a private certifier is in writing and the letter of commission must state the fee. Please return the attached letter of commission as confirmation of Philip Chun's appointment.

5. Your ongoing instruction in this matter signifies your acceptance of these terms and conditions.

We look forward to working with your company and should you have queries, please do not hesitate to call me.

Yours sincerely,

Peter Czerkaski
PHILIP CHUN BUILDING CODE CONSULTING

Philip Chun
49 Gregory Terrace
Spring Hill QLD 4000

Subject: Appointment of Private Building Certifier

PROJECT DETAILS

Project Address .....

Owner of the land .....

Building or Building Work .....

APPOINTMENT

I / we hereby appoint the Building Certifier nominated by Philip Chun ("the consultant"), pursuant to permitted functions of a Private Certifier as prescribed in Chapter 4, Part 2, Division 2 of the Queensland Building Act 1975 ("the Act"), to carry out the functions of Private Certifier in respect of the building work described above.

AGREEMENT

I/ we agree the consultant (and not the nominated Building Certifier) is engaged to provide the services of Private Certifier for the above project to carry out:

- The functions described above and any work associated with the carrying out of those functions.
- The services described in the consultant's fee submission Ref: Q5175 dated 30 March 2009.

It is agreed the fee payable to the consultant for the carrying out of the services shall be paid as outlined in the consultant's fee proposal Ref: Q5175 dated 30 March 2009 and as prescribed by Section 146 of the Act.

Signature ..... Date ...../...../.....

Name .....

NOTE:

1. Where this appointment and agreement is made by an agent authorised by the owner, written evidence of the authorisation is to be attached.
2. Where the owner, agent or person authorised by the owner is a corporation then this appointment and agreement is to be executed by the corporation or by a person having expressed authority to do so on behalf of the corporation and the company's ACN number included.
3. Philip Chun's nominated accredited Private Building Certifiers are Michael Moran, Peter Czerkaski, Franco Velasco, Terry Moran, Andrew Harman and Willie Tait.

SCOPE OF WORK

Adolescent High Dependency Unit

LOCATION: **Barrett D**
Adolescent Unit
The Park, Centre for Mental Health.

BACKGROUND:

The Park Centre for Mental Health (The Park) provides a safe and secure accommodation for people with mental illness to obtain treatment.
The Barrett Adolescent D block is for adolescents with mental illness and "The Park" wish to modify the original 32 bed ward built in the 1970's to include a High Dependency Unit (HDU) within that building.
The HDU will consist of 2 single bedrooms, a lounge area and ensuite, as indicated in the attached drawings.
The patient(s) will be locked in the bedroom/s of this HDU unit for their and others safety nursing staff will be carrying out periodic observations of the patient (s) as outlined in the state wide policy for HDU's and will be forwarded to you when required.
We are aware this does not comply with the building code and that we require an "Engineered Solution" as we have the same units in other parts of this facility and in other Queensland Health facilities throughout the state.
This staff member can key open the lounge/hallway door and the bedroom doors in the case of fire and escort the patient out of the building.
The proposed plumbing & drainage drawings are also attached awaiting approval.
The Structural design is attached and has a form 15.
Fire and evacuation system design is attached and has a form 15.
We would like assistance in Certifying all of the proposed work before we proceed so we can occupy as soon as the job is complete and the area can be put to use as required.

WORKS REQUIRED

1. Assess project documentation against the deemed to satisfy provisions of BCA and all relevant Australian Standards complete with the provision of timely regulatory advice.
2. Attend meeting of consultants on site (1)
3. Attend additional site meetings (hourly rate nominated)
4. Advise during construction (hourly rate nominated)
5. Issue a Development permit
6. Final inspection of completed work
7. Issue certificate of classification/ building occupancy, ensuring all Form 16 compliance is obtained for each part of the works, including QFRS certification for the works as well.
8. Ensure a special dispensation is provided to allow bedroom doors to remain in the locked position until the Q Health nurse/carer unlocks them to allow clients to egress the building in a fire emergency.
9. Fire evacuation procedures and supporting documents are attached for assessment and provision of a special dispensation.

RELEVANT DRAWINGS:
This scope of work shall be read in conjunction with the following plans

Barrettd_new-model
6187-CS01 (P1) lighting and fire drawing
2009-100 S1 10 mar '08
Q9001-H01.plumbing
Lighting spread
Site-Layout3

VARIATIONS: Any variations to original scope of work must be submitted to The Park Project Manager in writing and may only be treated as a variation with the mutual agreement between Q Health Facility manager and the Contractor.

CONTRACTORS HANDBOOK:
This specification is to be read in conjunction with the West Moreton South Burnett District Contractors Induction Handbook, July 2007.

Prices to be faxed or mailed within 14 Calendar days of received Scope of Work

Michael Thompson
Coordinator Projects and New Work
Building Engineering and Maintenance Services
The Park, Centre for Mental Health
Locked bag 500
Richlands, 4076

Queensland Government
Queensland Health

The Park – Centre for Mental Health
Workplace Instruction

Unit Name: Barrett Adolescent Centre (BAC)		**Applies To:** All BAC Staff
Title: High Acuity Area (HAA)		**Instruction No:** WI.2009.**1036**v1
Author: Nurse Unit Manager, BAC		**Date Developed:** 25 June 2009
Authorisation Date: 25 June 2009		**Review Date:** 25 June 2010
Authorised By:	Director of Clinical Services	**Signature:**
Endorsed By:	**TPCAG:** N/A	**SIC:** 02 July 2009

DEFINITIONS:

A High Acuity Area (HAA) is a separate, potentially lockable, area within a mental health inpatient facility, designed to provide for the safe management of involuntary consumers requiring a higher level of individual care.

BACKGROUND:

Consumers who cannot be safely managed on an open ward environment or involved in normal ward program require a modified restricted program in a low stimulus environment.

This will result in separation from peers and the milieu until it is safe for them to resume normal program.

Consumers who have high risk ratings for self harm, aggression and absconding will require differing levels of containment from their peers and to minimise the disruption to the therapeutic milieu, the consumers with high risk may need to access a more restrictive environment.

PROCEDURE:

Transfer to the High Acuity Area (HAA)

Transfer to the HAA is based on clinical need and made in context of a management plan that indicates the consumers' diagnosis, clinical need, treatment goals and expected outcomes.

The transfer of a consumer into the HAA can be initiated by the Medical Officer (MO) and/or the Nurse in Charge. Medical staff must review the consumer immediately (or as soon as practicable). In the case of a nurse initiated transfer and the consumer is voluntary and not consenting to go to HAA, then nursing staff must have reasonable grounds to commence a request and recommendation for assessment under the MHA 2000.

Process

- the MO/Nurse in Charge clearly documents the decision to transfer the consumer to the HAA. If nurse initiated, a MO needs to ratify the decision in the clinical file
- a search is conducted of the consumer and their property prior to admission to the HAA. This search may require the use of the metal detector if consumer is suspected of having concealed metal objects upon their persons
- potentially harmful property/objects removed are to be stored in the consumers property drawer located in the Store Room
- consumer informed of environment change and restrictions involved

- Next of kin/carer/significant other to be informed – ensure there is no confidentiality request
- risk assessments are to be updated
- completion of PRIME if applicable

Upon Entry

The consumer is to be orientated to the HAA by having the following explained to them:

- level of observation
- HAA layout
- telephone calls
- staffing
- no smoking policy
- rights
- responsibilities
- medical review protocols
- complaints procedure

Review of HAA Placement

Medical staff should review consumers in HAA daily, on commencement of morning duty, and as requested by nursing staff. Medical staff should clearly document the consumers' mental status, risk assessment and management plan in their clinical file and update changes as the consumers' mental health status condition changes.

- one (1) review each day should be by a Psychiatrist or Registrar
- on-call Registrar will review consumers in the HAA when treating MO/consultant unavailable (eg. weekend/public holidays). The on-call MO will review any urgent requests/admissions to HAA from nursing staff in hours when the on-call Registrar is not on site (eg. overnight). The on-call Registrar will be alerted to this prior to the review and, based on the urgency, may be required to come into the unit
- reviews should take place in consultation with both the HAA staff and the shift coordinator
- the Consultant Psychiatrist is to regularly review HAA consumers (at least twice a week) and review their current personal recovery plan
- documentation should include regular entry into the clinical chart (at least one entry per shift) and entry in the ward report book

Management of Consumers in HAA

- if the consumers' mental state and risk assessment indicate they are clinically suitable to access activities/groups on the open ward, or are able to take part in a reintegration program to the unit, then this information, the risk assessment and the levels of observation the consumer will be on whilst out of the HAA, will be documented by the Registrar or Consultant Psychiatrist in the clinical file
- medications will be dispensed in the HAA area by the Clinic Nurse
- meals will be consumed in the HAA unless otherwise specified by the treating team

Consumer Visits

Visits by family, carers or significant others are encouraged. All visits will be at the discretion of the shift coordinator who may need to liaise with the medical staff. Numbers of visitors and lengths of stay will be influenced by acuity of the consumer and the behaviour/interaction of the visit.

- at the MO discretion (after liaison with shift coordinator), an alternative visiting area may be offered outside of HAA utilising suitable level of observation. This order will be documented in the consumers' clinical file by the MO. The availability of suitable staff to supervise visits will be considered in the decision-making process
- visitors will be made aware of restrictions on items that can be taken into the HAA. Items that visitors bring for consumers in the HAA area are to be searched by nursing staff. Visitors will have this explained to them prior to a search being conducted
- staff member/s are to be present in HAA whilst visitors are with consumers

Consumer Numbers

The HAA has two (2) beds.

Transfer Out of HAA

The decision to transfer a consumer from the HAA into the open ward can only be made by a Psychiatrist/ Registrar in consultation with the shift coordinator.

- MO clearly documents in the clinical file the level of observation, level of risk, and the management plan for the decision to transfer the consumer to the open ward
- next of kin/carer/significant other is to be informed – ensure there is no confidentiality request
- risk assessment is to be updated

Staffing

Minimum staffing requirements will be determined by the clinical care needs of the individual consumers.

Consumers in seclusion requiring intermittent levels of observation do not require a HAA staff member.

Two (2) consumers not in seclusion will require a minimum of one staff member in the HAA.

NB: **No staff member is to enter the HAA area without a duress alarm and without the knowledge of the shift coordinator.**

Clinical Issues

The HAA, when locked, is not considered seclusion, providing a consumer is not confined alone.

Ethical Issues

Voluntary consumers should not routinely be managed in HAA. However, if this becomes necessary informed consent is required.

Safety/Risk Issues

Items Not Allowed in HAA

The acuity and risk for aggression and self harm of the consumer and the other consumers in HAA needs to be reviewed prior to some items being allowed into the HAA area. Items can be taken into HAA after being checked and approved by the Nurse in Charge and this being documented in the consumer's file. If these items are allowed into the HAA this must be handed over to the oncoming shift and registered on the HAA environmental checklist. The items may need to be removed overnight.

The list of items below would not be considered suitable:

- cans
- lighters
- razors
- scissors
- knives
- spray cans
- crockery/glass
- toiletries (store in HAA officer cupboard)
- spare clothing (store in HAA office cupboard

REFERENCES / LINKS:

- *Guidelines for Operation of Mental Health High Dependency Units in Queensland*
- *Mental Health Visual Observations – Clinical Practice Guidelines (October 2008)*
- *Policy Statement on Reducing and where possible eliminating restraint and seclusion in Queensland Mental Health Services*
- *Searches in Authorised Mental Health Services – Clinical Practice guidelines (December 2008)*
- *Mental Health Act 2000*

Queensland Government
Queensland Health

The Park – Centre for Mental Health
Workplace Instruction

Unit Name: Business Unit 7 - Barrett Adolescent Centre (BAC)		**Applies To:** All BAC Staff
Title: Fire and Evacuation		**Instruction No:** WI.2008.**1053**v2
Author: Nurse Unit Manager (NUM), BAC		**Date Developed:** 14 April 2008
Authorisation Date: 19 June 2009		**Review Date:** 19 June 2010
Authorised By:	Director, Business Unit 7	**Signature:**
Endorsed By:	**TPCAG:** N/A	**SIC:** 02 July 2009

DEFINITIONS:

N/A

ISSUE/S

All staff working within the BAC will receive orientation to the fire equipment and procedures concerning Codes Red and Orange. They will be aware of their responsibilities concerning fire and evacuation procedures.

APPROACH/ES

Orientation

- all staff will undertake fire and evacuation orientation for both 'C' and 'D' block buildings with their direct Line Manager or delegate, eg. NUM on the first day of duty
- all staff will undertake fire and evacuation orientation of the High Acuity Area (HAA) with their direct Line Manager or delegate on the first day of duty

Fire Management System and Alerts

- BAC has two buildings - 'C' Block and 'D' Block which contains a HAA. All buildings are supported by an integrated fire management system. Each building is equipped with a fire alarm in the form of an internal speaker system, smoke detectors, heat detectors and a sprinkler system. Fire extinguishers are located in various rooms, fire hose reels are located in the hallways and each kitchen and the Nurses' Station has a fire blanket. (Refer to evacuation plans for exact location)
- in the event of a smoke or heat detection, internal speakers will sound an alert. Fire Prevention and Security (FP&S) staff will also be alerted electronically to the activation and contact the ward to advise of the Code Red. The Queensland Fire and Rescue Service (QF&RS) will be automatically alerted to respond

Staff Responsibilities

- FP&S staff will advise BAC staff by phone or 2-way of the area in which detection has occurred
- in the event of a staff member discovering smoke or a fire, the QF&RS (0-000) and FP&S staff (ext 8444 or by 2-way) will need to be advised if the detection systems have not activated
- the most senior person on duty in the building will act as the Floor Emergency Officer (FEO). Their duty will be to coordinate the staff's response to the fire situation. The FEO is to instruct staff to search and inspect the work area for smoke and fire in order to decide the most appropriate response to the situation. This may include identifying the detector which has been activated (LED

remains lit), attempting to contain or extinguish the fire and/or removal of all persons from immediate danger through either a partial or full evacuation (Refer to Emergency and Evacuation Procedure Manual for Code Orange details)
- the FEO is to provide the necessary information required by QF&RS staff on their arrival. (Refer to Emergency and Evacuation Procedure Manual for details)

NB. Fire exits at the end of all corridors are locked. In the event of an evacuation, these exits are to be unlocked to allow free egress for anyone who may be trapped inside the building. The FEO is required to instruct staff to unlock these fire exits if it is safe to do so. If not safe, the QF&RS staff will need to be advised immediately on their arrival. Access to the designated assembly area from the HAA will be through the fire exit door at the end of the girl's dormitory, or the front entrance door.

- one person shall be allocated to unlocking the doors and escorting the consumer to the designated evacuation area. Two persons can be allocated this task dependent on mental state
- if a consumer is being nursed on high acuity the nurse designated to high acuity would be responsible for ensuring that person is safely evacuated to designated assembly area

Night Shift

- minimum staffing levels on 2300-0700hrs shift is two. Process for evacuation is as per *Staff Responsibilities* mentioned above.

Fire Evacuation Areas

- identified fire evacuation assembly areas are:
  - grassed car park area directed across from BAC. Access to this area can be through front door or back door down female dormitory end
  - hill-side grassed area behind BAC - access through side door or left hand side of building OR through fire exit door at bottom of male dormitory
- in the event of no smoke or fire being found following an alarm, the FEO is to be advised. The FEO will then notify FP&S staff to stop the alarm from cascading into the evacuation phase
- once the emergency situation is over, the FEO, in consultation with the appropriate emergency services, shall declare an all clear status for normal services to resume
- it is the role of the FP&S staff to manage the fire affected area and materials following the all clear

GENERAL COMMENTS:

- staff are not expected to fight fires. However, fire blankets and fire extinguishers are provided to contain small fires or smoldering materials to prevent an escalation in the seriousness of the fire. (Training in the use of this equipment is provided on an annual basis)
- staff are to familiarise themselves with the evacuation plans in each building. Please note that the BBQ pergola may be used as an alternative assembly point after nightfall
- all staff need to be aware of the Code Red and Orange protocols contained in the Emergency and Evacuation Procedure Manual. A copy is located in each building
- staff are to keep fire egress routes clear of obstructions

REFERENCES/LINKS:

- *Emergency and Evacuation Procedure Manual*

The Park – Centre for Mental Health

Emergency Drill Schedule 2009
CODE RED

Drills for Code Red are to be conducted in all areas at least twice throughout the year. (Please note that drills for Codes Yellow, Purple and Brown may also be run in consultation with District throughout the year).

Code Red drills will be conducted during allocated weeks and are to be organised in consultation with Coordinator, Fire Prevention and Security (The Park) and/or District Fire Safety Advisor a week prior to the drills occurring.

Schedule for 2009 is as follows:

Date	Area
16 to 20 Feb 09	Yuggera **Still to be conducted** Administration Building) Powerhouse) Completed 18 Feb 09 Anderson House)
16 to 20 Mar 09	Extended Treatment & Rehabilitation) Medium Secure) Completed 16 Mar 09 Dual Diagnosis)
20 to 24 Apr 09	General Health Service / Pharmacy) Completed 22 Apr 09 Adolescent Unit) Completed 25 Mar 09 Prison Mental Health Service) Completed 23 Apr 09
04 to 08 May 09	Dawson House Yuggera
15 to 19 Jun 09	High Security Hotel Services / Grounds & Gardens / BEMS
20 to 24 Jul 09	Administration Building Powerhouse Anderson House
17 to 21 Aug 09	Extended Treatment & Rehabilitation Medium Secure Dual Diagnosis
14 to 18 Sep 09	General Health Service / Pharmacy Adolescent Unit Prison Mental Health Service
05 to 09 Oct 09	Dawson House Yuggera
23 to 27 Nov 09	High Security Hotel Services / Grounds & Gardens / BEMS

Please note: *Drills can be conducted any day of the allocated week*

Process for conducting Code Red Drills

- Coordinator, Fire Prevention and Security (The Park) and/or District Fire Safety Advisor will contact staff responsible for coordinating emergency drills in their area the week prior to allocated dates to organise a date and time for conducting the Code Red Drill.
- Reports and attendance sheets are to be compiled on completion of all Code Red drills by Emergency Officers and Coordinator, Fire Prevention and Security (The Park) and/or District Fire Safety Advisor and forwarded to the Service Improvement Coordinator. The Report template and attendance sheet is available on G:\Everyone\Emergency Drills\Code Red.
- Copy of attendance sheets are to be forwarded to the Training Coordinator, District Mental Health Education Service for recording purposes.

A notice listing your area/unit Designated Emergency Officers (DEO) should be placed on area/unit noticeboards to ensure staff are aware of Designated Floor and Area Emergency Officers within their work area. A register of Designated Emergency Officers for the facility is to be maintained by the Coordinator, Fire Prevention and Security (The Park) and District Fire Safety Advisor.

Designated Emergency Officers are required to attend a training sessions annually. To organise Emergency Officer training in your area/unit please contact the Training Coordinator, District Mental Health Education Service

If you require further information or have any queries in relation to Code Red Drills, please contact:

Coordinator, Fire Prevention & Security
District Fire Safety Advisor
Service Improvement Coordinator

West Moreton South Burnett Health Service District

Evacuation Exercise (Evaluation Form)

Facility:	**Date of Exercise:**
Time Exercise Commenced:	**Time Exercise Completed:**
Exercise Facilitated by:	

OBSERVATIONS	YES	NO	Other
Did the person discovering "Fire " act calmly and correctly			
Was alarm sounded in accordance with plan			
Could alert and evacuation signals be heard			
Did Emergency Officer/s report to emergency stations			
Did staff know what to do			
Was there any confusion			
Did staff act correctly			
Was evacuation orderly			
Were directions to staff by Emergency officers clear			
Were there any obstructions or problems in paths of travel			
Was there any crowding in paths of travel			
Was fire fighting equipment available			
Was a search made to ensure no one was left behind			
Was there a process in place to ensure no one entered or re-entered the building			
Did staff move to assembly area			
Was roll call reported to relevant DEO & Fire Service			
Did relevant DEO meet and brief fire service			
Was it clear whether everyone was out of the building or not			
Debrief was carried out			

Comments:

Recommendations / Actions:

Facilitator/s Signature

_____ (Signature)

_____ (Signature)

_____ (Signature

_____ (Date)

Forward completed form to Service Improvement Coordinator

Register of Code Red Drills – 2009

Area / Unit	Date Conducted	Comments	Recommendations / Actions
Administration Building	18.02.09	Excellent Procedure, FEO rang FP&S to advise	Emergency Officers to advise others when not in building
Anderson House	18.02.09	Yet to train Emergency Officers and some confusion over tones, clarified in de-brief	Have officers trained ASAP. ***Contacted Paul Brennan – DEOs to be allocated and attend training, Manuals to be provided***
Powerhouse	18.02.09	Very good, toilets and doors checked	
Dual Diagnosis	16-03-09	Staff were orderly in the evacuation procedures	
Extended Treatment & Rehab	16-03-09	Great response time. Staff were excellent	
Medium Secure	16-03-09	Staff were excellent all carried out professionally.	Check zones – can confuse staff. Should be implemented upon induction
Adolescent Unit	25-03-09	Live Code Red – conducted well	
GHS / Pharmacy	22.04.09	All staff conducted in an orderly fashion	Made sure oxygen was off. Staff knew their roles
PMHS	23-04-09	Staff responded well	Need to discuss issues with District Fire Officer. No fire detection equipment in the building ***Contacted Service Manager – BEMS installing fire systems.***
Dawson House	07-05-09	Staff were orderly and controlled in the evacuation	Accident and Emergency Officer training needs updating. Spoke to staff re this. ***Contacted Nursing Director, Education – designated staff to attend emergency officer training and notification sheets updated***
Yuggera	06-05-09	Staff need to be aware that if M Coulson is not in area that one of them needs to take over her role of AEO/FEO	Another drill in the near future. ***Contacted Manager Hotel Services – staff in kiosk to attend Emergency Officer Training***
High Security			
Hotel Services / G&G /			

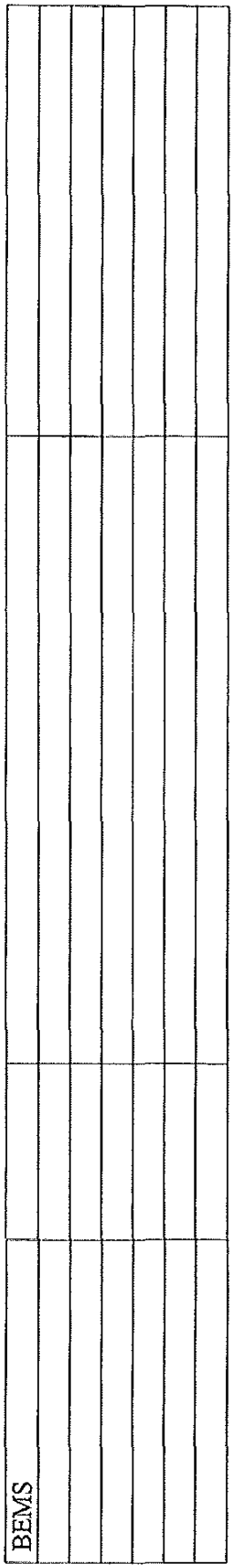

BEMS

EXHIBIT 75

Queensland Government
Queensland Health

Darling Downs – West Moreton Health Service District

THE PARK – CENTRE FOR MENTAL HEALTH

GENERAL EVACUATION INSTRUCTION CHECKLIST TO UNIT EMERGENCY (FIRE) PROCEDURES

(All new staff are to undertake general evacuation instruction within 2 days of commencing in the unit)

Staff Name: ..... Unit: .....

- ☐ **Show / Explain the Evacuation Signage**
- ☐ **Emergency Officer Identification**
- ☐ **The procedure to be followed in the event of fire**
- ☐ **The means of escape from the building in the event of fire**
- ☐ **Location of Assembly Area/s**
- ☐ **The location of fire fighting equipment (fire extinguishers, fire hose reels)**
- ☐ **Fire alarms or equipment for warning of fire or emergencies.**
- ☐ **Location of Emergency Manual**
- ☐ **RACE Acronym**
  - ➢ **REMOVE persons from immediate danger**
  - ➢ **ALERT nearby staff and members of the public and call your Site Emergency Number**
  - ➢ **CONFINE fire and smoke, close windows and doors (if safe)**
  - ➢ **EXTINGUISH and control the (if safe to do so)**

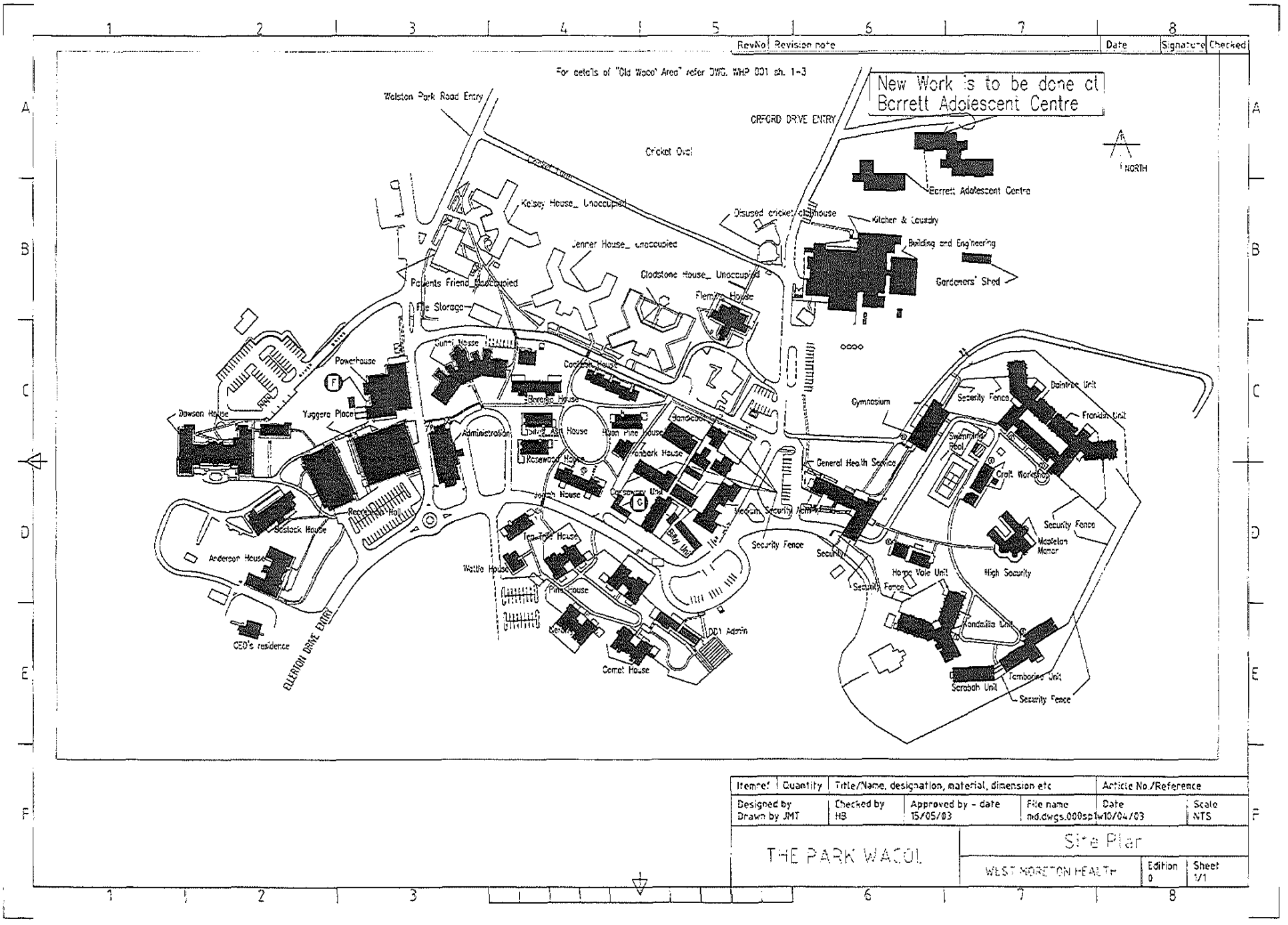
Emergency (Fire) General Evacuation Instruction to the unit has been completed:

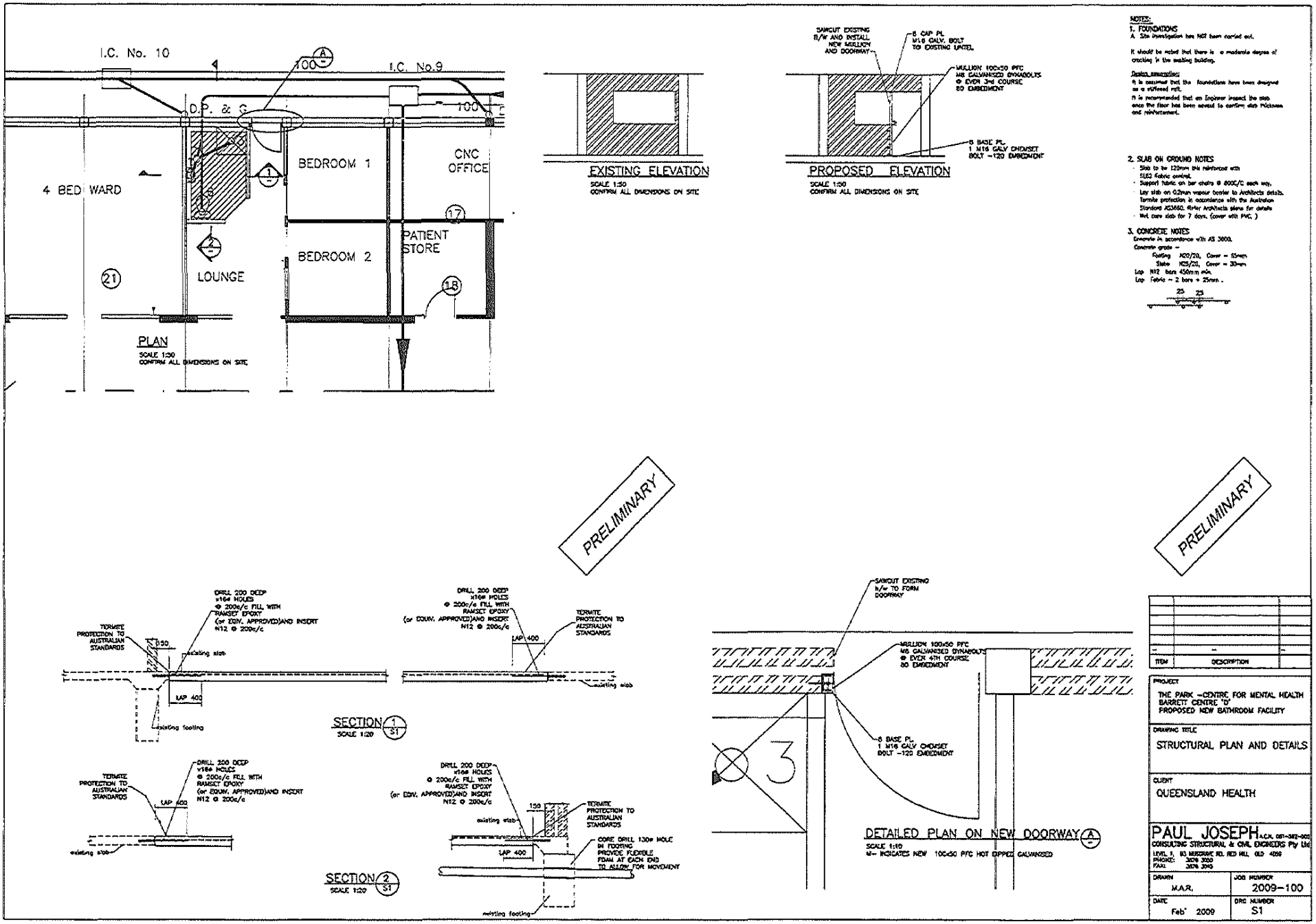
_____ _____
(Date Completed) (Staff Member Signature)

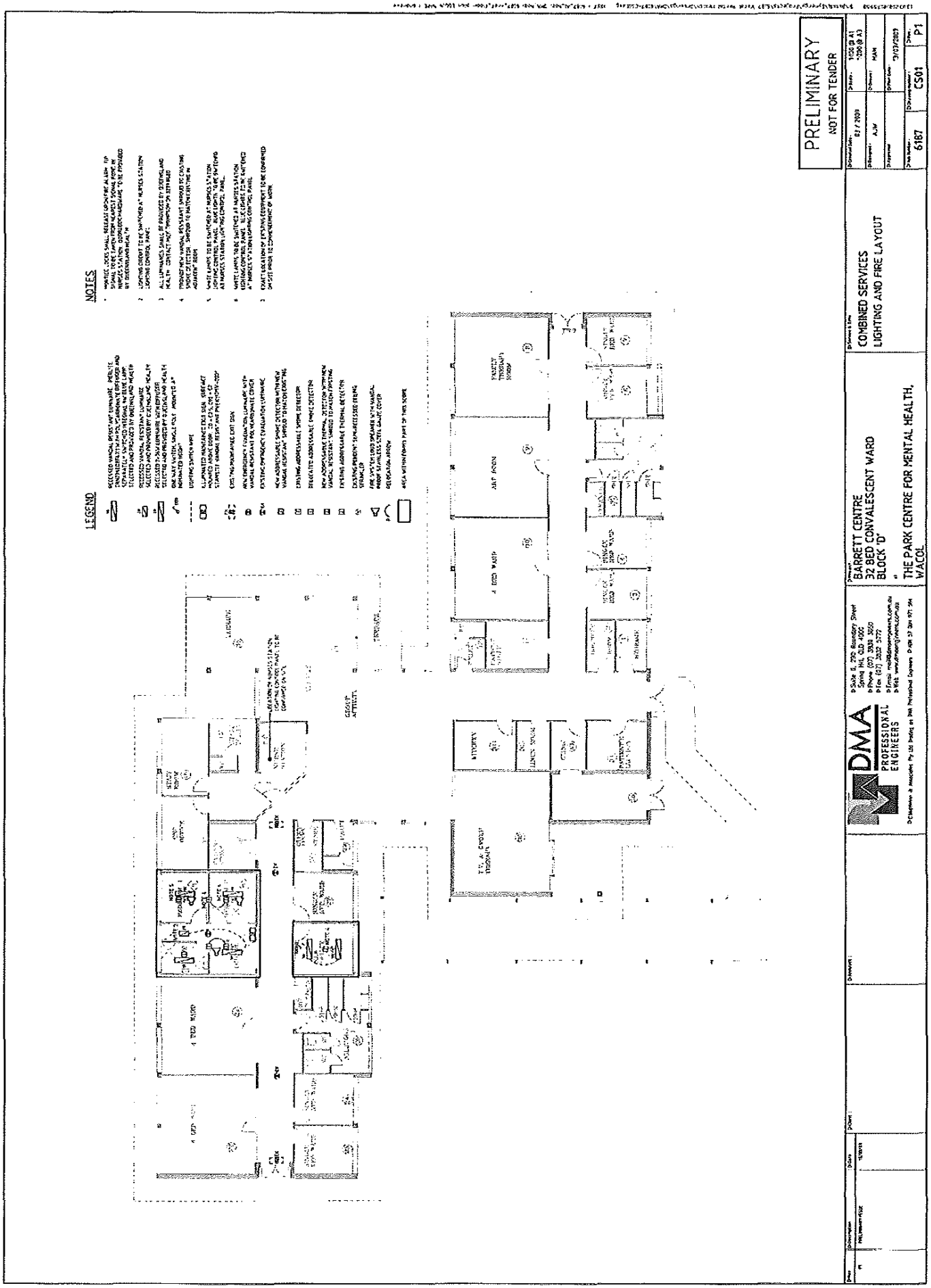
_____ _____
(Emergency Officer / Delegate Name) **(Signature)**

Completed form to be forwarded to Facility Training Coordinator

NEW STAFF MUST BE BOOKED INTO THE FACILITY ORIENTATION SESSION WITHIN 30 DAYS OF COMMENCING AT THE FACILITY.


For details of "Old Wood" Area" refer DWG. WHP 001 sh. 1-3
New Work is to be done at Barrett Adolescent Centre
Rev No
Revision note
Date
Signature
Checked
Wolston Park Road Entry
CRFORD DRIVE ENTRY
Cricket Oval
NORTH
Barrett Adolescent Centre
Kelsey House_ Unoccupied
Disused cricket clubhouse
Kitchen & Laundry
Building and Engineering
Gardeners' Shed
Jenner House_ unoccupied
Gladstone House_ Unoccupied
Parents Friend_Unoccupied
Fleming House
File Storage
Powerhouse
Yuggera Place
Dawson House
Administration
Boronia House
Rosewood House
Ironbark House
Hoop Pine House
Gymnasium
Security Fence
Daintree Unit
Franklin Unit
Swimming Pool
Craft Workshop
General Health Service
Security Fence
Mastelon Manor
High Security
Home Vale Unit
Kondalilla Unit
Tamborine Unit
Scrubb Unit
Security Fence
Sestock House
Anderson House
Recreation Hall
Wattle House
Tea Tree House
Pine House
Comet House
DD1 Admin
CEO's residence
ELLERTON DRIVE ENTRY
Item no
Quantity
Title/Name, designation, material, dimension etc
Article No./Reference
Designed by Drawn by JMT
Checked by HB
Approved by - date 15/05/03
File name md.dwgs.000sp1w
Date 10/04/03
Scale NTS
THE PARK WACOL
Site Plan
WEST MORETON HEALTH
Edition 0
Sheet 1/1


I.C. No. 10
I.C. No.9
D.P. & C
100
BEDROOM 1
CNC OFFICE
4 BED WARD
PATIENT STORE
BEDROOM 2
LOUNGE
PLAN
SCALE 1:20
CONFIRM ALL DIMENSIONS ON SITE
EXISTING ELEVATION
SCALE 1:20
CONFIRM ALL DIMENSIONS ON SITE
SAWCUT EXISTING S/W AND INSTALL NEW MULLION AND DOORWAY
6 CAP PL M16 GALV. BOLT TO EXISTING LINTEL
MULLION 100x50 PFC M8 GALVANISED DYNABOLTS @ EVERY 3rd COURSE SO EMBEDMENT
6 BASE PL 1 M16 GALV CHEMSET BOLT -120 EMBEDMENT
PROPOSED ELEVATION
SCALE 1:20
CONFIRM ALL DIMENSIONS ON SITE
NOTES:
1. FOUNDATIONS
A Site investigation has NOT been carried out.
It should be noted that there is a moderate degree of cracking in the existing building.
Design assumption:
It is assumed that the foundations have been designed as a stiffened raft.
It is recommended that an Engineer inspect the slab once the floor has been sawcut to confirm slab thickness and reinforcement.
2. SLAB ON GROUND NOTES
Slab to be 120mm thk reinforced with SL82 Fabric centred.
Support fabric on bar chairs @ 800C/C each way.
Lay slab on 0.2mm vapour barrier to Architects details.
Termite protection in accordance with the Australian Standard AS3660. Refer Architects plans for details
Wet cure slab for 7 days. (cover with PVC.)
3. CONCRETE NOTES
Concrete in accordance with AS 3600.
Concrete grade –
Footing N20/20, Cover = 50mm
Slabs N25/20, Cover = 30mm
Lap N12 bars 450mm min.
Lap Fabric – 2 bars + 25mm.
25
25
PRELIMINARY
DRILL 200 DEEP x16# HOLES @ 200c/c FILL WITH RAMSET EPOXY (or EQUV. APPROVED)AND INSERT N12 @ 200c/c
TERMITE PROTECTION TO AUSTRALIAN STANDARDS
150
existing slab
LAP 400
existing footing
SECTION 1 S1
SCALE 1:20
DRILL 200 DEEP x10# HOLES @ 200c/c FILL WITH RAMSET EPOXY (or EQUV. APPROVED)AND INSERT N12 @ 200c/c
TERMITE PROTECTION TO AUSTRALIAN STANDARDS
LAP 400
existing slab
SECTION 2 S1
SCALE 1:20
CORE DRILL 130# HOLE IN FOOTING PROVIDE FLEXIBLE FOAM AT EACH END TO ALLOW FOR MOVEMENT
SAWCUT EXISTING S/W TO FORM DOORWAY
MULLION 100x50 PFC M8 GALVANISED DYNABOLTS @ EVERY 6TH COURSE SO EMBEDMENT
6 BASE PL 1 M16 GALV CHEMSET BOLT -120 EMBEDMENT
3
DETAILED PLAN ON NEW DOORWAY A
SCALE 1:10
+– INDICATES NEW 100x50 PFC HOT DIPPED GALVANISED
PRELIMINARY
ITEM
DESCRIPTION
PROJECT
THE PARK –CENTRE FOR MENTAL HEALTH
BARRETT CENTRE "D"
PROPOSED NEW BATHROOM FACILITY
DRAWING TITLE
STRUCTURAL PLAN AND DETAILS
CLIENT
QUEENSLAND HEALTH
PAUL JOSEPH A.C.N. 087-382-903
CONSULTING STRUCTURAL & CIVIL ENGINEERS Pty Ltd
LEVEL 9, 80 MCDOUGALL ST. RED HILL QLD 4059
PHONE: 3878 2020
FAX: 3878 2040
DRAWN
M.A.R.
JOB NUMBER
2009–100
DATE
Feb' 2009
DRG NUMBER
S1


PRELIMINARY
NOT FOR TENDER
NOTES
LEGEND
DMA
PROFESSIONAL ENGINEERS
BARRETT CENTRE
32 BED CONVALESCENT WARD
BLOCK "D"
THE PARK CENTRE FOR MENTAL HEALTH, WACOL
COMBINED SERVICES
LIGHTING AND FIRE LAYOUT
6187
CS01
P1

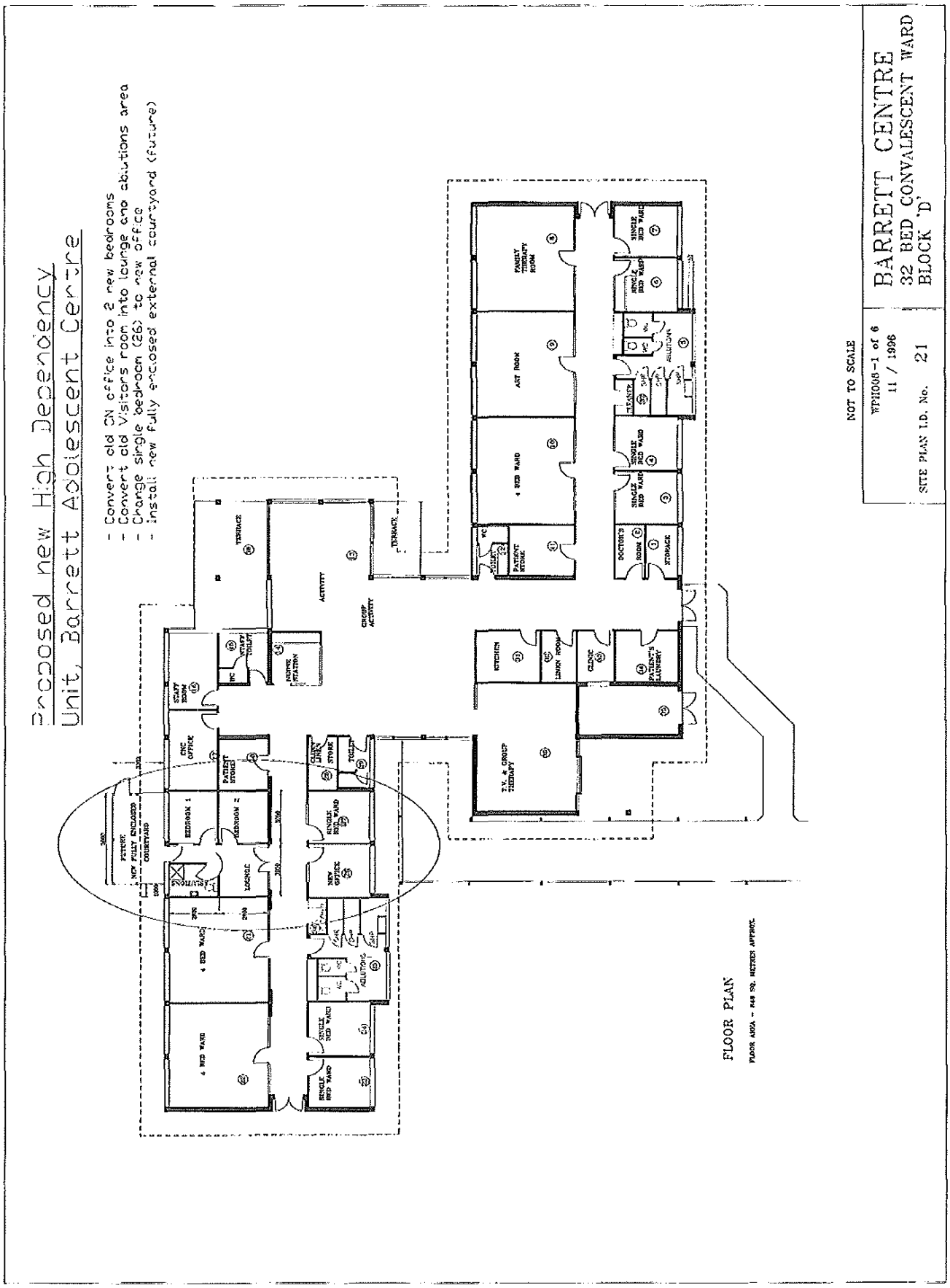
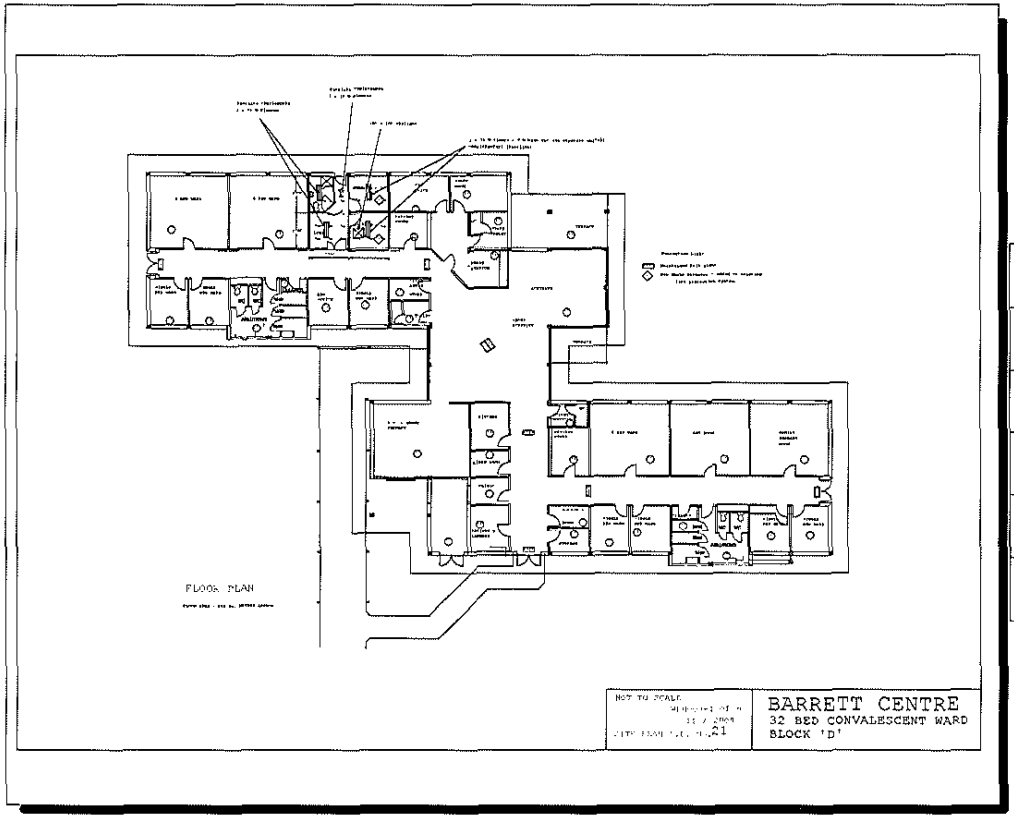

Proposed new High Dependency
Unit, Barrett Adolescent Centre
- Convert old CN office into 2 new bedrooms
- Convert old Visitors room into lounge and ablutions area
- Change single bedroom (26) to new office
- Install new fully enclosed external courtyard (future)
NOT TO SCALE
WP11008-1 of 6
11 / 1996
SITE PLAN I.D. No. 21
BARRETT CENTRE
32 BED CONVALESCENT WARD
BLOCK 'D'
FLOOR PLAN

EXHIBIT 75



Calculation Summary

Label	CalcType	Units	Avg	Max	Min	Min/Avg	Min/Max
BED 1	Illuminance	Lux	187.33	218	169	0.90	0.78
BED 2	Illuminance	Lux	185.00	223	158	0.85	0.71
LOUNGE	Illuminance	Lux	155.00	224	59	0.38	0.26
WC	Illuminance	Lux	241.00	244	238	0.99	0.98

Luminaire Schedule

Symbol	Qty	Label	Lumens	LLF	Description
	4	a	3350	0.700	CRN236EQBF4
	1	B	1350	0.700	CRN118IBF4SP

PIERLITE
Professional lighting solutions

Project:	Client:
BARRETT CENTRE	MICK THOMPSON

Date:	Scale:	Designer:
9/03/2009		R.SIMPSON
Project No:	Page No:	Revision:

EXHIBIT 75

Report of the Indepth Review of the

West Moreton South Burnett Health Service District Mental Health Services

Ipswich, Qld

Incorporating the
National Standards for Mental Health Services into EQuIP

Organisation code: 71 51 30

Survey date: 19-22 August 2008

Advanced Completion: 15 December 2008

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

FUNCTION SUMMARY: CLINICAL

The organisation has shown efforts to integrate services between the Integrated Mental Health Service (IMHS) and The Park. There are a number of initiatives that deserve mentioning for their quality and example of continuing improvement. These include: GP Clinic Program, Prison Mental Health Service, Risk Assessment Process in High Secure Unit, the Diet Management Program, Barrett Adolescent Unit Program, Rehabilitation Team, and the Kingaroy and Rural Mental Health Teams. The Police Liaison Project was very impressive, especially its recent training program which brought together mental health workers, police and ambulance staff. The Goodna Community Team appears to have very reasonable risk evaluation and risk management practices that reflect the nature of the client group. The Research Unit provides a resource for clinically-driven research which is then put into practice within the programs, although not to the extent which could be achieved.

The consumer surveyor had a number of observations and concerns:

Barrett Adolescent Unit

This unit is not purpose built, so it is not ideal for adolescents but could be improved by redoing skylights to let in natural light. Skylights are there but do not work well and new types would be more effective.

The South Burnett Team

This team has made excellent links with non-government organisations and the school nurse program with career supports.

Non-government organisations are helping develop life skills for clients. The team would like more support with the recent merger. Space is a serious concern, with the privacy of clients being compromised, and a poor work environment provided. The lack of transport for clients to get appointments in outer areas needs to be addressed.

The team would like dedicated aged persons as well as someone with drug and alcohol training. The team has had no formal CAG for five years but a consumer advocate is slated to assess and address this problem soon.

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.1
Criterion: 1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.

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

Surveyor's Comments:

The West Moreton South Burnett Health Service District [the District] has established a comprehensive suite of assessment policies, guidelines and forms available at clinical sites across the District and on the intranet.

Detailed information is collected from referrers at triage [for example, the Community Assessment and Treatment Team (CATT)] and as the patient journeys along the care pathway supervised by a care co-ordinator/case manager. There is opportunity for consumer/carer/family/primary care provider participation [for example, Barrett Adolescent Unit intake processes] and regular review by multi-disciplinary teams who take into account assessment, care planning, monitoring of risk factors [a suite of risk assessment tools is available] and transfer of care issues.

Consumers and staff did, however, identify some obstacles to the timely conduct of assessment processes. These included staffing resources and staff workloads. For example, there is an increasing demand upon services delivered by the consultation/liaison nurses within the emergency department of the Ipswich Hospital. The CAT Team has a number of vacant positions. Problems with adequacy of office space [including inadequate sound proofing generating privacy issues and security at South Burnett] were identified. The limited availability of computer access was said by CAT Team medical staff to delay timely entry of important clinical data onto the medical record. Transport adequacy [both for consumers and staff] was also reported to create delay, at times, in completion of assessment and care processes. Particular disadvantage for the older age group living in more remote areas was also identified. For example, the South Burnett Community Team relies on limited outreach services from Toowoomba should additional clinical assistance be necessary.

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

(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.

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

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

Surveyor's Comments:

The District supports the development of a comprehensive, multi-disciplinary care plan with input from consumers, carers and family members. Details are entered into the medical record and updated on a regular basis consequent upon ongoing review of patient progress. This includes risk assessment and, where necessary, contingency planning in order to minimise potential crises.

A wide range of informative brochures and several consumer/carer manuals are provided. Working together [including joint decision making processes and the collection of consumer/carer feedback] strengthens the partnership between clinician and consumer/carer and is much more likely to lead to the achievement of desired outcomes.

The surveyors were impressed with the wide range of innovative treatment and support programs currently in place. For example, gardens have been developed at the Barrett Adolescent Unit and Aged Care Inpatient Unit. Sand play therapy has been introduced at the Barrett Adolescent Unit. The Dual Diagnosis Unit has developed a particularly strong focus on rehabilitation and recovery models of care. The Medium Secure Unit has developed a program to address the problem of patients going absent without leave. A consumer companion project has been established, as has a consumer and carer representation program. There is a health improvement project focusing on physical health issues associated with diet. This program is likely to be of particular value in regard to metabolic syndromes associated with the use of atypical anti-psychotic medications. An employment project is underway. There is a transitional housing program. Mental health nurses are working in a primary care setting in partnership with general practitioners. The South Burnett Community Team is developing programs focused on building capacity within primary care services and strengthening resilience within the community. The Goodna Community Team follows up all patients who do not keep appointments, as do other community teams. This team works hard to maintain strong links with inpatient services. However, time spent in travelling to visit hospitalised patients detracts from the opportunity to deliver clinical care. Access to video-conference facilities would overcome this problem and also strengthen opportunities for continuing professional development.

The Medium Secure Unit has, in addition to refurbishment of secure areas, joined with other units in the implementation of a seclusion reduction program. The seclusion reduction program currently underway is worthy of strong encouragement. There is a world-wide move in this direction. Studies in North America and in Europe have identified significant risk [including death] associated with restraint and seclusion practices. There is also considerable evidence to demonstrate that pro-active, early identification of behavioural disturbance, supported by de-escalation techniques, allows the use of alternative interventions such as 'comfort' rooms, 'time out' rooms and 'snoezelen' rooms. The Aged Care Inpatient Unit has ready access to the high dependency facility of the Adult Inpatient Unit. Accordingly, it is well positioned to review the use of its seclusion room, this being a possible site for development into a snoezelen room or similar, given that sensory stimulation techniques are employed as part of the treatment program.

The District is most fortunate to have the Queensland Centre for Mental Health Research [QCMHR] located within its area. This unit has an established national and international reputation for the quality and importance of its work. In addition to fundamental research investigation of mental illness, QCMHR is engaged in several promising applied research programs. Particularly impressive is its work on employment and on screening for depression. Both projects have enormous potential to not only substantially improve the health of very many members of the community but also to reduce the financial burden of mental ill-health upon the broader community. QCMHR is congratulated upon the quality and extent of its many achievements. Whilst some use of QCMHR expertise is being made, nevertheless, the District is well positioned to strongly support and to make even greater use of this valuable resource.

Some evaluation of care planning has been undertaken. Policies and protocols have been reviewed. There have been clinical audits and benchmarking activities are performed by some units [High Security, Dual Diagnosis, Medium Security, Extended Treatment and Rehabilitation]. However, there has not been such intensive review of many other programs. Accordingly, a rating of EA is not warranted at this point in time but may well be achieved once robust evaluation processes are extended across all units/teams and programs, including those introduced more recently.

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

(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.

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

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

Surveyor's Comments:

The District has developed, within the requirements of Queensland Health, policies and guidelines for consent procedures. There is a process for the management of consent when the consumer is not competent [for example, Dual Disability Unit]. Extensive information about giving consent is made available to consumers and carers via brochures, orientation manuals and in discussions with clinicians who take a patient focused approach to clinical care delivery.

Case management documentation provides opportunity for consumer/carer consent to be collected. A written entry can be made on the hard copy medical record and noted on the electronic system where utilised [for example, Barrett Adolescent Unit]. Whilst consents for electro-convulsive therapy and prescription of medication are readily documented, it is also important to obtain informed consent in regard to all other therapeutic interventions such as group work, family therapy, participation in rehabilitation programs and the broad care plan. This process can play a vital role in the development of engagement or partnership with the patient, leading to more successful outcomes.

An audit process has been established in order to monitor compliance. The District is now well positioned to extend this process by benchmarking within teams, between teams and externally, with other services. The participation rate in collection of data is of critical importance to its meaningful interpretation. Therefore, every encouragement and every support must be given to those staff members responsible for collecting and entering data.

Surveyor's Recommendation:

Function: Clinical **Standard:** 1.1
Criterion: 1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.

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

Surveyor's Comments:

The District supports multi-disciplinary team assessments and the clinical review of each patient and their care plan at team meetings and ward rounds, as frequently as is necessary. Outcomes of care are discussed with the consumer/carer as is discharge planning, transfer of care and the development of risk management strategies or crisis plans.

Adverse events are monitored via a risk register. The patient incident monitoring system is PRIME. Information is collected, for example, about patient absence without leave. Root cause analysis is undertaken consequent upon any sentinel event.

A complaints policy and register are in place. Consumes/carers are encouraged to provide feedback about health care and needs. Options include feedback forms, feedback surveys and consumer focus groups. These activities are well exemplified by Ipswich Rural Team members who also engage with consumers and carers at community meetings, and support activities such as 'Christmas in July' functions. The Community Visitor Program provides another avenue for consumer/carer feedback.

Clinical audits are undertaken and the results discussed with the respective teams. ACHS indicators are collected. Outcome measures [including Honos and LSP] are collected and reported. This information gives useful feedback about clinical outcomes and the achievement of desired goals.

The Rehabilitation Service, The Park, undertakes pre and post-intervention evaluations. This represents sound evidence-based practice in regard to each of its modules. Programs are subsequently modified according to need. Functioning as a separate service, it was not entirely clear to the surveyors how satisfactorily this allowed the rehabilitation teams to integrate with the clinical units in regard to care planning and evaluation. This service highlighted the difficulty experienced with availability of suitable transport for disabled consumers - the undesirable outcome often being that some consumers are effectively denied access to program participation should travel be required.

Some units [High Dependency, Medium Security, Dual Diagnosis, Extended Treatment and Rehabilitation] are engaged in benchmarking activities and have the opportunity to make comparisons with each other and with other similar units across Queensland. However, this is not the case for all units. Accordingly, whilst a solid rating of MA on this criterion has been achieved, a rating of EA will not be warranted until benchmarking activities have become systematic across all components of the District Mental Health Service.

The consumer surveyor had a number of observations and concerns:

Adult Mental Health Unit (IMHS)

The care plans are used service-wide; however, some are signed by clients and some by staff. The IMHS is well linked with non-government organisations (supported accommodation hostels) for referrals. The back fence needs to be taller and the smoking area finished. Staff said that both were underway.

Medium Secure Unit

Staff Indicated a large drop in the use of seclusion. Many client rooms were very untidy. Staff indicated that they did not intervene in how clients kept their rooms.

Community Assessment and Treatment Team (CATT)

The program indicated good links to the Emergency Department, non-government organisations, and Disability Services Queensland. The in-house courier service was reported to not always be working well, and records frequently do not arrive so clinicians have to pick up records at the hospital.

Rural Mental Health

This team is well run with long-term team members who coordinate runs through their outer areas to make the best use of vehicles and time. The team has undertaken education with police. Barbecues have been set up and run by clients on visiting days, which were integrated with suicide prevention days. Education of the public is also conducted in rural markets. Stakeholder forums are held to direct the service. The team would like an extra full time worker so they can do double visits.

Staff said that when they had an inner support worker (non-clinical) to help with the organisation, they were better able to respond to the needs of clients. Rural staff indicated the need for a vehicle dedicated to them alone to alleviate extra work and delays in services (kit can be left in car overnight).

Adult Mental Health Unit

The taps in bathrooms are definite hanging points as well as some hand rails. There appear to be a large number of absences without leave due to the short fence in the outside area. Staff indicated that the fence was to be heightened soon, as well as a smoking area to be constructed.

This unit has excellent consumer workers, which the nurses overuse to do their work for them. Staff attitudes to clients are extremely poor and no respect is shown to clients. Ward staff do not believe that their job is to take part in any recovery programs. No one-on-one interaction seems to occur, which seems to be backed up in consumer satisfaction surveys done by consumer consultants/consumer liaison officers. This surveyor saw first-hand the way that clients were treated and spoken to by senior staff, which the surveyor found appalling.

The consumer consultants/consumer liaison officers indicated that it is extremely hard to get anything done on the ward, ie exercise bikes were bought a year ago but cannot be accessed by clients because staff have not been able to find a site to put them. Consumer consultants/consumer liaison officers get no help or support from nurses and cannot get any cooperation from Occupational Therapy. All client feedback to them shows that clients are extremely bored and the only activities are run by consumer consultants/consumer liaison officers. Consultants/liaison officers have run satisfaction surveys showing that clients are not engaged by staff or shown respect or anything in the recovery model of care.

Rehabilitation at The Park

The rehabilitation team indicated that they received no help or cooperation from the ward and unit staff. This surveyor was told by staff at the Medium Secure Unit that it was not their job to run or help with programs. Clients were left to walk around a ring path to pass the time. Consumers indicate that rehabilitation is too thinly spread across The Park services, and staffing levels always result in clients not being able to use facilities, ie pool, gym and craft venues.

Some groups of staff volunteered the same information in complete ignorance of consumer information supplied.

The consumer surveyor witnessed work practices that in no way reflect humane or proper health care. Management should refer to consumer satisfaction surveys run by consumer advocates to address issues of care within the Adult Mental Health Unit.

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

(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.

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

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

Surveyor's Comments:

Discharge planning begins at assessment. The process is further strengthened with clinical reviews at ward rounds and team meetings conducted during the period of care. A transfer of management process ensures continuity of care when patients move from a team in one part of the District to another, or to a partnership agency. The personal information and photo album prepared for consumers about to transfer care from the Dual Diagnosis Unit is a wonderful example of this. Congratulations to all staff involved in the development and implementation of this very worthwhile initiative.

Policies and guidelines are reviewed regularly. Consumers/carers are given information about community support agencies. Patient feedback is elicited. Outcome measures are collected. Discharge summaries are forwarded to primary care providers or referring agencies. This process has recently been reviewed. Guidelines for medical staff have been established. Additional administrative support may further strengthen effectiveness and efficiency in this area. Meetings are undertaken on a regular basis with general practitioner groups and non-government organisations.

The inreach/outreach model of care practised by the Aged Care Inpatient Unit and Community Team, in addition to strengthening staff skills, has the potential to facilitate patient transfer in either direction. There may be considerable value for the District should it choose to explore the development of a patient flow model [with clearly identified clinical pathways]. A patient flow model allows the ready identification of obstructions to smooth patient flow [such as difficulty in accessing community supports at home, lack of transitional facilities, insufficient nursing home beds] and the opportunity to develop strategies to overcome them. The notion of Lean Thinking has a good deal to offer in this regard. Lean Thinking describes a set of industrial principles that smoothes the manufacturing journey. These principles can be applied equally well to identifying obstructions in the patient's journey and smoothing the individual's flow, seamlessly, through the health care delivery system.

Surveyor's Recommendation:

Function: Clinical **Standard:** 1.1
Criterion: 1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.

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

Surveyor's Comments:

The integrated mental health service has a comprehensive system for monitoring the quality of the health record. It has an ongoing auditing system in place that is used to improve the health record. Arrangements have been made to allow access to health records after-hours for the CAT team.

This criterion is to ensure that medical records are maintained appropriately, so that the information kept within them is comprehensive and accurate. The organisation needs to have processes in place that ensure that this comprehensiveness and accuracy is occurring. Without accurate and comprehensive information, there is the risk that the organisation will not be able to provide appropriate care. In terms of The Park, the organisation has no systematic auditing process to help determine that medical record content is sufficiently detailed to allow care delivery to be tracked, monitored and evaluated.

The mental health service does not have a robust system in place to ensure that all programs within its service area are effectively managing medical record content. This places the organisation at some risk for adverse outcome related to this criterion.

Advanced Completion in 60 Days (AC-60)
An AC-60 was conducted on the following recommendations from the In-Depth Review:
(i) The Park Campus develop a system for reporting the results of clinical record audits to clinical teams.
(ii) The Park Campus develop a system for reviewing any trends discovered from the clinical record audit and a plan be developed for improving performance in identified areas.
(iii) All mental health programs implement an audit of the quality of clinical notes for each clinical discipline.

Action Taken by Organisation to Address Recommendation
(i) The Park has reviewed the established audit processes and tools to ensure a linking system is in place for the collection of data. A system for reporting the findings/recommendations of the clinical chart audits has been developed and formalised in the following clinical chart audits:
* Health Information Service - Area Administrative Officer Clinical Chart Audit. Compliance of the audit looks at the administrative components of the medical record.
* Clinical Programs - Clinical Chart Audit. To ensure that clinicians, by discipline, comply with facility policy and professional standards regarding clinical charts.
* Clinical Initiatives - Care Plan Audit. Compliance of the audit measures the Individual Care Plan in the Medical Record.
* Medical Services - Limited Community Treatment Audit. Compliance with Mental Health Act 2000 and other legislation and standards.

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

All clinical chart audits have had proposals documented which outline the scope and procedure of work for each clinical chart audit. Documentation includes proposal, audit tool, flowchart, audit report and action plans.

(ii) A flowchart incorporating each clinical chart audit has been developed for The Park that links audit tools and outlines the process for reviewing any trends or patterns identified in the findings of each audit. This also incorporates the flow of communication and feedback from and to Executive and the clinical teams.

(iii) The Park - An audit of the quality of clinical notes has been implemented for each discipline. This can be evidenced through the proposal, flowchart, findings and audit summary report for the clinical chart audit.

IMHS - Audit reports are tabled at Executive meetings and findings/recommendations are referred to the appropriate discipline team leader.

Completion Due By:15 December 2008
Responsibility: Health Information Manager

Surveyor's Comments
Having reviewed the range of audit processes in place, the service has developed a flow chart which demonstrates the flow of communications to appropriate clinical staff and committees, to ensure that the results of audits are communicated and acted upon. There is a process in place for escalation to the Executive Committee in the event that action is inadequate or unsuccessful.

The surveyors are confident that the processes in place will now address the shortcomings identified during the In-Depth Review.

The Conditional Survey team will need to confirm that the changes have been sustained, and this process will be facilitated if the District develops and collects some relevant performance indicators to demonstrate the effectiveness and sustainability of the changes.

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

Stage 2 (by August 2009)

(i) The effectiveness of the clinical record audit process implemented be evaluated.
(ii) West Moreton Health District complete an audit to ensure that all mental health services have a clinical record audit system in place and operational.

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

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

Surveyor's Comments:

The overall planning processes for the District incorporate planning for mental health services as part of the comprehensive provision of health services to the community. There is a wide range of literature available for consumers through all the mental health facilities in the District about the range of services provided.

Strong links exist with other providers and information about their services is provided to consumers. Access to these services is facilitated as appropriate.

Surveyor's Recommendation:

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.2
Criterion: 1.2.2 Access and admission to the system of care is prioritised according to clinical need.

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

Surveyor's Comments:

Admission processes are carefully managed to ensure that impediments to swift admission are minimised and that admissions are prioritised according to need. Waiting lists are monitored and reviewed, and admissions are facilitated by the Access Team with daily intake meetings. An innovative approach to alternative accommodation has eased the demand for admission. Review of the admission process has identified opportunities for improvement, which have been implemented with good effect.

Surveyor's 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:**

Surveyor's Comments:

The District has systems in place to facilitate the delivery of appropriate services in the most appropriate setting. With the exception of the Barrett Adolescent Centre, the physical facilities are, largely, appropriate for their purposes.

A range of delivery modalities is utilised, ranging from inpatient services through community services to non-governmental community-based services. The range of services provided is monitored through a range of performance indicators including utilisation, demand and clinical outcomes. Clinical review monitors the clinical outcomes and relevance of services.

This criterion is an ACHS developmental criterion. Therefore a surveyor rating is not applied to this criterion.

Surveyor's Recommendation:

Function: Clinical **Standard:** 1.5
Criterion: 1.5.1 Medications are managed to ensure safe and effective practice.

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

Surveyor's Comments:

The integrated mental health service has established procedures that are regularly audited and help ensure that medications are managed safely. The inpatient ward areas have access to the pharmacy to provide input to the clinical team regarding medication issues.

In terms of The Park, the organisation has no systematic auditing process to help determine that medication is managed safely and effectively. An audit of medications in the service is generally conducted only once a year. Additionally, the pharmacists on campus have little time to provide clinical pharmacy services on the ward, such as attending ward rounds or providing education to consumers or their carers.

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

(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.

Risk Rating: Moderate

Risk Comments:

There is a moderate risk to patients in the absence of a robust audit of medication management.

Function: Clinical **Standard:** 1.6
Criterion: 1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service

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

Surveyor's Comments:

Rehabilitation Team

Consumer advocates and representatives are working well, providing many areas of advocacy across the services, supplying divergent programs in lieu of staff who decide not to participate in best practice. Consumer advocates also take part in executive meetings.

Consumer advocates indicated that major problems exist with staff attitudes at The Park, pay back for clients that complain and trouble with long-term staff; also that there is no one-on-one interaction with staff and in many cases staff refuse to talk with clients.

Bullying is said to be commonplace, even with doctors telling clients the benefits of compliance.

Adult Mental Health Unit

Consultants report good relationships and cooperation from senior management.

Consumer advocates indicated that they were supported by senior management in their endeavours to improve the service, but said that retirement may come soon as they are frustrated by lack of help and the way the ward is run.

Medium Secure Unit

Staff indicated that non-government organisations supplied leave clients with diversional programs. On the ward, clients that do not get leave were reportedly engaged in activities for three hours a day. However, the activities board did not bear this out and staff said it was not their job to entertain clients. The surveyor understood that staff only wanted to supply medical services.

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

(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.

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

Surveyor's Comments:

Consumer/patient rights and responsibilities were explained by consumer advocates to clients on wards. There was no evidence of this in clients' records as nurses were said to not take part because they did not see that as part of their jobs. Consumer advocates often went back and repeated explanations when clients were more able to absorb the meaning of their rights and responsibilities.

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

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.

Function: Clinical **Standard:** 1.6
Criterion: 1.6.3 The organisation makes provision for consumers / patients from culturally and linguistically diverse backgrounds and consumers / patients with special needs.

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

Surveyor's Comments:

The organisation was able to demonstrate that it makes provision for consumers/patients from culturally and linguistically diverse backgrounds and consumers/patients with special needs. The CAT team had staff with an Asian background which was very beneficial for consumers from a similar background. There was evidence of consumer information available in different languages.

The Prison Mental Health Service has implemented a project to review the referral and assessment processes for Aboriginal prisoners and prisoners from other culturally and linguistically diverse backgrounds, which identified barriers to these individuals receiving mental health assessment.

Surveyor's Recommendation:

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

FUNCTION SUMMARY: SUPPORT

There is a demonstrated commitment by mental health leadership to quality across the program. There is a system for resourcing quality activities that are linked to specific funded and unfunded projects - care planning, seclusion reduction, models of care (evolving care), healthy living and recovery model training. A project management approach is supported in most of the larger quality projects. The Work Improvement Groups (WIGS) across The Park and integrated mental health service are reflective of a framework that supports a quality improvement approach to care delivery. There are examples of local and unit quality and risk structures that were sufficiently robust to ensure that areas and issues that vary from the expected standard are addressed in a timely and safe way. Some of the WIGS clearly evidenced progressive and sustainable improvement activities and some have little evidence of effectiveness

Staff across the West Moreton South Burnett Health Service District (WMSBHSD) mental health sector are aware of their responsibilities for managing risk and do so through communication and consultation. The risk management policy is District-wide, executive endorsed, addresses clinical and corporate risks and is available to staff electronically. The policy is based on the Hunter Valley framework, and is detailed and in parts specific about processes.

There is organisational recognition of the need to record incidents, and there is information pertaining to both staff and managers' respnsibilities available on G drive. Staff know of the PRIME system and their responsibility for recording and reporting incidents, although there were several instances of staff talking about incidents that were not recorded in PRIME and of which managers were not aware. This is an indication that the system may not be as robust and therefore effective as thought.

Auditing is embraced and resourced but little demonstrated evidence of how this process and its outcomes improve care. There is a lack of evaluation of the effectiveness of models and programs completed at the unit level. There is a recommendation in relation to the lack of an overarching knowledge or articulation of the quality improvement outcomes.

It is evident that human resource planning is part of the organisation's strategic planning process. It is in the governance and reporting framework of WMSBHSD and aligned with the Queensland Health Workforce Plan 2007-2012, the Mental Health Plan and the Allied Health Workforce Plan, and is supported by information from the LATTICE database.

The WMSBHSD has undertaken development of graduate and post-graduate placement and support programs, as well as providing student placements across all areas and participation in the Transition in Practice initiative. The relationships developed with the tertiary institutions have resulted in a high rate of retention of new staff and staff in the training programs, and in attracting students to work there. The relationships currently benefit both the tertiary institutions and WMSB Mental Health Service and provide a good foundation on which to build future initiatives.

The recruitment, selection and appointment process has shown improvements in recruitment time and user friendliness, as reported by staff. Position descriptions are up-to-date and staff are provided with the support to improve the efficiency and timeliness of recruitment.

Workplace relations are managed well. Staff are supported with education, peer support and employee assistance. The PAD system, put in place over the last year, has provided evidence that it will become a robust system of support for staff once all areas are involved.

There is a wealth of education services available to staff in most areas, with the outer rural areas experiencing restricted access. The mandatory training day provided by district services and the mental health training days together cover a range of basic skills and knowledge requirements. The DMHES has a very inclusive education calendar available and staff are encouraged by the leaders to take up the opportunities.

WMSBHSD has taken up the statewide information technology systems that support the programs. These respond to clinical need and to most governance and business needs.

Staff have access to computer terminals across the program. Information technology support is provided through the district, and staff proffered no issues with the timeliness and reliability of the support service.

The WMSBHSD has an intranet that has policy, procedures, guidelines and protocols available 24hours. Staff use the intranet and the associated drives to complete daily business and to access Queensland resources, district and local reports and information.

The ability of some of the rural areas to access the same resources was restricted and it is suggested that teleconferencing/e-learning options be investigated as one solution to improving the access of staff from all areas to education and clinical resources.

The feedback and closure section of the PDCA loop is not as robust as it needs to be and specific recommendations related to this and the risks associated with the community staff completing home visits are covered in the body of the report.

Staff know of the PRIME system and their responsibility for recording and reporting incidents. The use of PRIME for recording of follow-up and outcomes from incidents is not as good as the database allows. The Peer Support Program provides follow-up after an incident for staff and staff know how to access it but the evaluation of the effectiveness identified a decrease in participation when compared with the number of incidents. The process for client follow-up and support following an incident was less clear and not at all formal.

The complaints process is clear and is coordinated and monitored by the Service Improvement Coordinator (The Park) and the District Patient Safety and Quality Unit for IMHS, and the upcoming addition of the PRIME CF module to the database should improve the recording of all complaints, including those resolved at the point of initial contact or first line.

Open disclosure understanding and education was not consistently demonstrated and there was some evidence of a lack of clarity of what open disclosure really means and the impact of the privacy principles.

Support services at The Park and IMHS are comprehensive, the catering services having undergone a change in approach to meal delivery and options clients can access. This was based on a survey of clients and families and a new menu monitor system has been put in place which is reportedly very effective. The gardens at The Park are really well maintained and reflect an environmentally friendly approach to providing a pleasant environment for clients, their families and staff. Laundry services comply with requirements for machine types, with a replacement process having been undertaken. Many of the clients at The Park are encourages to do their own washing and the machines are cleaned and serviced.

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

Surveyor's Comments:

There is a culture of improving but it is not evident that this exists in all areas. The quality framework is not recognised by all staff and there was some evidence from staff of quality being the responsibility of someone else, particularly if there is a project manager. The quality framework needs to be inclusive of everyone and while there are excellent examples of continuous improvement, there is a lack of a coordinated approach.

There is a lot of energy put into auditing and lots of data collected but again, not a lot of evidence of how this process and its outcomes improve care. There is not a great deal of evaluation of the effectiveness of models and programs completed at the unit level, some of which may be the result of the presence and input of the effective Mental Health Research Unit. Staff see evaluation as the domain of this unit. Evaluating improvement can be less about research and more about rapid review using the PDCA cycle but this is not apparent in the WIG activity. The aged care services and integrated mental health service have the Evolving Care model which includes rapid cycling review practices.

The project management approach has sustainability issues that are not addressed in some of the projects.

There is no overarching knowledge or articulation of the quality improvement outcomes or process that links together the activities and information. Many siloed activities are being undertaken in a responsive rather than in a planned and considered approach.

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

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.

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

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

Surveyor's Comments:

The current risk management framework identifies risks, and analyses, evaluates and addresses risks but there is a lack of evidence of site specific monitoring, review on a regular basis and communication of reassessment to the relevant site staff, committees and persons responsible as articulated in the policy *West Moreton South Burnett Health Service District Clinical Governance Operational Plan* and the *Risk Management Plan*. The risk register is centrally managed and again, access or full engagement by site-specific staff is not demonstrated.

There are specific committees for clinical risk management but the evidence of effective functioning or impact of the committees was not demonstrated. The corporate risk management system is inclusive of all sites but the interface between sites and the District process is not clearly demonstrated as providing effective bottom-up and top-down communication and follow-up.

The many audits, both clinical and corporate, completed across the sites are compliance directed and there was little evidence of a collective approach to the coordination of, purpose of and outcomes that improved safety or quality.

Staff did report that they could initiate an action related to risk, had some control over response to an identified risk, but were unsure of who in the risk management framework held overall responsibility for any incident follow-up.

The recommendations for root cause analysis and HEAPS (local investigations) are recorded in PRIME and do come to the Patient Safety Committee, however, there is not a demonstrated control over the actioning, timeframes and outcomes from them, with little if any detail recorded in minutes and an inability of staff, either directly involved or management, to articulate what were the outcomes of many of the HEAPS/root cause analysis recommendations. A system for the tracking of recommendation progress was not established.

There is an explainable reliance on the central patient safety process for monitoring but the effectiveness of the interface of District with integrated mental health service, Kingaroy, Goodna and The Park was not established.

Trending and reporting of incident data occurs and is reported to staff but there was, again, an "ad hoc" approach to engaging staff in understanding or using the aggregate data to improve care.

The following issues were notable:

The home visiting safety policy - *Home Visiting in the Community – PROWMSB20080258,* for mental health service community staff does not provide a formal requirement for completion or formal recording of home visiting risks for individual clients. There is an "ad hoc" approach by some teams to utilising the alert process to inform colleagues of identified risks. The policy is also not inclusive enough, for example, the recording of staff exposure to cigarette smoke/dogs.

The risk associated with this recommendation is rated as unlikely with moderate consequences, as the components of an appropriate risk management system are in place and the concerns surround the effective integration of the system.

Advanced Completion in 60 Days (AC-60)
An AC-60 was undertaken on the following recommendations from the In-Depth Review:
(i) An audit of the current control and tracking of the progress of the recommendations from root cause analysis and HEAPS be undertaken in the mental health service, and the focus be on ownership by site staff and leaders as well as the District system with the development of an identified pathway of open, two-way communication.
(ii) A formal and inclusive home visiting risk assessment process be put in place in the mental health service and evaluated.

Action Taken by Organisation to Address Recommendation
(i) An audit has been completed in relation to the monitoring and progress of RCA and HEAPS recommendations. This audit identified deficits in the RCA and HEAPS recommendation process. In response, the RCA and HEAPS process has been revised to include:
* Flowchart now includes the defined sequence of events and reporting processes which must occur for each RCA/HEAPS with particular reference to improved flow of communication for the Mental Health Service.
* An electronic and paper checklist has been implemented to monitor the progress of each RCA/HEAPS recommendation for completion and closure of the clinical incident.
* Feedback mechanisms to clinical teams have been revised and occur at Patient Safety Rounds, Mental Health Patient Safety and Quality Committee and relevant Mental Health Services committee meetings (ie Work Improvement Groups, Business Unit Management Committee)

Appointment of a Patient Safety Officer with the Mental Health portfolio, with a direct reporting line to the District Director Patient Safety and Quality and situated in the District Patient Safety and Quality Unit. The Officer is responsible for the management of the RCA/HEAPS reviews.

(ii) The District Home Visiting policy has been reviewed and endorsed at the District Executive Committee on the 14 November 2008 and is accessible on the District Intranet Site. The risk assessment tool has been widely consulted and reviewed to include environmental risks (cigarette smoke/dogs/weapons). An evaluation of the tool is underway and results will be available for the surveyors in December 2008.

Completion Due By: 15 December 2008
Responsibility: Executive Director Mental Health Service WMSBHSD

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Surveyor's Comments
A database of all Root Cause Analysis and HEAPS recommendations since 2008 has been compiled, their implementation tracked, and those which have not been implemented have been identified and are being followed up.

A system is now in place which will ensure that all recommendations are communicated to the relevant personnel and tracked for implementation.

A District-wide home visiting policy has been developed and implemented and is shortly to be evaluated for effectiveness through a new audit tool.

The Conditional survey team will need to confirm that the changes have been sustained, and this process will be facilitated if the District develops and collects some relevant performance indicators to demonstrate the effectiveness and sustainability of the changes.

Surveyor's Recommendation:

Function: Support **Standard:** 2.1
Criterion: 2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.

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

Surveyor's Comments:

The complaints process is clear and is coordinated and monitored by the Service Improvement Coordinator (The Park) and the District Patient Safety and Quality Unit for the IMHS, with a process that feeds the information through to the District.

The incident management system includes identification, review and action, with responsibility identified. There is support provided to clients and staff (Peer Support Program) following an incident. The Peer Support Program provides the opportunity for uptake but there has been a decline in numbers of staff utilising it since 2002. This may be due to the (as reported by District Mental Health Education Service), decrease in the overall number of incidents reported by the program, but the effectiveness of the program in attracting staff participation post-incident could be reviewed. The support provided to clients is less clear, except with the seclusion reduction project where it is more formalised.

Open disclosure understanding and education was not consistently demonstrated and there was some evidence of a lack of clarity of what open disclosure really means and the impact of the privacy principles. The effectiveness of the open disclosure training as with all training should be evaluated for effectiveness.

Clients are informed of the complaints process, both in written form and through the education on rights and responsibilities completed by the consumer consultants. The system for complaints is reported to be the same for Kingaroy and Gooda.

The opportunities for feedback provided to clients at the integrated mental health service and The Park through the consumer consultants is considerable, and it is not clear that these are captured or responded to with the same process as the more formal complaints made. The use of PRIME CF when it is available, by the consumer consultants, may go some way to capturing the information. The contribution to trending of first line and/or resolved complaints should not be underestimated.

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

(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.

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

(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.

Function: Support **Standard:** 2.2
Criterion: 2.2.1 Human resources planning supports the organisation's current and future ability to address needs.

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

Surveyor's Comments:

There is a clear recognition of the need for a focus on recruitment and retention across the district, with demonstrated workforce planning.

There is a workforce planning process, which addresses the plans for all staffing areas – PMHS Workforce Development Plan. The LATTICE database provides accurate reports on position occupancy and opportunities, and there has been involvement in the statewide Allied Health Workforce Planning Project.

There is a draft District Human Resources Strategic Plan, and the local service plans are aligned with the Queensland Health Workforce Plan 2007-2012, Mental Health Plan and the Allied Health Workforce Plan.
A skills profiling process was undertaken in some areas of the mental health sector, and the use of consumer employees to complement clinical staff is indicative of the creative approach to future staffing needs.

There has been an increase in the Transition in Practice Nurse Education Program (TPNEP) placements broadening the areas from which to attract future staff.

Residential Support Officer hours have been increased, with specific training in the Dual Diagnosis, High Security and Adolescent Units. There is an indigenous consumer staff position, and a multicultural mental health coordinator. These approaches to providing skilled staff into the future are based on a clear understanding of the current and identified future needs of the WMSBHSD mental health sector.

Surveyor's Recommendation:

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

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

Surveyor's Comments:

The recruitment, retention, selection and appointment process is standard across the mental health areas, with human resource representatives available at the integrated mental health service and The Park.

The mental health service has concerns about the sustainability of the current skilled and experienced workforce, which is nearing retirement age en masse in the not too distant future. The push is to make the best of the staff experience and support and up-skill the less experienced staff. The adoption of the Transition Nurse Program is a good example of the innovation being used to build up the mental health workforce, as is the expanding consumer advocate and consumer representative programs.

The allied health area targets the universities to attract students completing graduate qualifications. The offer of therapy positions for university students during holidays has led to the attraction of many allied staff to the service on completion of their course. The Extended Treatment and Rehabilitation Unit (ET&R) program has good staff retention, as do most areas of The Park and integrated mental health service. The ability to fill some of the more rural positions is less successful.

There are ten nursing graduate student placements available, which has led to an increase in retention rates – loss at 25%. There is some difficultly in providing adequate undergraduate and graduate training placements for allied health that is reported to affect the ability of the allied health areas to attract new staff.

A nurse specific preceptorship program exists with 54 currently trained preceptors across The Park and integrated mental health service. The capacity of the program to be more effective was identified as an issue by staff, with the reflection that there is little to reward participating staff for what is a voluntary program and an extremely important one to the service.

There is an indication that the recruitment, retention and workforce planning activities completed by the District have, on occasion, not included or represented the mental health sector. It would be advantageous to the mental health sector if all the recruitment activities of the District were inclusive and vice versa, as the mental health sector has developed quite effective systems.

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

(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.

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

Surveyor's Comments:

Position descriptions are available and include role specification, accountabilities, functions and activities. There has been a specific review of the District Mental Health Education Service position descriptions, in light of the service moving from The Park responsibilities to the District mental health staff.

There are competencies aligned with the ABM aggression management training, but most other training provided does not have formal assessment attached. WMSBHSD has a process for responding to complaints made against staff – *refer criterion 2.1.3.*

Registration with regulatory bodies is monitored annually and for all new employees, and the system includes required police checks.

The Professional, Appraisal and Development System (PADS) was put in place last year across the District. Uptake in mental health units is reliant on the individual unit manager. The mental health staff have “started afresh” with the new PADS process, and in most units there is evidence of uptake with schedules available for staff awaiting PADS. Once completed the PADS plan is sent to Human Resources, signed off locally at the integrated mental health service and The Park, and then forwarded to the District system. The process for rural areas was less clear.

A formal operational supervision system is in place and supported by policy. There are requirements for a session per month for usual staff, and more often for identified staff. There is a formal record of the session and records are available.

There is a draft Peer Review Meetings and Clinical Audit Meetings policy in place consisting of case presentations and a formulation group, and there are plans to establish a mortality and morbidity forum.

There is a preceptorship program in place that provides support to students on placement.

Surveyor's 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

Surveyor's Comments:

There is a comprehensive education and training program for mental health staff, especially at The Park, Goodna and the integrated mental health service. The orientation process is comprehensive with recently developed orientation manuals for staff and consumers. A good example is the orientation program at CYMHS, which is six weeks in length and provides education and training that reflects the specialist skills required for the position. The comprehensive operational supervision process at the Extended Treatment and Rehabilitation Unit (ET&R), is inclusive of clinical as well as line supervision, with a large component of role play and other techniques to increase the skills of staff to provide the service required. There is evidence of increased support for inexperienced staff in the Child and Youth Mental Health Service, The Park and the integrated mental health service.

The District policy identifies “just in time” training by the Patient Safety and Quality Unit covering Introduction to patient safety, incident analysis using the root cause analysis process, HEAPS tool use, incident recording and management, conducting a clinical audit, implementing quality improvement, graded assertiveness, frontline communication skills, and complaints management. There was little evidence other than PRIME education, that mental health staff accessed the training or understood its importance.

The District Mental Health Education Service (DMHES), originally specific to The Park, provides a comprehensive training calendar to staff at Goodna, The Park and the integrated mental health service but the rural areas, Kingaroy and Cherbourg, have little or no access.

At orientation and annually staff have mandatory education inclusive of cardio-pulmonary resuscitation, fire safety, medication, code of conduct, child abuse and neglect, and workplace equity and harassment. Staff undertake either the three or five day ABM violence management training, and consumer representatives in high security undertake the two day training.

Mental Health has one day compulsory training inclusive of suicide prevention, clinical risk assessment, mental state examination, and the recovery model. A database records and allows monitoring of attendance. Thirty-nine integrated mental health service staff are trained as authorised mental health practitioners.

The library service, based at The Park, is comprehensive and provides a great resource for all staff, including an unfunded statewide support service. The library has undertaken surveys by stakeholders and plans to provide more training on literature searching techniques for staff.

The DMHES has undertaken a lot of work in the area of curriculum content and negotiation with universities for advanced standing for staff who complete the courses. The adoption of the Transition Nurse Program is a good example of the innovation being used to build up the mental health workforce. The attractiveness of full-time employment rather than completing the Transition Nurse Program has impacted on outcomes, but after a review by DMHES there is now a contract change to allow for the completion of the training program and then return to the substantive role.

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

The work completed on attracting advanced credit standing for mental health nurse practice education goes a long way to making the program more attractive. The Forensic Mental Health Program, a collaborative course between Queensland Mental Health and Griffith University, is supported by DMHES and the uptake in high security is good.

Medical staff receive college specified supervision and support.

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

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.

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

Surveyor's Comments:

WMSBHSD provides staff with the options of job-share, part-time, full-time and casual employment. Workplace relations are managed by the Human Resource Department in conjunction with the discipline head. There is a code of conduct by which all staff undertake training. There is a Workplace Equity and Harassment Officer and training is provided through orientation and annual sessions.

There are other site specific activities such as the FISH project at the integrated mental health service, which includes a staff recognition and reward system.

Staff satisfaction levels have been sought through statewide survey participation and specifically for some local projects. There have been no issues identified through either process.

There is a District employee assistance program, with the Peer Support Program specific to The Park, Goodna and integrated mental health service and access available by rural areas. The program has been evaluated since its beginning in 2001. The evaluation does show a steady decrease in the use of the service over time. Refer to recommendation at criterion 2.1.3.

The Peer Support Program provides the opportunity for uptake but there has been a decline in numbers of staff utilising it since 2002. This may be due to a (as reported by DMHES), decrease in the overall number of incidents reported by the program, but the effectiveness of the program in attracting staff participation post-incident could be reviewed.

Surveyor's Recommendation:

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Support **Standard:** 2.3
Criterion: 2.3.2 Information and data management and collection systems are used to help meet the strategic and operational needs of the organisation.

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

Surveyor's Comments:

WMSBHSD has taken up the statewide information technology systems that support the programs. These respond to both clinical need and to most governance and business needs. The PRIME system supports incident management and the complaints element – PRIME CF – is soon to come on-line providing the opportunity for a single point of entry for complaints. Staff have access to computer terminals across the program.

Information technology support is provided through the district and staff proffered no issues with the timeliness and reliability of the support service.

The WMSBHSD has an intranet that has policy, procedures, guidelines and protocols all available 24 hours. Staff use the intranet and the associated drives to complete daily business and to access Queensland resources, and district and local reports and information.

The ability of some of the rural areas to access the same resources was restricted, and it is suggested that teleconferencing/e-learning options be investigated as one solution to improving the access of staff from all areas to education and clinical resources.

The mental health benchmarking unit based at The Park is a statewide unit that provides support and education to all voluntary participant mental health services in Queensland. It has progressed to a stage where most services are represented in the work of the unit. The service is the coordination of data collection, report development, education and support. The Park has taken full advantage of its co-location with the unit and has benefitted from its expertise. The integrated mental health service is less involved but there is impetus to increase the uptake of the unit's services over the next 12 months. The unit is committed to evaluating the usefulness to direct care staff and managers and the perceived impact of the project. This is an excellent example of a centralised unit providing specialised support and skills to mental health services.

Surveyor's Recommendation:

Function: Support **Standard:** 2.4
Criterion: 2.4.1 Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation.

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

Surveyor's Comments:

Population health figures and statistics are utilised by the service to inform service development and priorities, and this is reflected in the strategic plan.

The mental health services provide smoking cessation advice and treatment options to clients, and physical assessment is an integral part of the assessment process at both entry into the service and at review. The aged care services at the integrated mental health service provide education to residential service and hostels, as well as other support service staff, to improve their capacity to provide a service that includes all aspects of care associated with mental illness in the aged population.

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

The general practitioner nurses in mental health, the forerunner to the COAG initiative of 2007, have provided education and support to general practitioners across the area, and the establishment of the transitional housing program provides education to community services as part of its brief.

An example of creative access to the population that resulted in education and demystifying of mental health and the services was the “Remembering Goodna” project, a combined program with The Park, the Council and Griffith University held at the Museum of Queensland. Approximately 60,000 people visited the exhibition at which current service information and staff were available.

The Child and Youth Mental Health Service provides education to Community Linkages and the School Linkages project, and the staff ensured the attendance of clients and their families at the COPMI family fun day, increasing community education and exposure to mental health issues. The Child and Youth Mental Health Service has also established a drum group with the Ipswich police.

WMSBHSD mental health service has a proactive approach to promoting health to the community and all service users, and the “Facts on Snacks” set of information booklets on eating healthy foods and lifestyle choices is a good example. These booklets, for clients, families and staff, have been provided free, and have information that is easy to read and based on sound evidence. The change in focus of the on-site cafeteria/shops from high calorie foods to a choice of an alternative healthy selection has had an impact on staff, the clients and all who visit the site. The health improvement project identified the environment as “obesogenic”, with 60% clients having a metabolic syndrome and all of the actions since have been to change this.

Surveyor's Recommendation:

FUNCTION SUMMARY: CORPORATE

The District will again be restructured following the announcement by Queensland Health of an amalgamation with an adjoining Health Service District. The surveyors were cognisant of the impact of restructuring and the associated continual change, notably in regard to this function.

During the last 18 months the mental health service has been pursuing the integration of its services within a District model and has made discernible progress. The preparation of an integrated strategic plan is progressing, with current processes based on the individual strategic plans which have been developed for The Park and the integrated mental health service. It was readily apparent that considerable consultation had taken place in the preparation of the plan, and staff were able to articulate a sound understanding of issues confronting the service.

The surveyors were briefed on the current status of the corporate and organisational structure and its governance framework. Due to the relatively short period since the last restructure (18 months) many aspects are work in progress. Notwithstanding, the fundamentals are in place and there was abundant evidence to demonstrate the commitment to progressing the integration at all levels of the service.

Accountability for governance and management rests with the Health Service District Executive and the local executive for the mental health service. A responsibility and accountability organisation/committee structure, together with a corporate systems support framework, has been established to underpin the functioning of the mental health service, and its application at the local level is progressing. The District provides corporate, logistical and governance support and has established a monitoring and reporting framework against which the mental health service is required to report. Decision making processes appeared to be clearly defined and there appeared to be appropriate delineation of responsibilities between the District Executive and the executive of the mental health service.

The surveyors found evidence at the operational level of systems and processes that support local safety and quality objectives. It was clear that over recent years, many improvements have been instigated across all of the criteria reviewed under this function. Progress was noted, for example, in the body of work undertaken to review and bring together, where appropriate, policies and procedures whilst at the same time ensuring the integration of available best practice evidence, legislative requirements and professional guidelines as relevant. Work to review and enhance the safety management system was evidenced in reduced lost time injury related to manual handling and object handling. Further, the success of the Aggressive Behaviour Minimisation training program is another example of the responsiveness of the service to reducing its risk exposure whilst enhancing staff and patient safety.

Whilst there are identified areas for further improvement addressed under two of the specific criteria addressed in the In-Depth Review, initiatives are being taken to ensure that the mental health service is able to function effectively and make the transition to a District model in a timely manner.

There are significant patient and staff safety issues identified under criterion 3.2.2 relating to the Barrett Adolescent Centre built environment. A high priority recommendation designed to ensure that immediate modifications are made to the patient accommodation areas to improve patient and staff safety has been included.

The surveyors' comments and recommendations relate to the need to build on current foundations through the application of a systematic approach to review, evaluation and improvement activities.

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

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

Surveyor's Comments:

Strategic and operational planning is essentially in transition as the West Moreton South Burnett Health Service District continues to progress the integration of its mental health programs including the merger with services provided in the South Burnett area. The six underlying principles and five key priorities for reform articulated in the Queensland Plan for Mental Health 2007-2017 are reflected in the strategic and operational plans for both the inpatient and community focused services. Models of service delivery incorporated into each plan provide the framework for practice guidelines, strategic planning and service development. A body of work is in progress to translate the two strategic plans into operational plans, and there is evidence of work in progress to develop an integrated strategic plan for the entire mental health service.

Evidence of the use of demographic and clinical service prediction data is readily apparent, as is the involvement of consumers, stakeholders and staff. Relationships with community partners are considered integral to the service, and considerable effort is being assigned into developing and maintaining a wide range of partnerships.

There is evidence that priorities are identified and key performance indicators are used to monitor and promote progress across the mental health services and in its relationship to the Health Service District. Evaluation is undertaken through committee activities and utilising the data obtained through the use of key performance indicators to identify areas for further improvement.

Surveyor's 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

Surveyor's Comments:

The Director-General of Health is the governing body but for practical purposes the District Executive is the local governing body, which has appropriate terms of reference and procedures in place. There is a Mental Health Executive which manages the day to day requirements of the service.

There are terms of reference for all committees but there is no clear statement of expected outcomes articulated for the mental health committees. It would be appropriate for all committees to set objectives each year and to evaluate performance against those objectives at the end of the year. Minutes of meetings do not clearly reflect decisions taken and the impact of implementation leading to evidence of continuous improvement. They should be recorded in such a way as to convey a clearly identifiable decision trail and the status of major issues under consideration.

The use of first names only or initials only in minutes should be ceased and replaced with a system which ensures that individual participants are clearly identified. These are historical documents which may need to be referred to in the future.

Financial and human resource delegations are established and are available on the intranet. Compliance is monitored through the finance, purchasing and human resource functions. Budgeting is zero based and reports are available electronically to all departments.

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Surveyor's Recommendation:

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

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

Surveyor's Comments:

A body of work has been undertaken over the last 18 months to ensure that the policy process is comprehensive and provides a robust approach to policy development, implementation, evaluation and compliance monitoring. Work is progressing to review and integrate mental health policies within the District policy as appropriate. Evidence of consultation and review across a range of work groups was sighted and a document management approach was evident.

Documented corporate and clinical policies are available for all staff. A range of policy manuals was reviewed during the course of the survey and found to be up-to-date and accessible to staff. The transition to an electronic system is progressing. The surveyors noted that to enable this approach to be effective, it would be prudent for the mental health service to concurrently review ease of access to the intranet and the level of computer literacy among staff.

Policies reviewed during the In-Depth Review incorporated relevant professional guidelines, statutory requirements, Australian Standards and legislation. Monitoring of legislation is undertaken centrally and managers are provided with relevant information for implementation at the local level. Evidence that this occurs was sighted in minutes and other reports. However the system for ensuring implementation of and compliance with new or amended legislative requirements could be strengthened by including into the policy management process a documented process which details changes, informs staff about legislative change, and enables routine evaluation of the implementation of changed policy or procedure.

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

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.

Function: Corporate **Standard:** 3.2
Criterion: 3.2.1 Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.

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

Surveyor's Comments:

The elements of a safety management system relevant to the role and function of the mental health service have been inculcated into the day to day management of the service. The nature of the services being provided and the mix of patients are appropriately reflected within the safety management system and in the supporting education programs, eg Aggressive Behaviour Minimisation training. This education program has had a significant positive influence across the entire service and is justifiably held in high regard.

The safety system is supported by the District occupational health and safety structures and the local Occupational Health and Safety Committee, both of which operate in accordance with legislative requirements. Identified risks are documented and processed within an established occupational health and safety framework, and evidence of how the system is used to enhance environmental safety was sighted in minutes and other reports. Relevant policies and procedures are available to guide staff, and there is a well established system of safe work practice guidelines which provide instruction and direction to staff and contractors on the maintenance of a safe working environment.

Occupational health and safety staff have received the designated training and since the last survey, active participation of representatives was reported to have improved. Evidence, however, of this within the occupational health and safety minutes was minimal. It is recommended that further efforts be made to more actively engage the occupational health and safety representatives in promoting and maintaining safe work practices and contributing their observations and actions to the committee's activities. Encouraging greater participation may be achieved by engaging occupational health and safety representatives and staff and managers in developing an annual program of initiatives identified by both staff and managers. Promoting shared leadership and responsibility for implementing the initiatives and reflecting this in the reporting and recognition processes is integral to the success of this bottom-up program suggestion.

The Occupational Health and Safety Committee meets regularly, however, the minutes do not provide clear insight into the effectiveness of the committee in fulfilling its terms of reference. Recommendations in regard to committee effectiveness have been included under criterion 3.1.2 in the Organisation-Wide Survey report.

Regular workplace inspections enable the identification of workplace hazards and inform the remedies implemented in response to the hazards identified. Patient safety rounds are undertaken regularly by different groups of staff (both management and staff groups) and the issues identified are addressed promptly. This is an excellent initiative and is providing the opportunity for both issue identification and resolution, and improved communication between and across the various components of the service..

The injury management system is overseen by designated staff across the service. A sound system is in place for addressing issues arising from workplace related illness or injury. The management of staff who have experienced a work related injury or illness was reported to be effective, with positive feedback from staff. There has been a significant reduction in paid time lost and a consequent reduction in the cost of work related injury/illness, indicating that workplace health and safety is contributing to enhanced staff safety and improved organisational outcomes.

Manual and object handling is a priority within the mandatory education program, and feedback in the form of data analysis regarding lost time injuries and related issues demonstrates the improvements being achieved.

There are a number of domestic chemicals used and stored in patient bathrooms and communal laundries, particularly noticeable in the Extended Treatment and Rehabilitation (ET&R) unit, where up to four types of bathroom cleaners were in use. All of the chemicals sighted contained first-aid warnings, however, there were no material safety data sheets available. There are suitable non-hazardous bathroom and laundry chemicals which could be substituted. The use of non-hazardous products would reduce the potential risk to patients from accidental or deliberate improper use, and reducing the number of chemicals available would reduce unnecessary expenditure and the negative impact on the environment. The surveyors acknowledge that there is a balance between safety requirements and promoting independent living for patients, however, the use of chemicals in any situation needs to be monitored and actions taken to minimise the potential risks involved.

There are communal washing machines in use, eg in the ET&R unit, but there are no safe practice guidelines in place to guide patients and staff in minimising the risk of cross-infection.

Elements of the overall safety system are evaluated on an ad hoc basis but performance would be enhanced if a more systematic evaluation was undertaken.

Part of the intent of this criterion is to ensure that all buildings (and utilities) owned or used by a health care organisation are managed and operated to support a safe health environment. The criterion addresses in a broader sense how the organisation maximises the safety, comfort and needs of the community it serves. The focus of this AC-60 recommendation and the accompanying subservient recommendations is the Barrett Adolescent Centre (BAC) located within The Park - Centre for Mental Health. Many of the patients admitted to the BAC have extensive histories of recurrent, severe self-harm and suicidal behaviours often associated with abuse and trauma. As a statewide service and the only facility capable of providing care for this high acuity group of patients, the BAC does not have a choice about the mix of patients it admits. The surveyors noted that as the redevelopment of The Park site progressed, BAC lost access to other buildings, eg nearby auditorium, high dependency unit and medical centre for the management of patients with eating disorders. This compounded the problems and placed greater strain on the patient accommodation, notably the ward environment.

The level of risk associated with the BAC patient accommodation and treatment areas has been identified over a long period of time, with reviews conducted in 2003-2004 and in 2006. In addition, internal reviews have been instigated following various critical incidents over the period from 2003 to the present time. Evidence in BAC and hospital records demonstrates an increasing level of incidents often associated with serious outcomes for both patients and staff. This has led to a high level of reliance on continuous observation as a patient safety strategy. Recommendations to address the associated staffing issues are included under criterion 2.1.2 in this In-Depth Review report.

Whilst there has been a decision to rebuild the facility, the timeframe for this to occur remains unclear and is reported as not likely to occur for another two or three years.

The current situation needs to be addressed immediately with interim measures to address and mitigate the risks associated with:
1. Requirement for contamination for high acuity patients and to provide for protection from self-harm or harm to others;
2. Accommodating physically fit seriously ill adolescents in a non-purpose built environment which it has been agreed in various reports is entirely unsuitable to their needs.

A further comprehensive review was conducted in March 2007 and a range of improvements recommended, to enable the unit to continue to provide a safe patient and staff environment pending the capital works program to rebuild the facility. This report reiterated the findings of previous reports and could provide a useful basis for addressing the immediate risk issues.

Advanced Completion in 60 Days (AC-60)
An AC-60 was conducted on the following High Priority Recommendations from the In-Depth Review:
Stage 1:
(i) Written confirmation of approval be obtained (with necessary budget allocation) to immediately make the necessary environmental modifications to the Barrett Adolescent Unit to reduce risk to acceptable levels and improve patient and staff safety.
(ii) Documented evidence of approved plans and work schedule for the environmental modifications be provided, with designated timeframes for completion.

Action Taken by Organisation to Address Recommendation
Stage 1:
(i) Written approval with appropriate budget allocation has been obtained for the environmental modifications to Barrett Adolescent Unit to reduce risk and improve patient safety. The environmental modifications include:
* Removal and replacement of glass with Perspex in identified areas of the unit has been completed.
* The front entrance door will be replaced with an aluminium frame and toughened glass. Scope of work has been developed and installation of the new door is to be completed by 05 Dec 08.
* High Dependency Unit (HDU) plans have been drawn up and are progressing through the building approval process. Associated plans are currently being drafted in relation to the under slab, sewerage and drainage services and the ducted air conditioning. Once plans are finalised they will be submitted for approval through Project Services. Fixtures such as lighting, doors, door frames, hinges associated with the project have been ordered. Project scheduled to be completed April/May 2009.

(ii) The evidence of the documented plans and the work schedules of environmental modifications is available from Building and Engineering Maintenance Services. The Park Service Manager and Service Improvement Coordinator also have access to copies of the plans and work schedules. Timeframes for the completion of the environmental modifications project are scheduled to be completed April/May 2009. The scope of work for all of these modifications

outlines the requirements/specifications of the work and the timeframes for the work to be completed.

Stage 2:
(ii) Corporately there has been a decision to relocate Barrett Adolescent Unit to another site. Negotiations are underway for the unit to be relocated and developed at Metro South Health Service District (Redlands). This is supported by documented evidence - "Report of the site evaluation sub-group" Site options paper for the redevelopment of the Barrett Adolescent Centre - October 2008 available through the District Chief Executive Officer's office.
Completion Due By: 15 December 2008
Responsibility: Executive Director Mental Health Service WMSBHSD

Surveyor's Comments
A budget allocation has been made for the temporary works. The design has been completed and final approval is awaited from Council for the plumbing works. In the meantime, some works have been completed and others are underway. Completion of the project is anticipated in April/May 2009. The rating remains at SA pending the completion of the Stage 1 works.

A site for the relocation of the unit has been agreed between the two relevant District Managers. Consultation with stakeholders is to be undertaken in the New Year. Funding is available and the project will proceed to the design stage as soon as the site is confirmed. The surveyors were encouraged by the progress to date.

The Conditional survey team will need to confirm the completion of the temporary building works to address the deficiencies in the building and will need to verify that continuing progress has been made towards the relocation of the facility. If both aspects are confirmed, the High Priority Recommendation can be closed and the criterion re-rated to MA.

Surveyor's Recommendation: **HPR:** Yes

(i) The bathroom 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.

Stage 2 (August 2009)
(i) The immediate works identified in Stage 1 to reduce risk to acceptable levels be completed.
(ii) The rebuilding of the Barrett Adolescent Unit be expedited to enable care and services to be provided for adolescent patients in a purpose-built facility which facilitates a safe health environment and maximises the safety, comfort and needs of the community.

Risk Rating: Extreme

Risk Comments:

The surveyors assessed the risk as in the extreme category (ie likelihood almost certain and consequences high) based on the history of incidents, near misses and root cause analysis investigations, discussions with clinicians working in the unit and observation of the area first-hand by the surveyors from both the in-depth review and organisation-wide survey teams. The rating was subsequently reduced to SA and a high priority recommendation assigned.

IDR Mental Health Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

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

Surveyor's Comments:

Purchasing is a shared service and measures are in place to ensure that the service is responsive to the needs of the mental health service.

Maintenance is undertaken with a strong emphasis on the preventive maintenance program. Plant logs are maintained and equipment is operated in accordance with the manufacturer's specifications. Lifecycle costing is utilised to identify the appropriate timing for equipment replacement. Systems are in place and monitored to ensure the efficient use of utilities. Signage is regularly reviewed and disabled access is provided.

Medical records are archived in a building adjacent to Dawson House known as the Dawson House Annexe and, whilst the building has suitable fire protection, the security of the building is minimal with unprotected windows, and the records are exposed to the sun. Steps should be taken to ensure that these records are stored so as to protect and preserve them.

Surveyor's Recommendation:

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

Surveyor's Comments:

The mental health service has utilised the various Queensland Health policy directives in conjunction with relevant legislation to develop a security management system. Closed circuit television facilities and access control are features of the system, and there is appropriate oversight, direction and evaluation in the management of the security system.

Risk assessments and internal security audits are undertaken and, where necessary, action plans are developed to address issues identified as requiring improvement. Records of mandatory staff training in security issues and aggression minimisation were reviewed, as were records of contractor compliance with requirements for signing in and out when undertaking work on site.

The incident reporting system provides evidence of how security breaches are monitored and addressed and the system is evaluated. Memoranda of agreement have been signed with the police and ambulance services for the management of mental health patients. Evidence of consultation with external agencies through joint service meetings, such as with the police, indicates a mature approach to security management and recognition of the importance of joint efforts in managing security issues.

The security management system is carefully monitored, and feedback from staff indicated a good level of confidence in the ability of the service to guide and assist when required. The responsiveness of the service is also monitored and action is taken promptly and effectively to address any areas requiring improvement.

Surveyor's Recommendation:

Rating Summary

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Clinical				
Criterion	Description	Organisation's self-rating	Surveyor Rating	HPR
Crit. 1.1.1	The assessment system ensures current and ongoing needs of the consumer / patient are identified.	MA	MA	
Crit. 1.1.2	Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.	EA	MA	
Crit. 1.1.3	Consumers / patients are informed of the consent process, understand and provide consent for their health care.	MA	MA	
Crit. 1.1.4	Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.	EA	MA	
Crit. 1.1.5	Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.	MA	MA	
Crit. 1.1.6	Systems for ongoing care of the consumer / patient are coordinated and effective.	N/A		
Crit. 1.1.7	Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.	N/A		
Crit. 1.1.8	The health record ensures comprehensive and accurate information is recorded and used in care delivery.	MA	MA	
Crit. 1.2.1	The community has information on, and access to, health services and care appropriate to its needs.	MA	MA	
Crit. 1.2.2	Access and admission to the system of care is prioritised according to clinical need.	MA	MA	
Crit. 1.3.1	Health care and services are appropriate and delivered in the most appropriate setting.	MA		
Crit. 1.4.1	Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.	N/A		
Crit. 1.5.1	Medications are managed to ensure safe and effective practice.	MA	SA	
Crit. 1.5.2	The infection control system supports safe practice and ensures a safe environment for consumers / patients and health care workers.	N/A		
Crit. 1.5.3	The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy.	N/A		
Crit. 1.5.4	The incidence of falls and fall injuries are minimised through a falls management program.	N/A		
Crit. 1.5.5	The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.	N/A		
Crit. 1.5.6	The organisation ensures that the correct patient receives the correct procedure on the correct site.	N/A		
Crit. 1.6.1	Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service	MA	MA	
Crit. 1.6.2	Consumers / patients are informed of their rights and responsibilities.	MA	MA	
Crit. 1.6.3	The organisation makes provision for consumers / patients from culturally and linguistically diverse backgrounds and consumers / patients with special needs.	MA	MA	

Rating Summary

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Support				
Criterion	Description	Organisation's self-rating	Surveyor Rating	HPR
Crit. 2.1.1	The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.	MA	MA	
Crit. 2.1.2	The integrated organisation-wide risk management policy and system ensure that clinical and corporate risks are identified, minimised and managed.	MA	MA	
Crit. 2.1.3	Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.	MA	MA	
Crit. 2.2.1	Human resources planning supports the organisation's current and future ability to address needs.	MA	MA	
Crit. 2.2.2	The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.	MA	MA	
Crit. 2.2.3	The continuing employment and performance development system ensures the competence of staff and volunteers.	MA	MA	
Crit. 2.2.4	The learning and development system ensures the skill and competence of staff and volunteers.	MA	MA	
Crit. 2.2.5	Employee support systems and workplace relations assist the organisation to achieve its goals.	MA	MA	
Crit. 2.3.1	Records management systems support the collection of information and meet the organisation's needs.	N/A		
Crit. 2.3.2	Information and data management and collection systems are used to help meet the strategic and operational needs of the organisation.	MA	MA	
Crit. 2.3.3	Data and information are used effectively to support and improve care and services.	N/A		
Crit. 2.3.4	The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).	N/A		
Crit. 2.4.1	Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation.	EA	EA	
Crit. 2.5.1	The organisation's research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research	N/A		

Corporate				
Criterion	Description	Organisation's self-rating	Surveyor Rating	HPR
Crit. 3.1.1	The organisation provides quality, safe care through strategic and operational planning and development.	MA	MA	
Crit. 3.1.2	Governance is assisted by formal structures and delegation practices within the organisation.	MA	MA	
Crit. 3.1.3	Processes for credentialing and defining the scope of clinical practice support safe, quality health care.	N/A		
Crit. 3.1.4	External service providers are managed to maximise quality care and service delivery.	N/A		

Rating Summary

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Crit. 3.1.5	Documented corporate and clinical policies assist the organisation to provide quality care.	MA	MA	
Crit. 3.2.1	Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.	MA	SA	Y
Crit. 3.2.2	Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.	MA	MA	
Crit. 3.2.3	Waste and environmental management supports safe practice and a safe environment.	N/A		
Crit. 3.2.4	Emergency and disaster management supports safe practice and a safe environment.	N/A		
Crit. 3.2.5	Security management supports safe practice and a safe environment.	MA	MA	

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.1
Criterion: 1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.

High Priority: No

Recommendation:

(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.

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

High Priority: No

Recommendation:

(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.

Function: Clinical **Standard:** 1.1
Criterion: 1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.

High Priority: No

Recommendation:

(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.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.1
Criterion: 1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.

High Priority: No

Recommendation:

Stage 2 (by August 2009)

(i) The effectiveness of the clinical record audit process implemented be evaluated.
(ii) West Moreton Health District complete an audit to ensure that all mental health services have a clinical record audit system in place and operational.

Function: Clinical **Standard:** 1.5
Criterion: 1.5.1 Medications are managed to ensure safe and effective practice.

High Priority: No

Recommendation:

(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.

Function: Clinical **Standard:** 1.6
Criterion: 1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service

High Priority: No

Recommendation:

(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.

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

High Priority: No

Recommendation:

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.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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.

High Priority: No

Recommendation:

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.

Function: Support **Standard:** 2.1
Criterion: 2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.

High Priority: No

Recommendation:

(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.

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

High Priority: No

Recommendation:

(i) The equity of access of allied health students to current under and post-graduate placements and the impact of inequity on future workplace planning be reviewed.
(ii) An evaluation of the effectiveness and sustainability of the current preceptorship program be undertaken, with a focus on its ability to support students in what is a multidisciplinary service model.

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

High Priority: No

Recommendation:

The District Mental Health Education Service undertake a review of service provision to all sections and disciplines of the mental health sector, develop a plan of action for the delivery of equitable education, and the District review the Mental Health Education Service's resource capacity to deliver.

EXHIBIT 75

WMS.9000.0003.00645

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

High Priority: No

Recommendation:

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.

Function: Corporate **Standard:** 3.2
Criterion: 3.2.1 Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.

High Priority: Yes

Recommendation:

(i) The bathroom 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 ensure that improvements are made as necessary.

Stage 2 (August 2009)
(i) The immediate works identified in Stage 1 to reduce risk to acceptable levels be completed.
(ii) The rebuilding of the Barrett Adolescent Unit be expedited to enable care and services to be provided for adolescent patients in a purpose-built facility which facilitates a safe health environment and maximises the safety, comfort and needs of the community.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: IDR0206.1.2.1
Function: Clinical **Standard:** 1.1
Criterion: 1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.

High Priority: No

Recommendation:

Formal processes be established to ensure that nursing handover (at The Park) occurs in an appropriate manner to facilitate the transition of clinical information which maximises and enhances consumer care.

Action:

ETR:

- Clinical handover completed
- Work Practice Guideline developed on clinical handover
- tool and process for transfer of information from clinical teams to staff developed
- Entry and Discharge processes reviewed
- All processes and tools used in clinical handover reviewed - changes made where necessary relating to content, responsibilities for, and roles
- Project outcomes communicated to all staff.
- Electronic conveying of clinical information between NUMs and After Hours Nurse Manager on daily basis - communication across all shifts in relation to changes to acuity.

Joint policy developed between Ipswich Hospital and The Park for handover of information of patients assessed, treated or discharged at or from Ipswich Hospital and The Park

Completion Due By:

Responsibility:

Organisation Completed:

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

The organisation has demonstrated the establishment of formal processes for nursing handovers.

Recommendation: IDR0206.1.3.1
Function: Clinical **Standard:** 1.1
Criterion: 1.1.2 Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.

High Priority: No

Recommendation:

1. A review of the current (15 desk space) open office plan in the Extended Treatment & Rehabilitation Unit be undertaken, to ensure that there is lockable space for information, appropriate desk allocation and regard for the provision of confidential conversations and/or discussions.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

2. A review of the workspaces at Goodna Community Health be undertaken to ensure that staff and clients are provided the safest environment.

Action:

1. Office space project completed - report finalised.

- 2 additional officers and 1workstation for students operationalised
- Additional computers installed
- Additional furniture obtained
- Additional confidential interview room set aside

2. Review completed of work space for staff at Goodna in conjunction with Goodna Community Health (as per Integrated Mental Health Service (IMHS) Strategic Plan 2006 - 2011) (June 2007 - Service Manager IMHS)

Completion Due By: December 2007

Responsibility: ETR WIG / BU1 Management Committee

Organisation Completed:

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

The organisation has demonstrated completion of review of these facilities with appropriate renovations completed.

Recommendation: IDR0206.1.3.2
Function: Clinical **Standard:** 1.1
Criterion: 1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.

High Priority: No

Recommendation:

Ongoing review be undertaken of the level of seclusion within the Mental Health Service and strategies be implemented to ensure that the service performs at an industry standard based on best practice.

Action:

- Project and research commissioned to review issues related to seclusion use across all clinical programs at The Park. Priority areas in High Security, Medium Secure and Dual Diagnosis. The Park - Seclusion and Restraint Reduction Plan developed (2007).
- Benchmarking of seclusion use included in Statewide Benchmarking of Medium Secure Services.
- Workgroup established in Medium Secure to identify and implement strategies to reduce seclusion use.
- Evaluation project has been established to assess the efficacy of these.
- Beacon site for Prevention and Education of Seclusion and Restraint.
- Policies reviewed

IMHS

- Project Officer (1 day per week)

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

- Seclusion Action Plan
- Participation in clinical collaborative for seclusion and restraint
- Seclusion Committee meets monthly

Completion Due By: Ongoing

Responsibility: Clinical Steering Committee / SERU / Benchmarking

Organisation Completed:

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

The organisation has demonstrated review of its seclusion practices and implemented strategies to reduce usage of seclusion.

Recommendation: IDR0206.1.4.1
Function: Clinical **Standard:** 1.1
Criterion: 1.1.5 Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.

High Priority: No

Recommendation:

The process of completion and delivery of discharge summaries/letters continue to be reviewed and improved.

Action:

IMHS

- Regular audits
- Regular review of clinical indicators,
- Reviewed discharge summary form.

Future improvements - implementation of end of episode summary as part of Consumer Integrated Mental Health Application (CIMHA) standardised forms. Pilot site for statewide electronic discharge summary (Discharge Summary Report)

Completion Due By: December 07

Responsibility: Clinical Director / HIM

Organisation Completed:

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

The organisation has demonstrated review of its process for discharge summaries and has implemented strategies to improve performance in this area.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: IDR0206.2.4.1
Function: Clinical **Standard:** 1.6
Criterion: 1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service

High Priority: No

Recommendation:

1. Formal measures of consumer satisfaction be implemented consistently throughout the mental health services.
2. The level of consumer participation be increased in the Integrated Mental Health Service through the allocation of dedicated resources to ensure consumers and carers have access to similar consumer services regardless of the entry point into services.
3. Consumer participation and representation at The Park have strong links with the establishment of consumer participation practice in the Integrated Mental Health Service.

Action:

1. Integrated Consumer Satisfaction Survey conducted Oct / Nov 07. Action plan being developed from results of survey. Benchmarking between the 2 services. Monthly surveys Inpatient Unit.

3. Consumer Action Plan. Established CCAG. Training Program for Recruitment and Selection for some CAG members. Developed training program for volunteers.

4. Communication strategies and supportive network developed between Consumer Consultant and Liaison Officer and IMHS Consumer Consultant to enable effective information. Quarterly meeting established with District Director MHS, Consumer Services Staff IMHS & The Park, Service Improvement Coordinator The Park. Membership on District MHS committees. Proposal for integration of consumer services (The Park / IMHS) including Consumer & Carer Rep Program and Consumer Consultant and Liaison roles.

Completion Due By: 30/09/2008

Responsibility: Service Improvement Coordinator / Consumer Service

Organisation Completed:

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

The organisation has demonstrated measures for ongoing consumer satisfaction surveys, as well as an increased level of consumer participation and representation within the mental health service.

Recommendation: IDR0206.2.4.2
Function: Clinical **Standard:** 1.6
Criterion: 1.6.2 Consumers / patients are informed of their rights and responsibilities.

High Priority: No

Recommendation:

With the appointment of a consumer position for the Integrated Mental Health Service a similar model be implemented as currently exists at The Park with the ability for consumers to have access to information from consumers on their rights and responsibilities at all points of care.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Action:

Consumer Action Plan. Consumers are informed of their rights and responsibilities initially through their admission pack which contains all Qld Health relevant information as well as other service documentation.
MHU has a special display area with information on Mental Health Act 2000 and the Mental Health Review Tribunal.

Completion Due By: Ongoing

Responsibility: Service Manager / Consumer Consultant

Organisation Completed:

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

The organisation has demonstrated that it has implemented a similar mode of consumer advocates at the integrated mental health service.

Recommendation: IDR0206.2.1.1
Function: Corporate **Standard:** 3.1
Criterion: 3.1.1 The organisation provides quality, safe care through strategic and operational planning and development.

High Priority: No

Recommendation:

1. The Mental Health strategic plans be developed and implemented across sites, with clear review mechanisms in place. To ensure accountability a reporting structure on progress at a District level continue to be developed.
2. There be a clear focus and subsequent articulation on the desired level of integration of services for The Park and the Integrated Mental Health Service.

Action:

1. Strategic and Operational planning complete. Business Planning 2008-09 commenced - incorporated into District Plan.
Organisational Structure and reporting framework reviewed. Amendments made to The Park's governance Document reflecting outcome of review.

2. Mental Health Executive Meeting and Mental Health Service Patient Safety and Quality Committee established.
The DMHES has been established and is progressing the integration of aspects of mental health education, orientation, mandatory training and rotation of graduate placements.

Completion Due By: February 2007

Responsibility: Executive Management

Organisation Completed:

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

The organisation has demonstrated the development and implementation of mental health strategic plans across all sites, and an articulation of the level of integration of services for The Park and integrated mental health service.

EXHIBIT 75

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: IDR0206.2.1.5
Function: Corporate **Standard:** 3.1
Criterion: 3.1.5 Documented corporate and clinical policies assist the organisation to provide quality care.

High Priority: No

Recommendation:

1. Policies and procedures be reviewed to ensure consistency within the Mental Health Services.
2. A system be developed to provide back-up policy and procedure documentation in the event of the electronic system being unavailable.

Action:

1. Policy documents being reviewed and where practicable, to be integrated across mental health services. Review process for development, review and integration of policies completed and implemented.
2. Policy documents in the form of hard copy and CD held by Service Development at The Park. Hard copy access provided to After Hours Nurse Managers. As policy & procedures are endorsed through the review / integration process they are also published to WMSBHSD Intranet site.

Completion Due By: Ongoing

Responsibility: Service Development (TP) / PS&Q Officer (IMHS)

Organisation Completed:

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

The organisation has demonstrated consistency of its policies and procedures within mental health services. There is now a system to provide back-up of policy and procedure documentation to the electronic system.

Recommendation: IDR0206.5.1.1
Function: Corporate **Standard:** 3.2
Criterion: 3.2.1 Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.

High Priority: No

Recommendation:

1. A review of policies / procedures be initiated to more effectively support safe practice and a safe environment at The Park, with appropriate emphasis to be placed in identifying risks and preventing injuries to staff and clients.
2. IMHS staff be regularly reminded of the need to carefully assess and manage clients who are potentially suicidal or who self harm.
3. Management at The Park more strongly support and encourage staff participation in the Workplace Safety Committee.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Action:

1. Policies & Procedures and Work Practice Guidelines continue to be monitored and reviewed in line with National, State and District risk management and child safety guidelines and requirements. Manual Handling (Object Handling) training conducted for all operational and administration staff. (Ongoing - Service Development / WPH&S officer / Business Units)
2. Reviewed handover to review risk. Review processes in clinical reviews. Failure to Attend policy. (Ongoing - Nursing Director)
3. Election of OH&S Representatives across the District. Training provided to newly elected representatives and will be provided continuously. Attendance at meetings has increased. Meetings provide an opportunity for problem solving to occur between experienced members and new members. Flyers identifying OH&S Representatives in areas displayed in all units. (September 2007 - WPH&S Officer / Service Manager)

Completion Due By: September 2007

Responsibility: Service Development / WPH&S Officer / ND / Service

Organisation Completed:

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

The organisation has demonstrated a review of policies and procedures to support safe practice and environment at The Park. The integrated mental health service has developed an assessment process for the management of clients at risk of suicide and self-harm. Staff at The Park have been encouraged to participate in the Workplace Safety Committee.

Recommendation: OWS0206.5.1.2
Function: Corporate **Standard:** 3.2
Criterion: 3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

High Priority: No

Recommendation:

District Management pursue the redevelopment of the Barrett Adolescent Unit at The Park so that care can be provided in a modern facility designed to meet service delivery needs and support safe practice and a safe environment.

Action:

Redevelopment of Barrett Adolescent Unit remains a priority. Funding identified as part of the new Mental Health Plan. User Group established and meeting. Feasibility on location is progressing through the Area Managers. Interim actions undertaken to enhance service delivery include:

- All hanging points identified and rectified.
- Sensory room created.
- Improved quiet room.
- Created a bedroom to suit need of a specialised client.

Identified improvements are prioritised and will progress.

Completion Due By:

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Responsibility:

Organisation Completed:

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

This recommendation has been closed and revised recommendations are included in this report under criterion 3.2.1.

Recommendation: IDR0206.1.1.1
Function: Corporate **Standard:** 3.2
Criterion: 3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

High Priority: No

Recommendation:

Signage at the entrances to The Park be amended to include information on the nearest facility for hospital emergency services.

Action:

Major road works have commenced at both entrances to the facility and redevelopment of the old facility by Qld Police Service (QPS). Erecting / replacing signage at this time would be ill-advised. No progress

Completion Due By:

Responsibility:

Organisation Completed:

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

The signage at The Park has been amended to include information on the nearest facility for hospital emergency services.

Recommendation: OWS0206.5.1.4
Function: Corporate **Standard:** 3.2
Criterion: 3.2.4 Emergency and disaster management supports safe practice and a safe environment.

High Priority: No

Recommendation:

1. Outstanding fire safety works commenced at The Park be completed.
2. The current no smoking policy in residential units at The Park be enforced and any relevant client/staff education be undertaken.

EXHIBIT 75

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Action:

1. Works from the Bourne Report progressing with all required documentation related to amendments to the Fire and Engineering report forwarded for sign off. (Ongoing - Service Manager)
2. Anti-Smoking Legislation reviewed by the Tobacco Use Management Committee. Facility policy reviewed. Nominated smoking areas created in all clinical areas. Staff trained in smoking cessation guidelines. Signage displayed in all areas. NRT implemented for staff and consumers. Inhalers, lozenges and patches available to consumers. Physical environments reviewed in all clinical areas and changes made to conform with policy requirements. Line Manager responsibility for ongoing monitoring and compliance. Smoking included in assessment areas for benchmarking in ETR, Dual Diagnosis, and Medium Secure.

Completion Due By: December 2007

Responsibility: Tobacco Use Management C'tee / Clinical Business U

Organisation Completed:

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

The organisation has demonstrated that The Park fire safety works were completed. Changes have been made to the no smoking policy to ensure compliancy with the policy.

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

West Moreton South Burnett Health Service District

Ipswich, Qld

Organisation code: 71 51 30

Survey date: 18-22 August 2008

Advanced Completion: 15 December 2008

ACHS Accreditation Status: ACCREDITED

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 by a health care organisation, of requirements of national health care 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.

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 (except criterion 1.3.1 which is a developmental criterion)

- 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 need to be implemented but may have only basic systems in place. At this level there will be compliance with legislation and policy that relates to the criterion.

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 very little or no monitoring of outcomes or efforts at continuous improvement.

MA –Moderate Achievement- An MA rating requires that all the elements of LA and SA have been achieved and that efficient systems in collecting relevant outcome data, monitoring, evaluation procedures and methods of improvement are in place.

EA – Extensive Achievement- In the EQuIP 4 program, all the elements in LA, SA and MA must be achieved. Also organisations will be able to demonstrate extensive achievement in a criterion if they satisfy one or more of the following requirements:
• internal or external benchmarking and subsequent system improvement, and / or
• the conduct of research that relates to that particular criterion, and / or
• the implementation of what would be considered to be advanced systems that relate to that criterion, and / or
• proven, excellent outcomes in that particular criterion.
Some organisations may be able to demonstrate achievement in more than one of these elements.

OA- Outstanding Achievement- The 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 that organisation is the best in Australia. It may mean that the organisation can demonstrate that it is one of the best or is outstanding amongst its peers.

Developmental Criterion (1.3.1) -
A developmental criterion is one that the ACHS has introduced to organisations for the purpose of creating awareness and for commencing collaborative national action in a specific area of health care. There is one developmental criterion that has been introduced in EQuIP 4 – criterion 1.3.1 - Health care and services are appropriate and delivered in the most appropriate setting.
When a developmental criterion is introduced:
• organisations will work towards achieving the elements of the criterion
• progress towards achievement of the criterion will be discussed during survey but will not be taken into account when determining the accreditation status of the organisation
• a progressive evaluation of the implementation of the standard / criterion will be undertaken by the ACHS

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)-
These are applied to a particular criterion where
• 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 High Priority Recommendation. A HPR 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:
The criterion numbering relates to the month and year of survey and the criterion number. For example recommendation number OWS 0106.1.1.1 is a recommendation from an OWS conducted in January 2006 with a criterion number of 1.1.1

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.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

FUNCTION SUMMARY: CLINICAL

It was pleasing to note the steady improvement and standardisation of practice developing across the District since the previous EQuIP event. In particular, considerable resources and attention have been provided to the rural facilities, with resultant improvements in care systems and outcomes emerging in data to support anecdotal feedback by patients and staff. Examples include the extensive efforts to improve and standardise practice and equipment in rural emergency departments, improvements in clinical consultation and transfer processes between rural sites and Ipswich Emergency Department, moves to provide digital imaging facilities allowing consultation and reporting, investment in education, commencement of the Rural Rehabilitation Team, allocation of patient safety and quality resource personnel to all sites and clinical units, and the progressive roll out of best practice strategies across all sites.

Patient care is core business, and there is widespread evidence of improvements in patient risk assessment, documentation of care plans and care delivery, and early identification of discharge needs. Improvements are also noted in handover practice and communication strategies using the S (situation) B (background) A (assessment) R (recommendation) model, SBAR, which could be applied in many other settings to good effect. Increasing multidisciplinary case review is enhancing appropriate and timely management, with increasing use of information technology solutions such as "the Hub" at Laidley as a practical approach for rural facilities. Specific comments and recommendations have been made under each criterion.

Referrals are prioritised to ensure that clinical needs are addressed in an appropriate and timely manner. This is most evident by the changes to the processing of referrals to the Outpatient Clinics at Ipswich Hospital with resultant good outcomes. Referral links from the rural hospitals to Ipswich Hospital have consolidated.

Evidence-based pathways, such as the venous thromboembolism prevention program and the ‘Liverpool Care Pathway’ for palliative care, have been implemented. The introduction of the “Transforming Care at the Bedside” model of care has seen benefits for patients and staff at Ipswich Hospital. This model of care has attracted widespread interest throughout Australia.

Systems are in place to ensure that timely and safe discharge/transfer of patients occurs across the organisation. Discharge planning is commenced on admission and strong interdisciplinary teamwork exists to support patients who may be at risk of delayed discharge or unplanned readmission. Ipswich Hospital manages the Hand to Home program, which is active within both inpatient areas and in the community. The smaller sites utilise multidisciplinary staff effectively within resource allocation. Systems are in place to promote effective liaison with external services. A range of evaluative methods is used across the organisation, appropriate to various sites.

Support of patients with chronic illness is provided through a range of programs and services. There are established processes for referrals to and liaison with multiple external service providers. Programs for education and ongoing support for people with chronic illness are well established in each site. It is noted that the incidence of severe chronic disease is significant within some communities and teams, such as the community health team at Cherbourg, are commended for their efforts to increase uptake of programs by enhancing accessibility of services. Active participation from the local communities is encouraged by the hospitals, and the self-management of the consumer group by members of the local community at Laidley Hospital is an example of a sustainable support service for people with chronic disease.

The organisation provides for the needs of dying patients by providing appropriate environments for their care. Ipswich Hospital has an in-patient palliative care unit, and also provides an outreach service for those wishing to remain at home. The service also conducts outpatient clinics and consultancy service for patients in the District and at the local private hospice. Weekly case conferencing occurs, as well as monthly interagency meetings with the local private hospice and non-government agencies such as Blue Care. Rural hospitals have sought to dedicate special rooms for similar care in their centres so as to ensure the privacy and comfort of the patient and family. Cultural needs are also assisted in a supportive manner where possible. Of special note was the assistance to the indigenous community of Cherbourg in performing the ‘smoking ceremony’ for their deceased community members. There is excellent education for staff, and evaluation of client management occurs.

Clinical documentation improvements have resulted from regular auditing of patient record and discharge plan content and ongoing education of clinicians through a range of initiatives, such as coders attending grand rounds and meeting regularly with nurses and allied health staff.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.1
Criterion: 1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.

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

Surveyor's Comments:

Improvements have been made based on evaluation of the relevance and compliance with assessment tools in a wide variety of settings. Particular improvements have been made in the assessment of risk, with widespread use of multidisciplinary meetings to discuss clinical and discharge risk issues and new document tools are about to be implemented to consolidate this. At Ipswich the Medical Assessment and Planning Unit (MAPU) is demonstrating dramatic improvements in the quality and timeliness of assessment of medical patients presenting to the Emergency Department. The involvement of pharmacists at Ipswich and via telemedicine discussions at Laidley has improved the range of inputs to needs and risk assessment. Nutrition needs assessment is expanding across the service and access to allied health skills for assessment has improved, with the development of the Rural Rehabilitation Team and some successes with local recruitment, though efforts continue. The Fit for Surgery Program provided by physiotherapy at Ipswich is offering alternative and interim treatment based on best practice assessments, with demonstrated improved outcomes for patients.

Operating theatres review reasons for cancellations, including health condition factors, thus providing solid evaluation and feedback to clinicians of the adequacy of elective surgical patient assessment. Improved handover practices at Ipswich include a requirement to review the adequacy of nurse assessment at appropriate change of shift intervals relevant to the particular ward setting. All rural sites reported the great assistance that is now available for medical officers when they contact the senior medical officer on duty in the Emergency Department at Ipswich to assist with clinical assessment issues. Nevertheless, several doctors were unaware of the on-line evidence-based simple assessment flow charts for common presentations (eg chest pain, common paediatric presentations) except at Boonah where the wider experience of emergency medicine makes this readily known amongst the group. It is suggested that some of these one page guides might be printed and laminated for quick reference. This issue is particularly important for the inexperienced junior medical officers who rotate with minimal direct orientation and supervision of their assessments, except when they initiate support via telephone to Ipswich. This matter is further discussed under criterion 2.2.3 and is the subject of a recommendation.

Despite the availability of adequate current assessment document tools, compliance with completion is patchy, especially at Ipswich, Kingaroy and in mental health services (see separate report).

At the rural hospitals, decisions about admission and transfer are largely based on clinical judgement about the self-assessed capacity of those on duty at the time of presentation. The government's Service Capability Framework is available but unwieldy for quick reference and not specific to individual site resource availability on a day to day basis. This poses some risks for patients and challenges for staff on successive shifts, as well as occasional debate with receiving registrars at Ipswich.

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

(i) Compliance with the use of assessment documentation tools be improved.
(ii) Clearly documented, practical, easy reference admission and exclusion criteria be developed for each rural facility based on the site capability framework, so that front line staff can make consistent timely decisions about transfer out and that tertiary acceptance is more transparent.

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.

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

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

Surveyor's Comments:

Multidisciplinary meetings are held with varying frequency at most sites and in most departments, with key decisions documented in the patient record as well as some teams documenting group issues for further service development. These activities have increased across the service and represent an important improvement for care planning and delivery that needs to continue to expand. There are still deficiencies in access to on-site pharmacists in rural settings in order to oversee nurse and doctor clinical decision making and practice, and this is further discussed at criterion 1.5.1.

Although the use of evidence-based clinical pathways is still variable and little use is made of variance data, there is increasing implementation, both at Ipswich and at the peripheral sites, or reference to these as a guide for care planning and delivery. In general medicine, staff anticipated that implementation of pathways will improve accountability and evidence-based practice for common conditions, as well as assist legibility and consistency of documentation. Future evaluation will decide this. *Trend-care* is now widespread across the health service and being used to better match appropriate skill mix of nursing resources, with reports of actualisation demonstrating improvement across all shifts. In Oral Health there are regular evaluations of adequacy of content and documentation of care plans, and clinical coders also do this at rural and Ipswich Hospitals.

Tools are expanding for rural emergency departments to access best practice clinical guidelines consistently across the District. Refer to comments under criterion 1.1.1 about the need to make these readily available, especially to junior doctors and locums. Mechanisms for tracking changes in health status include a mapping tool seen at Boonah to track changes between admissions for recurrent patients and the use of the bedside handover model at Ipswich. It is suggested that clinical champions from Boonah and Ipswich, respectively, might assist to implement these widely, especially in the rural facilities. The data from the i-stat machines is being used, for example, at Laidley, where readily available reports track the links between blood results, eg troponin levels, and disposition of the patient which thus monitors implementation of best practice clinical guidelines. Improvements in access to allied health and uptake by some staff of training for flexible roles are improving the diversity of skills available to deliver patient care. The commitment of increased resources for nurse educators at rural sites is also enhancing skills, with a focus on core competency assessment and training. There is evidence of consumer participation and provision of information about care in patient satisfaction data, such as the Queensland patient satisfaction survey of 2005, which provides good performance on benchmarked data with the latest report of 2007 data currently awaited. The telephone follow-up of all surgical patients at Ipswich Hospital (not just day procedure as is typical elsewhere) is a remarkable effort to evaluate individual care, and improvements in systems have occurred as a result.

There are an increasing number of x-rays remaining unreported at Ipswich (around 20% currently) and Kingaroy (only reported by special request which is less than 5%). This poses some risk to the adequacy of care planning and its evaluation.

When patients are transferred to Ipswich from rural sites, there is no routine feedback to the sending clinicians unless they endeavour to pursue this themselves, which can be difficult. Consequently the evaluation of their care planning and immediate care delivery for the most at risk patients is greatly restricted, unless the patient returns to a local general practitioner or re-presents to hospital.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

(i) All x-rays be reported for safe patient care and quality assurance.
(ii) Routine feedback be provided to rural hospitals regarding outcomes of care when patients are referred to Ipswich.

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.

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

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

Surveyor's Comments:

There are appropriate policies and processes for consent for procedures/treatment, financial aspects and release of information. Various evaluation methods include patient satisfaction in relation to privacy and treatment information provision, participation in a statewide prospective audit of surgical consent and in-house record audits. A quality improvement activity reviewed at survey demonstrated a significant improvement in specific informed consent for epidural anaesthesia. There is a developing culture of consistent use of evidence-based risk information specific to each procedure in consent documents issued by Queensland Health. These documents include a statement that the procedure/treatment "may include transfusion" and the policy is to delete this if applicable to the consent of an individual. However, consistent with best practice regarding the use of blood products, a separate and specific consent for transfusion has been recently developed and is about to be implemented (refer also criterion 1.5.5). A Queensland Health policy document regarding invasive procedures provides that consent should be gained at least 24 hours prior to surgical procedures, unless an emergency situation requires otherwise. Consequently local improvements have been made to create a zero tolerance culture for "corridor consent" and audits are undertaken against the policy.

Although it was confirmed that the checks in place have resulted in 100% documentation of informed consent by the time a procedure is actually undertaken, a significant number of procedures do not achieve the organisational policy goal of being in place at least 24 hours prior to surgery (up to 28% in a survey covering two weeks from 23rd July) and this includes a number of cases that were booked elective procedures. There may be individual clinician practices that contribute to this result, with the correct process being undertaken in doctors' rooms, but delay in provision of the document to the hospital impairs the opportunity to confirm that consent is valid and correct and this poses some risk of last minute cancellation of the procedure if a patient is not adequately informed, a mistake has been made in the document, or perhaps the patient has a change of mind and needs time for further discussion.

At the Brisbane Youth Detention Centre, clinicians expressed a conflict with usual professional standards in relation to the gaining of consent from minors for immunisation procedures. This situation involves specific legal circumstances and public health imperatives that may outweigh the standard patient rights issues, so it is suggested that this be explored and staff can then respond accordingly.

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

Consistent with Queensland Health policy and based on best practice, the timeliness of provision of documented informed consent be improved for all elective invasive procedures so that it is available for further discussion and confirmation, either at the pre-admission clinic or on admission (as appropriate to the particular patient journey).

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.1
Criterion: 1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.

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

Surveyor's Comments:

There is considerable evidence of evaluation of individual care and increasing evidence of the use of aggregated outcome evaluation which can be used to improve systems of care. Use has been made of patient satisfaction data to monitor and improve outcomes. Coders review record content and at Ipswich also attend grand rounds to exchange information with clinical staff. Incident data is analysed and aggregated with opportunities for learning distributed across the District. Compliments and complaints are widely used as a measure of outcome evaluation. High risk indicators (falls, pressure ulcers, medication incidents, infections in general, urinary tract infections, for example) are collated and analysed to varying extents across the sites according to the frequency of such events. Specific units and projects are comprehensively evaluated including the Fit for Surgery physiotherapy program in orthopaedics, the VTE project, palliative care management, rehabilitation goals achievement, special care nursery infant outcomes, midwifery care outcomes, MAPU case review, to name but a few.

All deaths are centrally reviewed, and feedback is given about opportunities to improve care or regarding further in-depth review of potential preventable deaths. Patient Safety and Quality Officers are now assigned to every facility and clinical unit, providing a valuable resource that is independent and provides advice about possible trends or broad system opportunities for improvement. There is variable multidisciplinary participation, particularly by doctors, across the rural sites and some meetings are recently begun or have lapsed for periods of time. Minutes of these meetings do not generally reflect sound analytical discussion with decisions about strategies to improve, and it is suggested that this be a focus of structure and effort for the clinical risk meetings. The meetings typically discuss incidents, readmissions, clinical indicators and complaints. Many rural sites could also benefit by the participation of a pharmacist in these clinical risk meetings, perhaps by teleconference (refer comments at criterion 1.5.1).

Departmental mortality and morbidity meetings at Ipswich are at various stages of evolution and have varying practices of transparency, which may impede participation and organisational improvement. It is suggested that heads of departments explore practice elsewhere at similar large facilities where it is common practice to have well documented, multidisciplinary robust discussion that leads to improvement without clinician defensiveness about indemnity issues or other barriers. A standard model could be considered as organisational policy based on appropriate professional advice of medical colleges and respected peers.

It was noted in action-based minutes that there are frequent occasions of issues being referred to clinical heads of units/departments by the Patient Safety and Quality Officers, which either receive no response or there is a lengthy delay in response. Further efforts in relation to clarifying accountability of heads of departments in relation to clinical governance matters could also be considered, as part of the proposed performance review system for medical staff as discussed under criterion 3.1.3.

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

(i) The analysis of aggregated data concerning outcomes of care be strengthened and the participation by medical officers in multidisciplinary review be increased, so that there is more effective development of strategies to improve patient outcomes.
(ii) A simple system for tracking the timeliness of Clinical Unit Director response to clinical indicator queries and other matters forwarded by the Patient Safety and Quality Unit be developed, with reporting at District safety and quality meetings where delays or failure to respond have occurred, so that appropriate clinical governance can be assured.

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.

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

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

Surveyor's Comments:

Policy, procedure and guidelines relating to discharge planning exist across the organisation. The survey team also noted the commitment by the clinical staff to the early identification of day of discharge and to the management of risk of delayed discharge. A range of evaluation strategies is utilised, including medical record audits of the content of discharge and medication summaries. Unplanned readmission rates are reviewed at Ipswich Hospital and at the smaller rural sites; review of individual cases of unplanned readmissions occurs.

A strong culture of interdisciplinary team work is evident across all sites within the limitations of available resources. Under the auspices of the Hand to Home program, Ipswich Hospital has consolidated a range of resources dedicated to discharge support to realign the acute hospital/community interface. Screening occurs in the Emergency Department at Ipswich to identify patients at risk of discharge delay and to prevent avoidable admissions. Admitted patients are then followed up on the wards by staff from the Hand to Home program, to enhance the coordinated approach to discharge in collaboration with hospital staff.

Liaison with a wide range of community, respite and support programs occurs including general practitioners, general practice nurses, Blue Care, Meals on Wheels, non-government organisations and local councils. Feedback from these agencies about the effectiveness of liaison is obtained through various mechanisms, much of this being informal comment. Follow up of at risk day surgery patients occurs per telephone, and written protocols have been developed for discharge requirements such as voiding and for discharge analgesia. The effectiveness of the patient and carer education system is largely evaluated through follow-up of individual patient compliance with treatment plans. Review of the level of formal evaluation systems and formal follow-up of improvement actions would be useful in each site to further enhance systems.

Other examples of excellent discharge initiatives include the use of local planning and flow charts, assessment for discharge, referral processes to community agencies and the range of options for post-acute care at Wondai and Kingaroy, the early discharge home or transfer to rural sites of post- natal patients from Ipswich, and the effective use of interdisciplinary teamwork at Boonah, Laidley and Esk. The Rural Rehabilitation Team also works in collaboration with the rural sites and participates in case conferences for complex patients.

However, it was noted at the rural sites of Boonah, Laidley and Esk that, whilst admission and exclusion criteria exist to guide procedures around transfers to Ipswich Hospital and acceptance of transfers from Ipswich Hospital, significant negotiation and debate about the appropriateness of transfers have been required at times. This lack of clarity has the potential to compromise patient safety. A recommendation has been made under criterion 1.1.1 in relation to the development of admission and exclusion criteria for rural sites, which is agreed to and well understood by all parties. Achievement of consistent criteria will enhance and streamline the patient transfer processes.

The potential for further learning within the rural sites exists in relation to clinical judgement of the need to transfer patients from rural sites to Ipswich Hospital. Valuable feedback could be derived if formal mechanisms are established to ensure that information is provided by Ipswich to the rural sites about the appropriateness of transfers, and/or the clinical outcomes of patients who are transferred to Ipswich. A recommendation has been made under criterion 1.1.2 in relation to this issue.

Surveyor's Recommendation:

EXHIBIT 75

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

Surveyor's Comments:

Systems for ongoing care facilitate the support of patients with chronic illness. There are established processes for referrals to and liaison with multiple service providers, including general practitioners, Blue Care, non-government organisations, local government, aged care facilities, and other community providers.

Programs for education and ongoing support for people with diabetes and other chronic conditions are available locally across the organisation. For example, diabetes and heart failure programs are available at Laidley where previously patients had to travel to Ipswich. A significant focus on community awareness of services now available at Esk has resulted in increased referrals from the general practitioner of people with diabetes to the hospital, to access diabetes education programs. Ipswich Hospital, in liaison with local government, facilitates enhanced transport options to services through the provision of a shuttle bus from a car park situated some way from the hospital. Increased geriatrician support at Ipswich has enabled an enhanced support service to local general practitioners for care of the older person.

The community health team at Cherbourg is actively exploring ways to increase uptake of programs by delivering services in an accessible manner, and minimising the need for patient travel. It is noted that the incidence of severe chronic disease is significant within this community, and the survey team encourages the continued analysis of workload indicators to support business case requirements for future resourcing of services.

Readmission rates associated with chronic disease are reviewed at Ipswich Hospital, while the smaller rural sites are able to identify individuals who re-present frequently and review of care through interdisciplinary case conferencing occurs with these specific patients. Case studies indicate success in admission prevention for this group of patients in the rural areas.

Other examples of programs and practices observed which contribute to the ongoing care of patients with chronic illness include:-
* Chronic Disease Service at Ipswich Hospital including programs for congestive heart failure, lung health and diabetes;
* Collaborative program between Ipswich Hospital and the Division of General Practice's "Better Health Diabetes";
* Chronic disease programs at Boonah, such as the "Lighten Up" healthy eating program for diabetes;
* Living with Cancer Program at Laidley;
* Proactive approach at Kingaroy to identify geographic areas of high need for post-natal support;
* Diabetes education at Cherbourg;
*Collaborative approach at Kingaroy with non-government organisatons and local government to establish respite programs.

Surveyor's Recommendation:

EXHIBIT 75

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.1
Criterion: 1.1.7 Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.

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

Surveyor's Comments:

The health service has in place policies and procedures which provide guidance to staff in managing end of life care and the management of the deceased patient. These guidelines are available both on the intranet and in hard copy. Ipswich Hospital has a ten bed Palliative Care Unit and a comprehensive palliative care service led by a palliative care physician. This service also conducts outpatient clinics and has an outreach component so that patients wishing to die at home are afforded this opportunity, either by staff of the health service or contracted out to other agencies, as they do at Esk. Rural hospitals in the District have dedicated patient rooms for palliative and dying patients, which provide for privacy, family involvement and comfort. The health service is congratulated on this initiative to ensure that all health services have an appropriate space to allow for dying with dignity. At Cherbourg Hospital the cultural needs of the indigenous people are respected, which allows them to perform their cultural practices for end of life situations. Many of the site facilities have active volunteer groups which donate furniture and equipment for these special rooms.

Education for staff involved in caring for end-stage of life situations is ongoing practice. The palliative care physician is very active in providing workshops and in-service for multidisciplinary staff on the subject of palliative care and its management. Nursing is also very proactive in this regard, with membership of palliative care networks and associations. There is a comprehensive induction program for staff when they join the ward team. Support processes to assist staff and carers are undertaken where possible, however, due to resource issues, referral to bereavement and counselling services outside the health service needs to be undertaken.

The in-patient unit at Ipswich has implemented a modified version of the Liverpool Clinical Care Pathway for palliative care patients. The whole team, including family, has to agree to the patient being placed on this pathway, and then information from this pathway is submitted for evaluation to the national palliative care data collection collaborative. Performance indicator data reports comparing to national average data submitted is then returned to the centre for quality improvement action if necessary. Documentation audits are undertaken in relation to variance with the pathway, care documentation and medication administration. Case conference occurs weekly with all members of the multidisciplinary team having input, and a monthly inter-agency meeting occurs. The unit takes part in clinical studies and is currently enrolled in pancreatic and medication use studies.

There is a statutory obligation in Queensland requiring all deaths to be audited by health facilities and data submitted to the Health Quality and Complaints Commission (HQCC). This process is both a learning tool and monitoring methodology to ensure that improvement in care can be detected. At Ipswich the palliative care physician audits death in the clinical unit. Peer review may be a more objective way of reviewing the case management.

Surveyor's Recommendation:

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.1
Criterion: 1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.

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

Surveyor's Comments:

The quality of the content of patient records in areas other than mental health has improved following greater use of some excellent audit tools, and the monitoring of outcomes of audits. Performance improvement is being monitored through the use of benchmarks and indicators. Audits of care plan and discharge plan content have been carried out across the District, which now includes the former South Burnett District. The data trends presented were (in most instances) across two to three years and in many indicators showed considerable improvement during that time, as a consequence of improving practices and ongoing education of both staff and clinicians.This criterion is to ensure that medical records are maintained appropriately, so that the information kept within them is comprehensive and accurate. The organisation needs to have processes in place that ensure that this comprehensiveness and accuracy is occurring. Without accurate and comprehensive information, there is the risk that the organisation will not be able to provide appropriate care. In terms of The Park, the organisation has no systematic auditing process to help determine that the medical record content is sufficiently detailed to allow care delivery to be tracked, monitored and evaluated.

It was noted that in audits of mental health records, the trended data provided evidence of continued poor compliance with identification of 'at risk' clients and other information required to improve the safety of both staff and clients.

Advanced Completion in 60 Days (AC-60)
An AC-60 was conducted on the following recommendations from the In-Depth Review:
(i) The Park Campus develop a system for reporting the results of clinical record audits to clinical teams.
(ii) The Park Campus develop a system for reviewing any trends discovered from the clinical record audit and a plan be developed for improving performance in identified areas.
(iii) All mental health programs implement an audit of the quality of clinical notes for each clinical discipline.

Action Taken by Organisation to Address Recommendation
(i) The Park has reviewed the established audit processes and tools to ensure a linking system is in place for the collection of data. A system for reporting the findings/recommendations of the clinical chart audits has been developed and formalised in the following clinical chart audits:
* Health Information Service - Area Administrative Officer Clinical Chart Audit. Compliance of the audit looks at the administrative components of the medical record.
* Clinical Programs - Clinical Chart Audit. To ensure that clinicians, by discipline, comply with facility policy and professional standards regarding clinical charts.
* Clinical Initiatives - Care Plan Audit. Compliance of the audit measures the Individual Care Plan in the Medical Record.
* Medical Services - Limited Community Treatment Audit. Compliance with Mental Health Act 2000 and other legislation and standards.

All clinical chart audits have had proposals documented which outline the scope and procedure of work for each clinical chart audit. Documentation includes proposal, audit tool, flowchart, audit report and action plans.

(ii) A flowchart incorporating each clinical chart audit has been developed for The Park that links audit tools and outlines the process for reviewing any trends or patterns identified in the findings of each audit. This also incorporates the flow of communication and feedback from and to Executive and the clinical teams.

(iii) The Park - An audit of the quality of clinical notes has been implemented for each discipline. This can be evidenced through the proposal, flowchart, findings and audit summary report for the clinical chart audit.

IMHS - Audit reports are tabled at Executive meetings and findings/recommendations are referred to the appropriate discipline team leader.

Completion Due By:15 December 2008

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Responsibility: Health Information Manager

Surveyor's Comments
Having reviewed the range of audit processes in place, the service has developed a flow chart which demonstrates the flow of communications to appropriate clinical staff and committees, to ensure that the results of audits are communicated and acted upon. There is a process in place for escalation to the Executive Committee in the event that action is inadequate or unsuccessful.

The surveyors are confident that the processes in place will now address the shortcomings identified during the In-Depth Review.

The Conditional Survey team will need to confirm that the changes have been sustained, and this process will be facilitated if the District develops and collects some relevant performance indicators to demonstrate the effectiveness and sustainability of the changes.

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

Mental Health

Stage 2 (by August 2009)
(i) The effectiveness of the clinical record audit process implemented be evaluated.
(ii) West Moreton Health District complete an audit to ensure that all mental health services have a clinical record audit system in place and operational.

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

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

Surveyor's Comments:

A Health Service Plan 2007-2012 has been prepared addressing the strategic approach to clinical and community services planning, with a clear path forward for service development.

Surveyor's Recommendation:

Function: Clinical **Standard:** 1.2
Criterion: 1.2.2 Access and admission to the system of care is prioritised according to clinical need.

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

Surveyor's Comments:

The establishment of the Outpatient Central Referral Centre at Ipswich Hospital has enhanced patient access to the appropriate clinics. Bookings are prioritised with the relevant clinician. Other strategies adopted include:

1. the establishment of a fast track endoscopy service;
2. the consolidation of the Orthopaedic Physiotherapy Screening Clinic;
3. the establishment by Podiatry of a high risk foot clinic for diabetic patients;
4. the establishment of the Podiatry Screening Clinic and case management of patients by podiatry services, reducing waiting times at the orthopaedic clinic from six months to four weeks;

5, intervention of babies with permanent hearing loss;
6. the assessment and subsequent streaming of antenatal patients, which has identified low risk obstetric patients suitable to be managed by the Midwifery Group Practice model of care;
7. the transfer of the management of patients with Type 2 diabetes to the community;
8. referrals to local optometrists to perform retinopathy screening for diabetic patients.

There has been a resultant reduction in the waiting lists, notably those who had had to wait longer than 12 months, particularly with the Faciomaxillary Clinic. Category One patients are seen usually within two weeks. The “failure to attend” rate has reduced. Waiting list audits are regularly performed to monitor the situation. Referral guidelines are being developed to expedite the prioritisation and appropriate access of patients to the relevant clinics. These strategies are commended.

Rural hospitals have implemented a series of improvements in response to recommendations from the State Coroner elsewhere in the Southern Area. This includes the adoption of and training in triage categorisation of emergency presentations that is best practice in emergency medicine. Also, systems have been set up to facilitate communication between doctors in the rural hospitals and the senior medical officer on duty in the Emergency Department at Ipswich Hospital, greatly improving the decision making and timeliness about transfers based on clinical need.

Recently there has been an extension of the clinic wait times involving the Child and Family Health Service (CAFHS) Young People’s Health Team outreach service affecting the timely review of young mothers and babies identified as ‘at risk’ due to domestic or financial risk, or maternal mood. The Day Stay Centre is experiencing increasing demand. The Occupational Therapy Service is ranked 10/16 of participating hospitals in reviewing stroke patients within 48 hours of admission.

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

A review of the staffing/resource levels be undertaken and strategies implemented to address the waiting times involved with the outreach service provided by the Child and Family Health Service Young People’s Health Team, Day Stay Centre and Occupational Therapy Service.

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:**

Surveyor's Comments:

Queensland Health has determined the role and function of its hospitals and the District operates within those parameters, ensuring that appropriate skills are maintained for each role, and that patients are treated in the most appropriate setting.

This criterion is an ACHS developmental criterion. Therefore, a surveyor rating is not applied to this criterion.

Surveyor's Recommendation:

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

Surveyor's Comments:

There is widespread evidence that Ipswich Hospital has implemented evidence-based care. Examples include the implementation of the venous thromboembolism prevention program hospital-wide, and adoption of the "Liverpool Care Pathway" by the Palliative Care Unit. There is evidence that some of the care pathways have been evaluated.

The adoption of "Transforming Care at the Bedside" model of care by the Medical Business Unit at Ipswich Hospital has resulted in positive outcomes. These include discharge efficiencies with a reduction of patient outliers. There has been a reduction of complaints. Staff satisfaction rates have increased. Staff vacancies have been reduced from 45 full-time equivalents in 2006 to zero in 2008.

The establishment and consolidation of the Orthopaedic Physiotherapy Screening Clinic has seen selective patients being appropriately managed non-operatively, reducing the load on the orthopaedic service. This model of service is being adopted by other institutions in Queensland. Such an initiative is commended.

Surveyor's Recommendation:

Function: Clinical **Standard:** 1.5
Criterion: 1.5.1 Medications are managed to ensure safe and effective practice.

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

Surveyor's Comments:

It was noted that medication error minimisation systems, as proposed nationally, were in place in all facilities in the District using tools such as competencies assessment and reporting of errors in a non- threatening manner.

It was identified that there was a reporting/notification format through to the District Director of Pharmacy level, who reports on issues involving pharmacy and medication management. In each facility, reporting through PRIME, incident reporting on such issues as medication error rates, adverse reaction rates, errors in prescribing along with results of medication audits, provided valuable information on incidents and near-misses. At the time the PRIME reporting audit revealed a plateau in reporting, the focus on observational audits to monitor correct medication administration was introduced. The observational audits are based on the national handwashing audit tool which had been so successful.

Clinical risk management meetings were found to have matters relating to medication management on the agenda and action was taken to address issues raised.

Some examples of creative ways of safely managing medication administration in the ward areas at Ipswich were:
• Introduction of medication safety vests with the intention that on a medication round the administrator of medications was not to be disturbed;
• Door signage on the dangerous drug cupboard door indicating a count was in progress and not to enter.

The national medication chart has been introduced and audits of compliance identified some areas of non-compliance in low risk areas of the chart only. These charts are on a continuing review program. In the area of dispensing at Ipswich, as a result of the employment of additional staff in the pharmacy department, efficiency in the time to dispense discharge medications was noted.

Access to mobile lap tops in the ward areas, especially in the medical business unit, has enhanced the service delivery. Access to electronic MIMS and guidelines for administration was found to be available in each area to ensure compliance with policy. The satellite pharmacy had created efficiencies, and standardised stock on shelf in all areas so as to minimise errors was noted as a significant risk minimisation initiative.

Drug calculation scenarios and self-directed learning packages provided evidence that every effort had been made to assist in accuracy of administration and medication management. Medication charts at Ipswich were found to be reviewed and improvements made as a result of audit findings. Errors, near misses and adverse drug reaction analyses and trending were also attended. The distribution of medications at Ipswich was managed by pharmacy and the service was evaluated and improved as required. The same could not be guaranteed in other hospitals of the District. Recommendations will be made to assist in overcoming this obvious deficit in the system.

In the smaller rural facilities the pharmacy is managed by nursing staff and there is a need for pharmacy support visits to each site to monitor operations, including stock control, and to audit the integrity of the discharge medication processes and record keeping. Drug refrigerators in rural facilities were not routinely fitted with alarms to identify loss of temperature.

At Kingaroy, it was apparent that the process for the administration and ongoing clinical management of patients on opioid maintenance, such as methadone and buprenorphine, could be enhanced with advice from Pharmacy and Alcohol, Tobacco and Other Drug Services (ATODS). Medication management in some of the mental health units was noted as less than ideal and this is addressed in the Mental Health In-depth Review Report.

This criterion is to ensure that medication practices are in place to ensure safe and effective practice. In terms of The Park, the organisation has no systematic auditing process to help determine that medication is managed safely and effectively. An audit of medications in the service is generally conducted only once a year. Additionally, the pharmacists on campus have little time to provide clinical pharmacy services on the ward, such as attending ward rounds or providing education to consumers or their carers.

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

(i) A pharmacy consulting service be provided to those rural facilities without a pharmacist and where the pharmacy service is provided by nursing staff.
(ii) The system for reviewing medication incidents and management practices be enhanced to ensure that there is always feedback to staff on outcomes of the reviews.
(iii) Specialist advice on appropriate protocols for the administration and ongoing clinical management of patients on opioid maintenance at Kingaroy be sought from Pharmacy or Alcohol, Tobacco and Other Drug Services.
(iv) Drug refrigerators be fitted with alarms to identify loss of temperature.

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.

Risk Rating: Moderate

Risk Comments:

There is a moderate risk to patients in the absence of a robust audit of medication management.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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 health care workers.

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

Surveyor's Comments:

The Infection Control District Management Plan Version 2.0 (August 2007) is based on the State plan and provides the overarching standard for the infection control program. The infection control program was guided by policy available on the hospital intranet site with the usage yet to be ascertained, although through communication with staff over the period of the survey, the survey team was reassured that staff did and could access the intranet site easily.

The change from controlling infections to prevention was the focus of the staff driving the program and they were supported by management as all recognised that where prevention is not possible, infections are managed effectively.

The District infection control program has support provided from the team at Ipswich Hospital with link staff on outlying sites. This team guides infection control management, conducts consultancies as required, evaluates clinical practice, provides surveillance and education (including ICMP), updates the infection control manual, oversees and monitors the business planning, is in charge of the annual reporting, the intranet update, and staff health (flu vaccination and MMR offer). Team meetings are held weekly for information sharing and networking.

There is effective management of patients with multi-resistant organisms so as to have minimal transmission or infections at Ipswich, with accommodation provided in the isolation area. The protocol for MRSA swabbing each Tuesday on the surgical ward was reported as effective in minimisation of the spread of infection, and the policy for the management of patients with MRSA on admission was mandatory.

There was evidence of a program available for the prompt and effective management of infectious outbreaks.

Pandemic influenza training occurs for all staff, with pre-reading and a video provided to the education program. Benchmarking results are published in CHRISP and the ACHS clinical indicator report. All are positive to sound practices for infection management District-wide. A review of antibiotic usage with a restriction policy was highlighted in the resident medical officer information handbook and at orientation. Pharmacy is involved in the monitoring of Vancomycin usage.

The hand hygiene campaign which commenced in 2004 has been very successful. Unit champions number 300 (10% of all staff). Volunteers, chaplains, work experience and students are all included in hand hygiene education, the flu vaccine program, ongoing education, and pandemic training. A review of the very important areas of CSSD, operating theatres, catering services and housekeeping provided evidence of adhering to policy. The use of single-use equipment was found to be in place in all hospitals throughout the district.

It was noted that in the nursing review of Surgical Services – Kingaroy Hospital - April 2007 *Central Sterilising and Supply Department Action Plan*, the priority 1 recommendations have been partially addressed with the washers ordered and the performance qualifications of the sterilisers attended, and temporary arrangements made to meet the recommendations.

Good procedures were noted to be in place at wards, and there is external storage to ensure that waste is identified and disposed of to ensure minimal risk to staff and external contractors. All staff consulted were aware of, and had undertaken, inservice on infection control procedures pertaining to waste management including the handling and transportation of soiled linen.

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

Alarm systems for refrigerators in outlying hospitals to denote a power loss be implemented.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.5
Criterion: 1.5.3 The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy.

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

Surveyor's Comments:

Assessment for pressure areas on admission, or when observed or reported as hospital acquired, was attended District-wide with a comprehensive awareness and prevention program. The assessments were undertaken across the District and guided by policy, with the program extending to the patient during surgical procedures in the operating theatres where pressure relieving devices were available.

Audit results are circulated and education is very willingly provided by a highly motivated team. A comprehensive and extensive equipment register is available and well maintained, and a replacement program for ageing/damaged equipment is apparent.

Changes in services which indicate improvement were dedicated resources (staff and equipment) to minimise the incidence of pressure ulcers and effectively manage pressure ulcers when they do exist, education to the general public and, in the Emergency Department, the purchase of safer trolleys, better suited for nursing elderly patients along with education of staff in the safe management of patients in the Emergency Department with mobility problems. Improvement was noted in the storage of mattresses and pressure relieving devices. *Waterloo Mondays* is an innovative program for regularly and routinely revisiting the pressure ulcer assessments.

The full time position of stoma/wound and pressure ulcer management at Ipswich Hospital has a District focus and a network with regional/national hospitals, domiciliary services, nursing homes, general practitioner pracices and the Flying Doctor. Distance consultation via photos of problem wounds and stomas (with consent) on email is well utilised.

Pressure ulcer statistics validated through PRIME for ACHS clinical indicators six monthly were found to be positive for sound assessment throughout the District. The guidance from Queensland Health is prescriptive and has been well adhered to in all facilities.

Surveyor's Recommendation:

Function: Clinical **Standard:** 1.5
Criterion: 1.5.4 The incidence of falls and fall injuries are minimised through a falls management program.

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

Surveyor's Comments:

Evidence was found of the implementation of the standard falls prevention strategies and auditing processes in Ipswich and the outlying facilities. Falls documentation and assessment and falls injury data are reviewed, and analysis is conducted and reported at unit levels on a regular basis. As a result of the very comprehensive education and awareness program a decrease in falls has been recognised.

The District program was found to be guided by a State policy with a local “draft” policy available and still under review. The falls assessment tool is still in its infancy and is used in all areas of the hospital, except the children’s ward, where it is considered not relevant. A mobility assessment program in the Emergency Department is used to identify those patients who are at high risk of falling.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

The District roll out of the Ipswich program with a dedicated coordinator is yet to be attended although, in the interim, the sites are adhering to policy. At ward levels it was recognised that a resource person was dedicated to promote falls risk assessment.

There was evidence of the development of falls reduction and promotion resources in self-directed learning packages and a day set aside to revisit the program annually, April Falls day (1 April).

To prevent falls from occurring, brochures and health promotion (refer to criterion 2.4.1) from Queensland Health are circulated to patients, carers and staff. Check lists for compliance and emphasis on safe footwear (brochures) were available and distributed. Prevention of injury from a fall is evident in the risk minimisation initiative called the “Bee Safe” program. This 5 bees program has been very effective in spreading the message. On review of the menu and the content, it was apparent that optimising nutritional status is recognised as a standard strategy for falls prevention, along with maintaining a safe environment.

The audits to determine compliance with the falls program are positive and provide evidence of success. The opportunity to benchmark results over time, given the sound platform now present, is apparent.

Surveyor's Recommendation:

Function: Clinical **Standard:** 1.5
Criterion: 1.5.5 The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.

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

Surveyor's Comments:

The pathology service is responsible for the collection, prescription, safety and appropriateness of blood component therapy. This service is also responsible for the analysis and reporting on disposal rates of blood products.

The link to appropriateness would be enhanced by the review of utilisation and performance indicators as provided by Auslab on wastage. A policy is in place to cover the transport, storage, ongoing monitoring and management of blood. The consent process, until recently, has been through the generic hospital-wide consent forms. The introduction of a statewide consent for blood form is to be introduced (refer to criterion 1.1.3). Evidence of evaluation of the safety and appropriateness of blood component therapy was not apparent, although the tools and data were available on the system.

Staff in all areas of the hospitals District-wide who administer blood and blood products are guided by policy and are assessed for competency.

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

(i) A blood management system which monitors and reviews the prescribing of blood and blood products to ensure appropriate practice be developed.
(ii) An education program for clinical staff on appropriate practices for prescribing blood and blood products be developed and implemented.
(iii) The maximum blood ordering schedule (MBOS) dated 1995 be updated.

Risk Rating: Low

Risk Comments:

The system for the prescription and use of blood and blood products does not provide the level of monitoring and review which would be expected in a contemporary system. There is nothing to suggest that practices are

inappropriate but neither is there evidence to demonstrate that practices are appropriate. Without appropriate monitoring and review there is an element of risk which is considered, at this stage, to be low.

Function: Clinical **Standard:** 1.5
Criterion: 1.5.6 The organisation ensures that the correct patient receives the correct procedure on the correct site.

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

Surveyor's Comments:

Throughout the District, the correct patient, correct procedure, correct site and ensuring intended surgery (EIS) program was found to be very comprehensive and effective. Systems and processes were found to be in place to minimise the risk of error. Pre-operative policies and compliance with the national protocol were found to have been introduced, with education and awareness programs ongoing. The identification of patients, pre-operative polices and compliance with national protocol including the mandatory “time out” policy in the operating theatre and procedure rooms was introduced with education for all parties involved.

Evidence was found that there was compliance on paper and in practice with policies at Kingaroy and Ipswich where surgery occurs. Additionally, the District compliance audit at State level (reported in CRISP) provided reassurance of positive compliance for the District. The PRIME reporting system is used to report non-compliance with the policy and the use of the root cause analysis module was available to review non-compliance and improve. A local compliance audit using the State audit tool will again be conducted (observation audit) in September. The time for the State audit is yet to be confirmed. The District will contribute to the statewide (Queensland Health) project on applying EIS in the oral health setting in September.

The survey team was reassured that there was 100% compliance with ensuring intended surgery.

The photo identification included in the referral documentation for methadone patients was one example of the correct patient, correct procedure other than the intended surgery model. Additionally, a process was introduced for patient identification with a coloured arm band applied early in the Emergency Department at triage so that the patient is properly identified and, in so doing, minimising the risk of an incorrect procedure, test or intervention especially for the aged. Much good work had occurred in this very important area of safe care and services.

Surveyor's Recommendation:

Function: Clinical **Standard:** 1.6
Criterion: 1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service

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

Surveyor's Comments:

Queensland Health is committed to community and consumer input into health service planning and operations. It has produced a ‘toolkit’ of effective ways to facilitate such input. The health service demonstrates its commitment to consumer input through its action to engage consumers in various ways and at different levels within the organisation.

At the governance level, the organisation has set up two Health Community Committees which represent the north and south areas of the District. The role of these committees is to monitor the safety and clinical performance of health services, as well as feed into the system community input and wishes. Minutes of these meetings reflect information on activity and performance within the District, but do not reflect any discussion by members or decisions made by the committees. Such information may be beneficial and should be considered. Consumer input and

feedback occur via a range of involvements such as participation on the Patient Safety and Quality Council and the Occupational Health and Safety Committee, and involvement in strategic planning days, along with consultation when developing the demand management strategy for the District. Other mechanisms for consumer input are reference and focus groups, local liaisons with community representatives in smaller centres such as Boonah, Laidley and Esk and centres in the South Burnett area. Liaisons with indigenous people in Cherbourg were positive. The maternity service has extensive community involvement in assisting them to develop and promote their new model of maternity care.

Feedback mechanisms, such as patient satisfaction surveys and their evaluation, along with complaints management processes, are used to ensure valuable consumer input. The organisation is currently awaiting results from their latest organisation-wide patient satisfaction survey for feedback from the public on their perceptions of their hospital experiences. The survey, undertaken in February 2006, indicated that strategies should be developed to elicit feedback from the patients at the hospital level on their degree of satisfaction. An action plan on such strategies was subject to a recommendation in the last Organisation-Wide Survey, but it does not appear to have eventuated.

Feedback from the public in the form of compliments and complaints is registered and data collected and provided to management and the Health Community Committee. The complaint management system aims to provide feedback and close off complaints within 35 days.

Evaluation of the input by consumers could be strengthened to give management an overall picture of the degree of involvement, the outcome of that involvement, and feedback to the community on the extent of community involvement. Acknowledgement of the involvement does occur at special recognition ceremonies at the various hospital and community facilities within the District.

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

The current profile of consumer input be mapped to identify any gaps and, if necessary, an action plan be developed to guide further input from the community.

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.

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

Surveyor's Comments:

Queensland Health produces a poster and pamphlet outlining the rights and responsibilities of consumers of the public health system. This document was published in 2002, and there does not appear to have been any revision or revised document since then. The pamphlet now contains inaccurate information and it does not refer to the Health Quality and Complaints Commission, which is a right for consumers of the health system to access when they have a concern about clinical care. Health services have code of conduct training, and information kits and pamphlets in order to guide their behaviour as well. There is a system for capturing complaints by consumers, and each health facility has a designated person or team to take complaints and manage the process of recording the complaints on the PRIME incident reporting system. Action is then taken to address the concerns within a 35 day turn-around period where possible. There seems to be good compliance with ensuring that clients and patients were aware of the rights and responsibilities issue either by posters on desks, counters or walls, pamphlets in admission packs and bedside lockers, and reference to rights embedded in the surgical consent forms.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

Queensland Health be approached to review and republish its Rights and Responsibilities pamphlets and posters in order to ensure that the content is current.

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.

Function: Clinical **Standard:** 1.6
Criterion: 1.6.3 The organisation makes provision for consumers / patients from culturally and linguistically diverse backgrounds and consumers / patients with special needs.

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

Surveyor's Comments:

There is a Queensland Health 'toolkit' which includes Guidelines for Use of Interpreters. There is a procedural guideline document for use in managing cultural and linguistic issues. The District has appointed a coordinator for multicultural awareness, with one position at Ipswich Hospital and another at 'The Park'. These positions manage the interpreter services, and have resulted in improved coordination of interpreters and reduced costs as a result of booked interpreters being notified of cancellations in advance. It is hoped that the installation of the ISIS information system will result in improved data collection and evaluation.

The District has a number of groups which are culturally diverse, these being the indigenous, Samoan and Vietnamese communities. Liaison with the various groups assists in meeting their needs. Information sessions for staff on multicultural and interpreter services are provided. Information is included in orientation programs. As new facilities are built, the signage is constructed in accordance with standards to assist multicultural ethnic groups with international symbols and also the visually impaired.

In the special needs area, the maternity unit holds a monthly memorial service for bereaved parents or those who have lost an infant through miscarriage. This has been widely appreciated by those with the special need to grieve. The unit is congratulated for this service. Equipment to assist with the bariatric patient has also been purchased. Evaluation is basic, and further development of evaluation which measures whether the organisation is meeting the needs of those with cultural diversity and special needs consumers would enhance this service.

Surveyor's Recommendation:

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

FUNCTION SUMMARY: SUPPORT

The West Moreton South Burnett Health Service utilises a District-wide approach to improving care and service delivery outcomes, which is coordinated through the Patient Safety and Quality Unit. The surveyors noted a high level of leadership and support from the District Executive and the Patient and Safety Quality Unit team for clinical and administrative staff undertaking a variety of improvement projects, which are referred to in the body of the report.

In general, quality activity projects appear to be aligned to strategic and operational priorities. It is suggested that a review be undertaken to ensure that this is the case across the District. The surveyors observed that with some activities there is a need to ensure that the quality cycle is completed. Staff undertaking improvement activities demonstrated commitment and spoke enthusiastically about their involvement, confirming that quality improvement is an essential part of the organisational culture. Staff are congratulated for their efforts and achievements. With the forthcoming amalgamation, the organisation has sound systems in place to sustain continuous quality improvement.

Whilst advocacy for risk management is evident in some areas of the organisation, there appears to be little clinical support across the District. The organisation will need to enlist clinician support in the promotion of quality improvement that has a risk focus. Local application of Queensland Health policies, PRIME and the complaints database ensure that information is available District-wide, with PRIME reports presented at relevant clinical meetings. Compliance with relevant legislation is evident with the inclusion of rural health facilities in the mortality audit, and the implementation of a three tier process.

Patient safety, quality improvement and complaints management are included in the District orientation program. Adherence to the principles of open disclosure is demonstrated, with some senior staff completing open disclosure education and a plan is in place for other staff to undertake education. The process for patients/clients to offer compliments and register concerns is well managed and improved with the establishment of Complaints Coordinators at Kingaroy Hospital which enables patients/clients to receive direct feedback.

The Human Resources Department (HRD) has stabilised under a permanent leadership/management structure for the past 12 months, after a protracted time of instability associated with the amalgamation of the new District. The surveyors were impressed with the enthusiasm and dynamic approach taken by the current HRD, particularly in response to, arguably, the major challenge to the organisation, namely the recruitment and retention of clinicians across the District, so as to maintain service provision. The HRD, in concert with Nursing support, has facilitated an array of creative and innovative programs and schemes that have been successful in recruiting and retaining staff in a very competitive market. The organisation is congratulated on these programs, which include local implementation of Queensland Health's Rural Return to Nursing Program, the On-boarding Project to provide a nurtured entry and ongoing support to new recruits from overseas and interstate, the Grow Your Own Health Employees, TAFE program at Cherbourg, which is targeting increased employment of indigenous health workers, and Health Employment Multicultural Equity and Diversity Project attended by 80 staff. Over and above these projects are the organisation's pervasive family friendly flexible work options which are clearly appreciated by both professional and support staff.

The development of a comprehensive workforce plan is a major objective of the HRD and to this end a special project officer has been employed to coordinate its development, which will have a time line of two years. The surveyors were impressed with the extensive preparatory work and research already undertaken to ensure that the plan is not a token exercise. A recommendation will be made to expedite this important planning process.

The HRD recently developed a new template for Performance Appraisal Development (PAD) and a roll out of training for managers was undertaken up until February 2008. Evidence provided to the surveyors indicated that this is one area that needs to be energised and assertively promoted as the current take up of PAD is relatively poor, with the notable exception of the Nursing Department at Ipswich Hospital which has an exemplary profile of successfully implementing the system. The surveyors were made aware of related issues concerning departmental access to the current registration and scope of practice of all health professionals, access to training, supervision and mandatory inservice for medical staff, particularly junior medical officers, and the implementation of the policy "Clinical Performance Concerns - Management of Senior Medical Staff". A number of recommendations are made to address these matters.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

The surveyors noted that the District does not have a comprehensive and viable learning and development plan, although some departments have exceptional, locally developed programs in place. An impressive recent initiative has been the allocation of nurse educator positions or sessions at rural sites. Generally, however, attendance at mandatory training is less than optimal, apart from fire training, and child protection is an undeveloped issue with respect to staff education. It was further noted that the functioning of the General Clinical Education Committee, which oversees the education and supervision of certain categories of the medical workforce, could be improved. Again recommendations have been made to ensure that each of these issues is appropriately reviewed and addressed.

The surveyors congratulate the District for ensuring that there is a comprehensive range of staff support systems in place across the District, the most notable being the Employee Assistance Service (EAS), provided by an external contractor, and the inhouse Workplace Equity and Harassment Officers (WEHOs), of which there are ten scattered across the District. These support services are the subject of regular review and evaluation and are clearly valued by staff, judged on their uptake. Much the same can be said of the workplace relations systems, which demonstrate their effectiveness by the relatively high level of staff morale noted and the good industrial climate pervading the District.

Data and information are captured effectively via a range of corporate systems, support care, and service improvement. The reports and data quality are evaluated through satisfaction surveys, benchmarking and audit tool application. In some of the rural services there has been an absence of feedback in the form of clinical indicators or other data that could be used to evaluate care outcomes. This has recently been rectified and staff were already using the outcome data provided. The recruitment of medical staff will also facilitate participation in clinical indicator monitoring.

Information technology services are part of Queensland Health's Shared Services. The integration of two Districts, West Moreton and South Burnett, has required the information technology and information management systems and their overall management to integrate. There was evidence across the District that this was being done in a manner that was supporting management and service delivery. An issue of varying access to personal computers across the District was noted and it is recommended that steps be taken to establish staff/personal computer ratios for use across the District.

Overall this standard has been comprehensively addressed but the recent integration of two districts into one has caused some inconsistency which will be addressed in time.

A number of staff were involved in health promotion strategies, and the survey team was encouraged by the innovation that has been shown and commitment to improving health and services in some challenging situations.

There was evidence that the Population Health Service contributes to a number of interventions as well, which provides overarching support across the District and a framework for process, while still allowing changes to the model to reflect community needs.

It was evident that the Population Health Service focuses on primary prevention strategies, while the Health Service District focuses on secondary and tertiary interventions. Some key initiatives which were noted for their achievements, notwithstanding others, were the national bowel and breast cancer screening programs, enhancing the health of mothers, infants and children such as the Cherbourg Health pregnancy project, promoting healthy weight by supporting the lighten up to a healthy lifestyle and living strong programs, vaccination and immunisation programs, Cherbourg's program for the management of diabetes, the commencement of regular health promotion segments on the local radio to increase knowledge and awareness of health issues and related service options in Cherbourg, mobile women's health service to improve the uptake of pap smears in more remote areas, evidence-based programs for chronic conditions and monitoring rate of re-presentation by the community health nurses, and the SNAP project, which is a general health screening and early intervention model. Cherbourg was also noted for its consumer participation in the development of its strategies.

It is suggested that staff involved in the implementation of these health promotion initiatives be more involved in the development of performance indicators, and associated collection and analysis of data to further inform clinical outcomes and service planning.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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: EA **Surveyor rating:** MA

Surveyor's Comments:

A variety of patient safety and quality improvement activities is demonstrated throughout the District.

A number of different templates are utilised for recording minutes of meetings. A single standardised outcome-based template would ensure consistent quality across the District. Whilst the development of the QASAR database has improved the recording and reporting of improvement activities, staff evaluation of this tool would identify areas for improvement.

The development of the Venous Thromboembolism and the Falls Prevention Programs prior to extending District-wide is an excellent initiative. Improved patient and staff satisfaction has been identified with the implementation of the clinical handover process. The reduction of the number and severity of hospital acquired pressure ulcers has been achieved through improved incident reporting, auditing and staff education. The Birth and Beyond Program offers women the opportunity to receive antenatal and postnatal care at home or community centre. A multidisciplinary team ensures that 'at risk' patients are reviewed, with all necessary investigations carried out prior to admission. The surveyors noted that there are no existing performance indicators for the Department of Medical Imaging. It is suggested that relevant indicators be developed to monitor, review and evaluate service.

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

(i) A standard, outcome-based template be developed for recording minutes of meetings, to improve the quality of minute taking across the District.
(ii) An analysis of the QASAR database be undertaken to identify users' perceptions, needs and level of satisfaction and make improvements as required.

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.

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

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

Surveyor's Comments:

The District utilises the Queensland Health risk management system and QHRisk, to manage risk but there are opportunities to improve its implementation across the District. Risk identification is reactive through using specific incidents to identify opportunities to develop risk reduction strategies. A proactive approach to identifying risks should be explored with (where necessary) staff training to assist in risk identification. The District's risk register which exists in QHRisk identifies, almost exclusively, risk at a District level. Risk identification and registration would be enhanced if responsibility was devolved throughout the organisation's structure, beginning with clinical and corporate business units and working down through wards and administrative units. QHRisk and PRIME are difficult to locate on the intranet and input to these systems may increase if they are easy to locate. A review of the location of the links/icons to these programs may simplify staff access and promote a shared responsibility and management of risk, complaints and incidents.

There is little apparent medical clinician leadership in risk management, which is reflected in the poor attendance of consultant medical staff at the District Patient Safety Committee, the District Drug and Therapeutic Committee, and the General Clinical Education Committee. The District Patient Safety Committee has no medical consultant membership and clinical issues are referred by the chairman (EDMS) to the Medical Advisory Council, however, there is no standing agenda item on the Medical Advisory Council for clinical incidents/complaints, nor are the minutes of the Patient Safety Committee tabled at the Medical Advisory Council.

Staff across the West Moreton South Burnett Health Service District mental health sector are aware of their responsibilities for managing risk and do so through communication and consultation. The risk management policy is District-wide, executive endorsed, addresses clinical and corporate risks and is available to staff electronically. The policy is based on the Hunter Valley framework and is detailed and in parts specific about processes.

The current risk management framework identifies risks, analyses, evaluates and treats them but there is a lack of evidence of site specific monitoring, review on a regular basis and communication of reassessment to the relevant site staff, committees and persons responsible as articulated in the policy *West Moreton South Burnett Health Service District Clinical Governance Operational Plan* and the *Risk Management Plan*. The risk register is centrally managed and again, access or full engagement by site-specific staff is not demonstrated.

There are specific committees for clinical risk management but the evidence of effective functioning or impact of the committees was not demonstrated. The corporate risk management system is inclusive of all sites but the interface between sites and the District process is not clearly demonstrated as providing effective bottom-up and top-down communication and follow-up.

The many audits, both clinical and corporate, completed across the sites are compliance directed and there was little evidence of a collective approach to the coordination of, purpose of and outcomes that improved safety or quality. Staff did report that they could initiate an action related to risk, had some control over response to an identified risk but were unsure of who in the risk management framework held overall responsibility for any incident follow-up.

The recommendations for root cause analysis and HEAPS (local investigations) are recorded in PRIME and do come to the Patient Safety Committee, however, there is not a demonstrated control over the actioning, timeframes and outcomes from them, with little if any detail recorded in minutes and an inability of staff, either directly involved or management, to articulate what was the outcomes of many of the HEAPS/root cause analysis recommendations. A system for the tracking of recommendation progress was not established.

There is an explainable reliance on the central patient safety process for monitoring but the effectiveness of the interface of District with the integrated mental health service, Kingaroy, Goodna and The Park was not established.

Trending and reporting of incident data occur and is reported to staff but there was, again, an ad hoc approach to engaging staff in understanding or using the aggregate data to improve care.

The following issues were notable:
The home visiting safety policy - *Home Visiting in the Community – PROWMSB20080258,* for mental health service community staff does not provide a formal requirement for completion or formal recording of home visiting risks for individual clients. There is an ad hoc approach by some teams to utilising the alert process to inform colleagues of identified risks. The policy is also not inclusive enough, for example, the recording of staff exposure to cigarette smoke/dogs.

Advanced Completion in 60 Days (AC-60)
An AC-60 was undertaken on the following recommendations from the In-Depth Review:
(i) An audit of the current control and tracking of the progress of the recommendations from root cause analysis and HEAPS be undertaken in the mental health service, and the focus be on ownership by site staff and leaders as well as the District system with the development of an identified pathway of open, two-way communication.
(ii) A formal and inclusive home visiting risk assessment process be put in place in the mental health service and evaluated.

Action Taken by Organisation to Address Recommendation
(i) An audit has been completed in relation to the monitoring and progress of RCA and HEAPS recommendations. This audit identified deficits in the RCA and HEAPS recommendation process. In response, the RCA and HEAPS process has been revised to include:
* Flowchart now includes the defined sequence of events and reporting processes which must occur for each

RCA/HEAPS with particular reference to improved flow of communication for the Mental Health Service.
* An electronic and paper checklist has been implemented to monitor the progress of each RCA/HEAPS recommendation for completion and closure of the clinical incident.
* Feedback mechanisms to clinical teams have been revised and occur at Patient Safety Rounds, Mental Health Patient Safety and Quality Committee and relevant Mental Health Services committee meetings (ie Work Improvement Groups, Business Unit Management Committee)

Appointment of a Patient Safety Officer with the Mental Health portfolio, with a direct reporting line to the District Director Patient Safety and Quality and situated in the District Patient Safety and Quality Unit. The Officer is responsible for the management of the RCA/HEAPS reviews.

(ii) The District Home Visiting policy has been reviewed and endorsed at the District Executive Committee on the 14 November 2008 and is accessible on the District Intranet Site. The risk assessment tool has been widely consulted and reviewed to include environmental risks (cigarette smoke/dogs/weapons). An evaluation of the tool is underway and results will be available for the surveyors in December 2008.

Completion Due By: 15 December 2008
Responsibility: Executive Director Mental Health Service WMSBHSD

Surveyor's Comments
A database of all Root Cause Analysis and HEAPS recommendations since 2008 has been compiled, their implementation tracked, and those which have not been implemented have been identified and are being followed up.

A system is now in place which will ensure that all recommendations are communicated to the relevant personnel and tracked for implementation.

A District-wide home visiting policy has been developed and implemented and is shortly to be evaluated for effectiveness through a new audit tool.

The Conditional survey team will need to confirm that the changes have been sustained, and this process will be facilitated if the District develops and collects some relevant performance indicators to demonstrate the effectiveness and sustainability of the changes.

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

(i) The role of clinical leadership in peak committees which consider risk be reviewed to ensure that there is sound medical input into the risk management system.
(ii) A proactive, multidisciplinary approach be developed for the identification of risk to enhance the existing system, which relies heavily on incidents to identify risk.

Function: Support **Standard:** 2.1
Criterion: 2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.

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

Surveyor's Comments:

Processes are in place to ensure that there is systemic analysis of incidents and complaints, with results reported at relevant committees. The inclusion of all HEAPS SAC 2 events for review has made this process more robust.

Whilst business units hold risk management meetings to review incidents and complaints, the surveyors noted that incidents/complaints are not a fixed agenda item for all departmental meetings. It is suggested that all departments include incidents and complaints as a standing agenda item.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

A number of senior staff have attended open disclosure training and a plan is in place for other senior staff to undertake this training.

Brochures and posters detail the process for patients/clients to give compliments and raise concerns. Responsibility for the management of complaints and clinical incidents has been delegated across the District. The appointment of Complaints Coordinators at Kingaroy Hospital and a dedicated phone number for client accessibility is an excellent initiative. A high majority of complainants receive feedback within the policy timeframe.

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

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.

Function: Support **Standard:** 2.2
Criterion: 2.2.1 Human resources planning supports the organisation's current and future ability to address needs.

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

Surveyor's Comments:

Prior to the appointment of the current Director of Human Resources, human resources leadership was fragile as there was a lengthy period when the position was filled on a temporary basis and the status quo was being maintained. In the past year, the amalgamated District Human Resources Department has been subject to a restructure and the Director has initiated a change management process using multiple projects (eg Health Employment Multicultural Equity and Diversity Project, the "Untapped" Migrant and Refugee Labour Market Workforce Partnerships Initiative) and has devolved recruitment to the business unit. There are plans endorsed by the District Executive to establish a Strategic Recruitment Unit within the Human Resources Department, and for the latter to have a focused planning and policy function. Once the restructured Human Resources Department is bedded down, the priority issue will be the development and implementation of the District workforce plan that will have a timeframe of approximately two years. This process has begun with a major presentation to the executive, outlining the current workforce issues confronting the organisation and the strategies to be included in the plan to address these issues. A Workforce Strategy Project Officer has been appointed to coordinate the development of the plan, and workforce issues have been included in the District 2008/09 Operational Plan, the progress of which is regularly reviewed by the executive. This component has the status of an interim workforce plan, and includes the Human Resources Department providing a viable human resources service and ongoing support to the smaller rural facilities, and promoting a multi-faceted staff retention strategy. The latter includes "emotional intelligence" training of Nurse Unit Managers and clinical nurses and a progressive needs assessment across all facilities, resulting in incrementally improved staffing mix/establishment for many services (eg new oral health therapist, upgrading of radiographers to be recruited, increased employment opportunities for health workers from a culturally and linguistically diverse background).

The interim workforce plan is informed by the Southern Area Health Service Workforce Plan 2007-2012, which was extrapolated from the Queensland Health Peoples Plan 2007-2012. The key elements of these policies being implemented by the District are the creation of a positive workplace culture through empowerment of departmental managers, the minimisation of bureaucratic barriers, and attracting and retaining people.

Consultation with a range of staff representative groups (eg consultative network involving industrial associations, Public Hospitals Oversights Committee, Medical Workforce Strategy Committee) about the major elements of the interim and proposed workforce plans has been undertaken.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Consultation with the allied health departmental heads indicated that as a result of protracted negotiations with the District Executive, agreement had been reached to fund and establish a new position of Director of Allied Health Services to sit on the District Executive. The organisation is encouraged to promptly recruit to this position as soon as the recently announced amalgamation with the Toowoomba and Darling Downs Health Service District is finalised.

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

The development of the workforce plan be expedited. (It is acknowledged that the District has made a significant commitment to achieving this objective and it is important that the imminent amalgamation with Toowoomba and Darling Downs Health Service District does not impede the progress of this development).

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

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

Surveyor's Comments:

The District has well established protocols in place for the recruitment, selection and appointment of new staff that are based on Queensland Health templates and guidelines. With the devolution of responsibility to departments for their respective staff recruitment and appointments, the organisation's Human Resources Department has developed a recruitment pack that contains guidelines and forms that departments are to access when they recruit staff. This information pack has been subject to regular evaluation and refinement. Professional departments (medical, nursing, allied health) ensure that recruited staff have their necessary licences, registration, qualifications, skills and experience and, prior to final offer, the Human Resources Department checks that all procedures have been appropriately followed.

The work of the Nurse Support Unit in facilitating an optimal recruitment and retention service for nursing staff is very impressive, and the surveyors congratulate the staff of this unit for their sensitive, respectful and creative approach to this endeavour.

The Ipswich Hospital Foundation has developed a policy and orientation program for volunteers which has been endorsed by the executive. The surveyors noted that volunteers provide an invaluable fund raising and health promotion service to the organisation, particularly in the smaller rural communities and their contribution is highly valued by the District.

The organisation has a very impressive day long orientation program for all new appointees and this is facilitated by a comprehensive orientation manual, which is regularly updated and evaluated. The surveyors noted that the orientation process had recently been revised and refined to focus on core and mandatory requirements.

The District has identified a number of performance indicators which reflect the effectiveness of current recruitment, selection and appointment systems. These include criminal record check turnaround (benchmark 72 hours), utilisation of agency nurses and number of medical vacancies. The organisation is congratulated on the success of its recruitment of overseas medical staff through the "Area of Need" program, and for its participation in the Queensland Country Relieving Doctors Program. The latter includes the provision of an information kit (compact disc and relevant information regarding protocols and clinical support) and was developed as part of the Southern Area project on emergency department medical workforce. The surveyors noted a local outcome of this strategy at Kingaroy Hospital which now has in place its full medical establishment of seven doctors.

The District recruitment system has recently been adapted by using the internet to advertise positions, and plans are in place to utilise You Tube for targeted recruitment.

The Human Resources Department has collaborated with departments to review their respective staff establishments when there are indications that the current staffing mix or complement is not meeting service needs. Examples of this process include the establishment of an administrative officer position for triage on the afternoon to evening shift at Ipswich Hospital Emergency Department, the recruitment of casual physiotherapists to work after hours and on

weekends in the intensive care unit, increase in the number of staff surgeons at Ipswich from two to three, and the employment of assistants in nursing in the acute setting of the Child and Family Health Service.

The District is congratulated on successfully initiating a comprehensive range of creative recruitment strategies which includes:
i. The Rural Return To Nursing Program;
ii. The On-boarding Project to facilitate a nurtured entry into the service for new staff from overseas and interstate;
iii. The Grow Your Own Health Employees Program at Cherbourg which provides a TAFE diploma course in nursing for local indigenous people;
iv. The Health Employment Multicultural Equity and Diversity Project.

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

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.

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:** SA

Surveyor's Comments:

The Performance Appraisal Development (PAD) system has been recently reviewed and updated in consultation with staff representatives and industrial associations. The outcome has been the development of new templates for position descriptions, now called role descriptions, and a revised protocol which includes sections for the employee to receive both positive feedback from management on their performance over the past year and to identify their goals for the coming year, and to provide management with their record of attendance/participation in mandatory training. The PAD protocol facilitates a two-way negotiating process between employee and management and, apart from providing the opportunity for the employee's role description to be updated, also includes a "career coaching" component whereby the training requirements/needs of the employee are identified and an agreed annual educational/training schedule is documented. This component ensures that the employee's goals and educational program are aligned with the needs and goals of the organisation.

An electronic database (Lattice) is maintained and documents when an employee has participated in the PAD process. Queensland Health monitors this database and provides the organisation with a status report with respect to the local implementation of PAD. The latest report indicates a less than satisfactory uptake and this is in part due to rural services not recording PADs in Lattice. A recommendation will be made to address the issue of less than optimal uptake of PAD in all departments other than Nursing at Ipswich Hospital, which has an exemplary record in this regard. The surveyors noted that some departments did not acknowledge that PAD was mandatory.

The surveyors noted further that there was relatively poor attendance of medical staff at educational inservices and mandatory training sessions. It is noted that some health services ensure that medical staff have "protected time" for their education and training, ie they do not need to be on call during these sessions. A recommendation will be made to address this specific issue.

The District has recently evaluated and updated its complaints policy and associated protocol, which reflects and meets the requirements of the Queensland Health Complaints Policy. It is required to report on all non-clinical complaints or reported concerns about staff, which usually involve alleged breaches of the code of conduct and/or professional code of practice, to Queensland Health and to provide regular reports on the local complaints management process and its outcome. Staff under investigation are also provided with regular reports to ensure that the process is fair and transparent.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

The surveyors had access to the District Policy and Procedure "Clinical Performance Concerns-Management of Senior Medical Staff" which was updated in August 2008. It was noted that the policy required that the clinical concerns triage meeting annually review the revised procedure. The surveyors suggest that this review process be formalised and that a report of the review be forwarded to the District Executive to oversee and ensure that the evaluation is robust and transparent.

Professional departments (medical, nursing, allied health) have systems in place which ensure that all clinical staff employed maintain their professional registration. There is an issue, however, in some rural services where Site Managers are not formally advised of the registration status and scope of practice of junior medical officers rostered for a ten week rural relief term when general practitioners are on leave or positions are vacant. In many instances these doctors do not have access to on-site medical supervision. It is possible that this situation places both the patient and junior medical officer at some risk from less than optimal clinical judgement.

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

(i) A strategy be developed to ensure that all employees participate in the new Performance and Development (PAD) system. The strategy could include enhanced promotion and training of PAD across the organisation and regular auditing of this requirement across all departments and facilities.
(ii) The supervision arrangements for junior medical staff undertaking rural relief duties be formalised to ensure that they receive adequate orientation, on-site teaching, supervision and general support.
(iii) The current registration status and scope of practice for all health professionals be readily accessible to rural managers.
(iv) Time be made available to ensure that there is adequate access to education and mandatory training for medical staff.

Risk Rating: Moderate

Risk Comments:

Some of these recommendations have the potential to be a low to moderate risk to the organisation, both with respect to patient safety and corporate reputation, if they are not implemented. It is important that the District address each of these recommendations to ensure that service provision is of optimal quality and that patient safety is a primary organisational objective.

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:** SA

Surveyor's Comments:

The District does not have a coordinated, comprehensive learning and development plan. There is a plethora of learning opportunities organised by departments to upskill their staff and these initiatives are impressive. The interim "Workforce Plan" contains some educational programs but these are focused on workforce-related issues.

The organisation's generic Learning and Development Department is minimally resourced and is located within the Human Resources Department. This mini-department arranges a number of training/educational programs (eg monthly one day orientation, monthly one day recruitment and selection training, bi-monthly cultural awareness training, PAD training up until early 2008) and coordinates a range of educational initiatives, including assistants in nursing traineeships, indigenous enrolled nurse cadetships, work experience students, the Administrative Officer Professional Program, Working Together Clinics, the Certificate IV in Business (Frontline Management) TAFE course run at Ipswich Hospital and the processing of SARAS (Study and Research Assistance Scheme) applications. The latter is a scheme whereby staff can apply for financial or other assistance to enrol in external courses.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

The organisation's Nurse Education Department offers an extensive array of nurse educational programs which are tailored to the needs of nurses in various departments. These are developed in response to either legislative or credentialling requirements, or informal channels of feedback from units. In all cases, upskilling of nurses is the objective. An impressive recent initiative at rural sites is the allocation of nurse educator positions or sessions to provide enhanced and increased training in mandatory and other courses for all staff based at these sites.

It was noted that the General Clinical Education Committee which oversees the education and training of post-graduate medical students and international medical graduates did not hold monthly meetings between September 2007 and May 2008 and that the Manager Medical Education position was vacant for the seven months until an appointment was made in May 2008. It was further noted that attendance by consultant and junior medical staff was poor when the meetings did occur. The surveyors regard these issues as unsatisfactory as they compromise the accreditation status of medical students.

Child protection training and management of related issues in the rural centres could be significantly improved. It is suggested that the District establish a mechanism to increase awareness of child protection issues to address this need. The surveyors identified a further training need, namely in evaluation methodology for projects and programs that are established or developed locally. It is suggested that the Learning and Development Department conduct a needs assessment as part of its development of a generic staff development plan.

The surveyors were provided with a profile of attendance at the organisation's mandatory training program and it was noted that participation was not optimal, apart from that for fire safety training. The District has a policy and procedure on "Mandatory Training" but at this time there is not a formal organisational response to encourage improved attendance at these sessions.

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

(i) A comprehensive all-encompassing staff development plan be developed, based on a formal needs assessment of all departments and disciplines.
(ii) A proactive approach be developed to ensuring that there is optimal participation in mandatory training sessions. (It is suggested that auditing the implementation of the Policy and Procedure "Mandatory Training" across all sites could be a pivotal component of this approach).

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.

Risk Rating: Low

Risk Comments:

The issues are assessed as having low risk potential to the organisation's reputation and patient safety.

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

Surveyor's Comments:

There is an Employee Assistance Service (EAS) provided by an external contractor. The service contract is reviewed every six months for its utilisation and effectiveness using several performance indicators, and is assertively promoted across the organisation by the placement of posters and brochures in prominent positions (staff rooms).

The EAS is also utilised as part of performance development programs in special cases, eg when a staff member is referred for a course in anger management.

Another employee support system is the appointment of selected staff as Workplace Equity and Harassment Officers (WEHOs). There are ten of these staff within the District and each has attended a three day training course and is mentored. They are staff who volunteer to undertake this additional responsibility in addition to their normal duties, which range from those of a District Manager to those of a registered nurse. Any member of staff can access a WEHO when they are rostered on duty. They report directly to the District Manager and a representative from the Human Resources Department attends all report-back meetings, at which de-identified issues are discussed.

The new PAD system has been specifically developed to motivate staff by acknowledgement of their personal contribution to the organisation. Every three years, the organisation contracts the University of Queensland to conduct a staff satisfaction survey which generates an action plan to address any areas of concern identified in the survey.

In early 2008 a group program for 110 managers on "Working Better Together" was conducted. The objective was to encourage managers to identify potential issues in the workplace before they became major problems. Feedback from the workshop became the basis of an action plan for the executive to implement that would hopefully raise the morale of staff across the organisation. Another initiative to nurture staff was arranging a train-the-trainer workshop on emotional intelligence for 85 managers.

The District has in place a two tier industrial consultative committee structure whereby each facility holds regular consultation meetings between management and union representatives concerning local or facility issues, and any unresolved issue is reported to the District Consultative Committee for resolution. This system is reviewed annually by the stakeholders and has been deemed an effective approach to establishing a cooperative workplace environment. The surveyors noted that an impressive contingency plan has been developed based on risk management, for the management of foreseeable industrial action that involved certain staff groups refraining from their allocated work for periods of time.

Flexible working hours, including nine day fortnights, a "working from home" option for eligible employees and breast feeding at work for mothers returning to work from maternity leave are available.

A number of performance indicators are in place to evaluate both staff support services and workplace relations, ie time lost in industrial disputes, staff satisfaction index, episodes of utilisation of the EAS.

The organisation is encouraged to benchmark its indicators on workplace relations to complement the current benchmarking of EAS indicators with comparable organisations.

Surveyor's Recommendation:

Function: Support **Standard:** 2.3
Criterion: 2.3.1 Records management systems support the collection of information and meet the organisation's needs.

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

Surveyor's Comments:

The standard of record management has benefited from a high level of effort in this area. The organisation has invested in the records management system and introduced improvements such as providing a ‘runner’ position, a Lamson Tube, H-record, and 24 hour staffing coverage for the department. The outcome has documented improvements in record accessibility and a reduction in lost charts. Performance improvement processes are carried out through the use of: satisfaction surveys, audit tools and outcomes evaluated against industry standards.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

At the Ipswich Hospital, there have been a number of improvements made in the area of patient record integration across the local services. There is also a flagging system to advise of charts held at other sites. While some of the rural services have also advanced the integration of patient records, others were found to be lacking record integration and flagging processes. Ensuring that all the relevant information is available to clinicians when making care-based-decisions is critical.

The standardisation of clinical forms is a priority for the District but is still a work-in-progress. It was noted that multiple forms and an apparent lack of control over the development of forms was causing concern, especially in the rural hospitals.

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

(i) The work to date on the integration of patient records across services and the flagging of records held at other sites be continued across the District.
(ii) The District's standardisation of clinical forms project continue to be implemented.

Function: Support **Standard:** 2.3
Criterion: 2.3.2 Information and data management and collection systems are used to help meet the strategic and operational needs of the organisation.

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

Surveyor's Comments:

Clinical documentation improvements have resulted from ongoing education of clinicians through a range of initiatives, such as coders attending grand rounds and meeting regularly with nurses and allied health staff.

There is an information strategic plan in place. Policies direct data collection and utilisation. There was linkage of data linkages and an excellent program of ongoing staff education.

External reviews of coding accuracy are undertaken and the subsequent recommendations are actively implemented. Audit reports indicated that the coding was of high quality and accuracy overall.

The data collected is evaluated. The satisfaction of management is audited and findings acted upon.

Surveyor's Recommendation:

Function: Support **Standard:** 2.3
Criterion: 2.3.3 Data and information are used effectively to support and improve care and services.

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

Surveyor's Comments:

The information management team is commended for the way in which it effectively and efficiently manages the huge amounts of information gathered via systems such as EDIS, ORMIS, HIBISCUS and many others and, via Transition 2, provides reports required by management and staff across the organisation in their strategic accountabilities.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

The quality of data and reports is monitored via business systems using benchmarks and key indicators. Access to data is managed via formal delegation processes. Customer satisfaction audits are undertaken annually. Ad hoc requests are managed via a request form and team evaluation processes.

Staff competency is managed via on-line education tools, competency-based training, processing manuals and check lists.

Surveyor's Recommendation:

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

Surveyor's Comments:

The statewide Information Technology Unit (ITU) is responsible for hardware, hubs, licensing and the network, and for integrity and support. There is a State Information Technology Plan (ITU). The ITU is also responsible for managing the phone system contract. The risk and crisis management systems are managed corporately but local needs are included. The ITU's District responsibility has been impacted upon in recent years by the integration of the two Districts and corporate information technology changes.

There is a District Information Technology Governance Committee which meets monthly. Its membership includes three senior clinicians. A staff satisfaction survey and an information technology training needs analysis survey is carried out annually. All personal computers are replaced every three years. Hibiscus is upgraded three times a year.

An excellent innovation, the Intellipos, has been implemented and its swipe card capability has streamlined the processing of clients at the patient kiosk and the staff dining room.

At Laidley, an electronic media resource room "the Hub" has been created adjacent to the ward area. It provides access to teleconferencing, personal computers, videoconferencing and fax equipment. This is a great resource for clinical and administrative consultation, eg twice weekly clinical case review which involves off-site pharmacy, allied health and senior medical officer at Ipswich. The development and use of "the Hub" is commended.

While the District strategic plan has elements of information technology, there appear to be significant issues emerging in relation to staff access to Novell applications, finance and human resource enterprise systems. There has also been an explosion in the growth of requests for mobiles and personal computers. Access and equity appear to be issues across the District with mental health, community health and the hospitals operating with different rules for personal computer/staff ratios. It seems that a planned approach addressing the local issues, including a budget and benchmarking of information technology service provision would enhance the resolution of the problems.

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

A District information technology plan (supporting the Queensland Health plan) be developed to address the local issues of information technology provision.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Support **Standard:** 2.4
Criterion: 2.4.1 Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation.

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

Surveyor's Comments:

There was evidence that the Queensland Government's Population Health Service contributes to the West Moreton South Burnett District's health prevention, promotion and protection program through the Southern Area Population Health Service. A multidisciplinary and multi-strategy approach is utilised to implement programs that are aligned with Queensland Health's strategic and statewide services plans and other related population health outcome and quality plans. The Health Indicators report provides the District with the ability to understand issues in the geographical locations. The Population Health Service focuses on primary prevention strategies, while the Health Service District focuses on secondary and tertiary interventions. Some key initiatives include the promotion of healthy eating and increasing the consumption of fruit and vegetables, national bowel and breast cancer screening programs, enhancing the health of mothers, infants and children such as the Cherbourg Health pregnancy project, promoting healthy weight by supporting the lighten up to a healthy lifestyle and living strong programs, and supporting vaccine service providers with expert advice and professional development, and undertaking surveillance of vaccination rates and systems. Feedback of vaccination programs is provided to the Health Service District so that comparisons with the national immunisation target of 95% can be made. These immunisation rates are trended over the last five years and compared across the District.

Other initiatives that were identified across the District include Cherbourg's program for the management of diabetes, and the commencement of regular health promotion segments on the local radio to increase knowledge and awareness of health issues and related service options. Cherbourg was also noted for its consumer participation in the development and review of these strategies, some of which were outlined in the 10 point plan.

Additionally, a mobile women's health service was established to improve the uptake of pap smears in more remote areas. This has resulted in a positive community response. A falls prevention program is currently underway. One strategy is the monitoring of older people who have had falls at home and referring them to relevant services, such as tai chi, for managing arthritis and improving core stability, occupational therapy services or rehabilitation, and subsequently monitoring if there is a reduction in falls. Community health nurses are running evidence-based programs for chronic conditions and monitoring the rate of re-presentations. Those patients who re-present are referred for individual or groupwork programs, as appropriate to their care needs. This has also been introduced to nurses in general practitioner practices, and initial data indicates that this has resulted in a reduction in re-presentations. A further research project with a health promotion framework is the SNAP project in the community, linked to research at Ipswich Hospital. This is a general health screening and early intervention model for individuals in the workplace, and referrals to appropriate health interventions/health promotion projects are made. This has resulted in improved health status for a range of indicators thus far.

It is suggested that staff involved in the implementation of these health promotion initiatives be more involved in the development of performance indicators and associated collection and analysis of data, to further inform clinical outcomes and service planning.

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

A suite of key performance indicators be established in consultation with relevant staff, to capture the outcomes of the health performance initiatives across the District and trend them over time.

EXHIBIT 75

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Support **Standard:** 2.5
Criterion: 2.5.1 The organisation's research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research

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

Surveyor's Comments:

The survey team was impressed with the outstanding research programs of the Queensland Centre for Mental Health Research (QCMHR). The Centre is a demonstrated national and international leader in mental health research, having gained international recognition through publication in national and international peer-reviewed journals, citations in texts and journals, and multiple collaborations with international partners. Research outcomes are influencing health policy at State and national level, and there is demonstrated evidence of improvements in health care.

QCMHR research achievements include:

* development and implementation of a new national model of employment support for people with schizophrenia, through the adoption of an inter-sectoral collaboration between mental health service and employment services, thus advancing the vocational rehabilitation of people with schizophrenia;
* implementation of a program of workplace screening for depression and related disorders, wherein, in collaboration with 52 industry partners, 270,000 employees have been screened in workplaces across Australia and followed up to facilitate access to treatment.

There are pockets of excellent research being done in the District including the service areas of audiology (neonatal screening), speech pathology (in the Barrett Adolescent Centre which is focused on patients with eating disorders), and Child Health CAFHS (open plan drop-in centre).

The survey team noted that staff have a limited knowledge of research being conducted in the District, other than the research being conducted in their services/departments. It is suggested that the District develop a communication strategy to inform the organisation of the research programs and projects being conducted in the District, and the demonstrated improvements in health care being achieved. This will facilitate the growth and development of a culture of research in the District, and enable services/departments to synergistically build upon the gains already made.

In the absence of evaluation of research governance within the District, performance under this criterion cannot be rated higher than MA at this time.

Surveyor's Recommendation:

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

FUNCTION SUMMARY: CORPORATE

Strategic and operational planning is very well done. Using Queensland Health's Strategic Plan 2007-12 and its statewide Health Services Plan 2007-12 as the launching platform, the District has developed its Operational Plan and its Health Services Plan 2007-12. Clinical units and major services have developed their own business plans, guided by Queensland Health objectives and District strategies. Progress towards achievement of the objectives is monitored during the year and strategies modified as necessary.

The Director-General of Queensland Health is the governing body of the District but day to day management is delegated to the District Manager. For the purposes of the survey, the District Executive has been considered to be the day to day governing body, recognising the ultimate authority of the Director-General. Documented terms of reference have been established for the District Executive and all other committees, although not all terms of reference are as robust as they may be. There is an annual self-evaluation of all committees and changes to terms of reference are recommended to the executive. Again, this is not always done as robustly as it could be and there are recommendations made around this. Wherever appropriate, time limited committees are established for specific purposes. The deliberations of committees are minuted and decisions remain on the agenda until actions are complete but in line with previous comments, the quality is not universally good and there are recommendations made for improvement.

Strong financial management systems are evident, with financial performance regularly evaluated and improved. Delegations are specific to positions and are regularly reviewed and updated. Compliance with delegations is monitored against rules incorporated into electronic purchasing systems. Budget development is zero based and staff are involved in the development, monitoring and management of their budgets.

The survey team was surprised to note that, in the light of Queensland's experience in another District, systems to define the scope of practice for clinical professionals and for the introduction of new interventions and new technology were not as robust as contemporary standards would dictate. Recommendations have been made to bring performance in these areas to an appropriate standard.

Contracts with external providers are negotiated and managed on behalf of the District by Shared Services.

Since the amalgamation of the two component Districts, opportunity has been taken to evaluate the system for developing, managing and reviewing policies and procedures and a new, improved system has been implemented. Policies have been risk rated and they are being reviewed and rewritten according to priority. This is a work-in-progress and there still remains much to do.

Safety management systems ensure safety and wellbeing for consumers/patients, staff, visitors and contractors. The amalgamation of the occupational health and safety unit with the fire service unit has created a single District unit that has responsibility for all safety management systems within the health service. Much work has been undertaken in the past 12 months to provide support and advice from Ipswich to the rural health services in safety management. Boonah, Laidley and Esk Hospitals have developed good links with the District unit and this has contributed to the implementation of District initiatives and a reduction in staff incidents.

An asbestos register is maintained across the District, however, there has not been an action plan developed which prioritises action to address risks at Laidley and Esk.

The Ipswich medical imaging department has been reviewed following the previous survey to seek solutions to the ongoing problems of space in the waiting area for non-inpatients and inpatients. There is still the opportunity to further review how best to manage inpatients who remain waiting for transfer back to ward areas.

While signposting across the District generally meets needs, there is the opportunity to further improve signposting to the emergency department at Kingaroy. Where the function of a facility has changed, the District should also ensure that signposting is updated to reflect current usage. This is required at the Sacred Heart oral health facility which has changed from a clinic to an administration unit.

It was noted that the new facilities at Wondai provide an excellent residential facility for the immediate district for aged persons. Currently the facility has capacity for additional residents and may provide an opportunity for residents of the older Farr Home facility to be given the option to move into the Wondai facility. Patient areas at Wondai meet residents' needs, however, a review of the current administrative area may provide an opportunity for improvement to the space and work area for administration staff.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Safe work practices were generally displayed across the District and this practice could be reinforced in the Kingaroy maintenance workshop, with safe practice posters and procedures prominently displayed.

The need for a full fire inspection of all facilities has been noted in other areas of this report. Fire training is evident and while the generic program is effective, the size and complexity of the various work areas would benefit from a tailored fire training package for hospitals, community health settings and remote sites, eg oral health.

Security of staff is acknowledged by management and much has been done to minimise risks to staff. Video surveillance is prominent and, where applicable, dedicated security staff are employed. For the smaller rural centres, particular at Laidley Hospital, Laidley oral health facility and Wondai, security measures should be reviewed and action taken to reduce risks.

Keys are generally well secured, however, there is general access to master keys at Kingaroy and this should be reviewed to ensure that inappropriate access to keys in minimised.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

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

Surveyor's Comments:

The District has diligently translated the Queensland Health strategic and clinical directions into a District Operational Plan and a District Clinical Service Plan, developed its strategies for implementing the resultant objectives and encouraging business and clinical units to develop their business plans to operationalise the District plans. This has been particularly well done. It is felt that operationalising the plans could be improved by setting milestones for review during the year to ensure that progress is more effectively monitored. At present, the plans specify the body of work to be achieved in the space of the year and, whilst progress is monitored mid-year, there is no established measure against which that progress can be evaluated until the end of the year. A draft demand management strategy has been developed to facilitate management as predicted increases in demand eventuate.

Planning has been undertaken with wide consultation involving staff, community and external stakeholders, utilising data modelling to inform decisions.

As an example of the internal planning process, the nursing division has developed its plan for the 2008-9 year following a consultative process involving both managers and staff within the context of the District plan. The plan addresses increasing demand, workforce requirements, risk management, work/life balance, education and development, models of practice and finance and resources. A workload management tool was developed in June 2008.

Surveyor's 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

Surveyor's Comments:

The organisational structure of the District was reviewed and revised following the Districts' amalgamation. The Executive Committee, as the day to day governing body, has been restructured recently following evaluation of its functioning since the amalgamation. The executive has formal terms of reference and evaluates its performance annually. Community input is facilitated through the District Community Council. Its members sit on appropriate District committees including the Patient Safety and Quality Council to provide a community perspective to deliberations. Effective links are maintained with the Division of General Practice and good relationships were demonstrated.

There are established terms of reference and membership for all committees, a requirement that they evaluate their performance annually and there is a template for the recording of minutes but it is not in universal use across the District. In a number of cases, and particularly in Mental Health, terms of reference do not provide for clear direction in relation to expected outcomes and evaluation of effectiveness, whilst minutes do not clearly reflect decisions taken and the impact of implementation leading to evidence of continuous improvement. Minutes can provide a rich source of verification of various aspects of care and service provision and, hence, need to be recorded in a way which reflects this. The use of first names and/or initials only in minutes should be eliminated and replaced by either using the position held or full names (initials supported by an explanatory key are an acceptable alternative). Evaluation of meeting effectiveness was sometimes observed to be as limited as an evaluation of attendance. Terms of reference

should include the criteria to be used for assessing effectiveness. A simple way of achieving this is to have a committee set its objectives for the year and evaluate performance against those objectives at the end of the year.

Queensland Health maintains a system-wide approach to delegations which are regularly reviewed and updated as necessary. There are controls in place through finance, purchasing and human resource systems to monitor compliance. Queensland Health's Integrated Resource Manual provides the operating and management requirements for staff and facilities which, in other jurisdictions, may appear in by-laws. These are regularly updated. Performance requirements for the District are incorporated into the District Manager's performance agreement.

There is a rigorous system for financial management. Accounting services are a shared service but financial management is provided within the District. Staff are involved in the preparation of their budgets and are then expected to manage within the allocated budget. Good information systems provide a wealth of financial information to District and unit management. Data is converted into easily interpreted information, trended, analysed and modelled to facilitate good financial management. Compliance with the Financial Management Act, including financial controls, is evaluated and certified annually.

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

(i) A suitable mechanism for the evaluation of the effectiveness of committees be developed and appropriate measures for evaluation be included in each committee's terms of reference.
(ii) Minutes be recorded to a standard which provides a clearly identifiable decision trail and the status of issues under discussion.
(iii) The use of abbreviated names within minutes be eliminated and replaced with a system which ensures that individual participants are clearly identifiable.

Function: Corporate **Standard:** 3.1
Criterion: 3.1.3 Processes for credentialing and defining the scope of clinical practice support safe, quality health care.

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

Surveyor's Comments:

The surveyors noted that there are rigorous processes in each professional discipline in the District to ensure credentialling and currency of registration with the respective registration authority.

Allied Health
There are rigorous processes to check credentialling and registration at time of appointment. It is noted that there is no registration authority for some craft groups (eg Social Work) and that membership of the professional association is non-mandatory.

It was noted that in some allied health disciplines checks of registration were not being done until some days after the registration renewal date on 1 July. It was also noted that in some allied health disciplines the responsibility for credentialling was a shared responsibility between the service manager and Director, and in others the responsibility rested with either the Director or service manager. It is suggested that responsibility for credentialling of allied health staff be standardised, and responsibility assigned to the Director of the respective allied health discipline, and that checking of registration renewal occur prior to 30 June each year.

Nursing
The surveyors noted that nursing administration has implemented rigorous processes around appointments and initial credentialling, and that there are systems for monitoring registration, education and competencies.

Junior and Senior Medical Staff
There are robust processes to check credentials and registration with the Queensland Medical Board, using the Queensland Medical Board public access register.

It was noted that evidence of current registration was missing from the files of two junior medical staff, which was not in accordance with the District policy (untitled). It is suggested that an internal audit process of personnel files be introduced in Medical Administration to ensure evidence of currency of registration of junior medical staff.

The survey team noted that the District has implemented a policy/procedure 'Credentials and Clinical Privileges for Medical Practitioners' and has a system for credentialling and clinical privileging of medical practitioners (other than junior medical staff), which is facility-specific and relates to the Service Capability Framework of the facility and/or health service. The surveyors noted, however, that there is currently no policy/procedure or system for defining the scope of clinical practice for medical practitioners, in particular for proceduralists, which defines those procedures which the consultant can or cannot perform.

The surveyors noted that there is no system or policy/procedure for credentialling and defining the scope of clinical practice of registrar or senior medical officer staff, with the exception of obstetric and gynaecology registrars where there is a robust process for credentialling and competency assessment of obstetric and gynaecology registrars to conduct unsupervised after-hours LUSCS. The clinical leadership of the Director Obstetrics and Gynaecology and high level of consultant engagement in this process, and the commitment to providing after-hours supervision for registrars and junior medical staff is commended.

The survey team recommends that a process of credentialling and defining the scope of clinical practice for registrar and senior medical officers be implemented as a priority for all registrars and senior medical officers who are performing interventional procedures. This will provide a framework for managing requests from registrars to perform procedures, as with the recent request by a surgical registrar to perform a laparoscopic appendicectomy.

The survey team noted that there is a District policy 'Introduction of New Equipment or Consumables for Surgical Services' however, there is no policy or system for the safe introduction of new interventions/services. The surveyors recommend that a policy and system for the safe introduction of new interventions/services be implemented as a priority, and that the scope of clinical practice of a clinician be reviewed prior to new services or interventions being introduced. The implementation of this system will provide a framework to appropriately manage applications from clinicians to perform new procedures, as with the recent request by a consultant to perform laparoscopic banding.
It is noted that there is a performance appraisal and development framework for consultant medical staff, however, few consultant staff have completed performance appraisals. This system of performance monitoring needs to be linked to the system of credentialling and defining the scope of clinical practice, in order that a consultant's scope of clinical practice can be varied where indicated.

The surveyors noted that there is no policy or system for performance management of junior medical staff, and that management of poorly performing junior medical staff has been identified as a key risk for the organisation.

The survey team noted that there is currently no process of formal communication to key stakeholders of the clinical privileges and scope of clinical practice of medical staff including consultant, general practitioner/visiting medical officer, registrar and senior medical officers. As a consequence, these staff are required to contact individual staff including the Executive Director Medical Services and Directors of Business Units to provide this information. It is recommended that a communication strategy be implemented which enables key stakeholders to have direct access to this information.

The surveyors noted that at Kingaroy there has been a long-standing medical workforce shortage of anaesthetist and obstetrician consultant staff, and that currently a general practitioner/visiting medical officer who has clinical privileges as a generalist obstetrician and anaesthetist is rostered to concurrently cover two rosters and provide after-hours cover, as both the on-call anaesthetist and obstetrician. It is the understanding of the surveyors that the general practitioner/visiting medical officer only performs epidural anaesthesia and not general anaesthesia in this situation. The surveyors noted that the District conducted an internal review of maternity services at Kingaroy in May 2007, and that as a result of this review several risk management strategies have been implemented, including screening of high risk pregnancies and transfer to higher level care, whilst concerted endeavours have been made to recruit additional obstetric and anaesthetist staff. The surveyors understand that a new consultant anaesthetist is expected to be appointed in 8-12 weeks and that the general practitioner/visiting medical officer will then only cover the after-hours obstetric roster.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Advanced Completion in 60 Days (AC-60)

An AC-60 was undertaken on the following High Priority Recommendations from the Organisation-Wide Survey:
Stage 1:
(i) A system be implemented for defining, monitoring and communicating the scope of clinical practice for all consultant, general practitioner/visiting medical officer, registrars and senior medical officers in the District, which specifically includes medical staff working in The Park Centre for Mental Health and registrars performing electro-convulsive therapy procedures.
(ii) A system of performance management for junior medical staff, and consultant and general practitioner/visiting medical officer medical staff be implemented, which is linked to the system of credentialling and defining the scope of clinical practice, and ensures that all consultant and general practitioner/visiting medical officer medical staff have an annual performance appraisal.
(iii) A system of performance management for junior medical staff be implemented, which is linked to the system of credentialling and defining the scope of clinical practice.
(iv) A policy be developed and a system implemented for the safe introduction of new interventions, which includes review of a clinician's scope of clinical practice prior to the introduction of new interventions.
(v) The systems developed in response to recommendations (i) and (ii) be implemented in at least two clinical services and an action plan developed for their implementation across the whole District.

Stage 2 :
(i) The organisation demonstrate that the scope of clinical practice and performance management systems developed in Stage 1 have been implemented across the whole District.

Action Taken by Organisation to Address Recommendations

Actions undertaken:
(i)
* The WSMB District Credentials and Clinical Privileges for Medical Practitioners Policy/Procedure has been revised to fully reflect the requirements in the Credentialing and defining the Scope of Clinical Practice for medical practitioners in Queensland - a policy and resource handbook v1.0 April 2008.
* Credentialling application forms have been revised to reflect the current Credentialing and defining the Scope of Clinical Practice for medical practitioners in Queensland – a policy and resource handbook v1.0 April 2008.
* A database has been developed which monitors and identifies all Senior Medical Officers and Visiting Medical Officers in the district and outlines their credentialling status.
* A district credentialling and clinical privileges intranet site has been created and published for all credentialling resources and to communicate the process for credentialling.
* The WMSB District Service Capability Framework has been revised and links with the district and Queensland Health credentialling policy and is accessible on the WMSB District intranet site.
* Registrars (except Psychiatric Registrars who perform ECT) have been excluded from the credentialling process as supported and referenced in the ACHS EQuIP 4 Update (No 4, October 2008) which states on page four of this document that credentialling of junior medical officers/registrars in training programs is not required by the ACHS standards, however organisations must provide evidence that junior medical officers are provided with appropriate levels of supervision at all times, by either the organisation or a college and that their scope of practice is defined, with inclusion and exclusion criteria readily available to other members of staff and clearly displayed. Please refer to Rec. No. (iii) below.
* Mental Health Medical Officer Consultants and Registrars that perform ECT have applied for credentialling. These applications are for review at the Credentialling committee meeting on the 9 December 2008.
(ii)
* The Senior Medical Officer Performance Appraisal and Development (PAD) form has been revised to incorporate additional credentials and clinical privileges sought in the coming 12 months. The PAD also incorporates additional complex/interventional procedures or equipment that a medical officer may wish to conduct/use in the coming 12 months at their current facility.
The PAD links with the revised WMSB District Credentialling policy/procedure and the revised WMSB District New Interventional policy/procedure. All three documents are now linked and appropriately make reference to each other.
* A referee report form and supervisors report form have been implemented to ensure all medical officers are subject to ongoing performance management. These reports may be called on if there are concerns about a clinician.
* The Terms of Reference for the Credentialling and Clinical Privileges committee have been revised to ensure a system of credentialling for medical officers is more robust and aligns itself with state and federal credentialling standards. The committee now allows for performance management of Senior Medical Officers as access to reports such as complaints, surgical complications and concerns about a clinician are able to be discussed in this forum.
(iii)
* In accordance with state and national directives, the Ipswich Hospital Junior doctor Medical Education program will undergo a full accreditation survey in March 2009 (date to be confirmed). The accreditation will be undertaken by the

Postgraduate Medical Education Council of Queensland (PMCQ), who are the accreditation authority for the Medical Board of Queensland.
PMCQ is responsible for ensuring that all health care facilities employing junior medical officers (PGY1, PGY2, and PGY3 and above not involved in a vocational training program) adhere to set standards in relation to supervision, assessment, evaluation, education provision, and general working conditions. In accordance with the requirements of the recently released new state and nationally supported accreditation standards, Ipswich Hospital is currently undertaking a comprehensive review of all policies, processes, and practices relating to these standards. This process will ensure that all junior doctors employed within Ipswich Hospital are appropriately supported, supervised, assessed, and educated.
The draft policies and guidelines will form the basis for junior doctor education, supervision and assessment in Ipswich Hospital and will be implemented at the beginning of 2009, for review by PMCQ in March 2009 as part of the full accreditation process. These include:
> Assessment Interview Process flow sheet
> Guidelines for Junior Medical Officers Assessment handbook
> Clinical Supervisors handbook for supervising Junior Medical Officers
> End Term Assessment form management flow chart for Junior Medical Officers
> Guidelines for completing Junior Medical Officer Assessment forms
> Junior Doctor Assessment Policy
> Protected Learning Time Policy for Junior Medical Officer
> Supervision of International Medical Graduates
> Supervision of Junior Medical Officers.

(iv)
District policy/procedure on New Interventional Procedures has been reviewed. The revised policy/procedure has been approved by District Executive and is accessible on the district intranet site. This policy/procedure links and references the revised WMSB District Credentials and Clinical Privileges for Medical Practitioners Policy/Procedure.

(v)
Recommendation (i) has been implemented across the district. This can be demonstrated through an up to date credentials database for Senior Medical Officers and Visiting Medical Officers for the district. Recommendation (ii) has been addressed through all new medical officer applicants and re-applicants now completing the new application form as documented through a revised credentialling process flow chart. Terms of reference for credentialling committee have been revised to ensure a system of credentialling for medical officers is more robust and aligns itself with state and federal credentialling standards.

Surveyor's Comments
The District has established and implemented a system for defining, monitoring and communicating scope of clinical practice across the District and this is available to staff on the intranet, thus satisfying both stages of the recommendation.

A revised senior medical staff performance and appraisal document is linked to credentialling and the processes for the introduction of new procedures or technology.

The District is in the process of undertaking a review of all policies, processes and practices relating to the supervision, management and education of junior medical staff. This will culminate with an accreditation review by the Postgraduate Medical Education Council of Queensland in early 2009, at which time these policies and practices will be finally reviewed and implemented.

A revised policy on the introduction of new interventions and technology has been approved and is available on the intranet.

The Conditional survey team will need to confirm that the changes have been sustained, and this process will be facilitated if the District develops and collects some relevant performance indicators to demonstrate the effectiveness and sustainability of the changes.

Surveyor's Recommendation:

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Corporate **Standard:** 3.1
Criterion: 3.1.4 External service providers are managed to maximise quality care and service delivery.

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

Surveyor's Comments:

External services are contracted by Shared Services on behalf of the Health Service Districts; the District, itself, does not negotiate or manage contracts. There is an operating level agreement between the District and Shared Services covering the responsibilities of the parties and performance requirements.

Preparatory to preparing contracts, the matters which are important to the end users are identified so that contracts can be assured of meeting the end user's needs. In negotiating contracts, Shared Services require contractors to have a system of quality assurance such as ISO accreditation or HACCP and to be legislatively compliant. Performance indicators are determined, included in contracts and monitored during the currency of the contract. There are annual reviews of longer term contracts undertaken with the end users. Whilst the District is required to manage the contractor, assistance is provided by Shared Services for dispute resolution. District specific contractor handbooks (including safety responsibilities) and induction requirements are referenced in contracts.

Surveyor's Recommendation:

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

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

Surveyor's Comments:

On amalgamation of the two former Districts a rationalisation of policies and procedures was necessary. The District has taken this as an opportunity to review and update its system for creating, managing and reviewing policies. A mapping process has been undertaken to identify a currently relevant suite of policies and procedures and to archive those no longer considered relevant. They have been risk rated and work is proceeding on their development. In the meantime, existing policies remain in place until replaced with the updated version.

The system provides for policies and procedures to be evidence-based, to reference current issues, Australian, industry and professional standards, legislation, codes of ethics and codes of practice and the evidence upon which they are based. A District Standards Committee oversees this work. Review dates are determined and appear on the policy or procedure. A comprehensive system for disseminating information about new or changed policies is in place, including email, posters and *Polly the Policy Parrot*. Education is provided for significant policies or significant change and, where appropriate, sign off is required to ensure that the information has been received.

It was noted during the survey that the policy and procedure applying to home visiting by staff does not adequately address the specific needs of those working in rural and remote areas, for example, when outside mobile phone coverage. It would be appropriate to review the policy to ensure that it adequately meets needs.

There is a system in place to monitor new or changed legislation and services offered by the Private Hospitals Association of Queensland and the Office of the Queensland Parliamentary Counsel are utilised for keeping abreast of changes. Legislative compliance is monitored by internal audit and the Health Quality and Complaints Commission. Staff were advised by the survey team of commercial services which are available to refine the compliance monitoring function.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

The policy and procedure relating to home visiting by staff be reviewed to ensure that it adequately covers the needs of those working in rural and remote areas, for example, when outside mobile phone coverage.

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.

Function: Corporate **Standard:** 3.2
Criterion: 3.2.1 Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.

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

Surveyor's Comments:

Risk assessments are undertaken at each site and there are sufficient lifting aids and appliances within each site to minimise risk. Where risks are identified, an action plan is in place to minimise impact. Generic manual handling training programs are in place and provide a sound general package to staff. The manual handling training package could benefit from further development and have packages tailored to specific work areas. It was identified in Ipswich Hospital that administration staff could benefit from a tailored package focused on document and office equipment movement. Administrative staff based at Sacred Heart dental unit would benefit from a full assessment of the dental record storage system and the potential manual handling risks associated with the current storage compactus.

A Radiation Safety Officer has been appointed and has responsibility to oversee all facets of radiation safety across the District. A report in April 2008 reviewed all aspects of safety and rated the radiation safety at a high standard. A radiation safety management plan is in place which ensures that consumer/patient exposure to radiation is minimal. There is a sound mechanism for feedback from the District radiographers to registered nurse operators at Boonah, Laidley and Esk Hospitals. This feedback should be extended to Kingaroy to ensure that professional development of staff includes raising awareness of radiation safety issues.

Material safety data sheets are readily available across all hospital sites and chemical storage is safe and contained in secure areas. Boonah, Laidley, Esk and Kingaroy Hospitals all have access to Chemalert systems which ensures that all information is current and relevant to practice. These same procedures should be further extended to The Park where material safety data sheet information was not readily available and chemicals were stored in patient rooms.

Policy and procedures are in place and supported through an identified and trained group of occupational health and safety representatives. Systems are evaluated and improvements identified and actioned.

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

(i) A manual handling program be developed at Ipswich to address specific needs of administrative staff, ie lifting, moving clinical records, moving computers, lifting boxes of copy paper.
(ii) The storage facility for patient records at Sacred Heart oral health unit be evaluated for compliance with manual handling principles.
(iii) Resources be assigned at Laidley and Esk to prioritise actions to address issues in asbestos reports.
(iv) The Radiation Safety Officer provide professional development to local staff at Kingaroy to increase awareness of radiation safety issues.

Mental Health
(i) The bathroom 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.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

(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.

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

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

Surveyor's Comments:

Plant and equipment are operated and maintained by a well organised District team. The team is made up of a composition of employees and external contractors who are all subject to the policies and procedures of the health service. A District-wide preventative maintenance program ensures that plant and equipment is maintained in good working order and that procedures are in place to ensure that repairs are identified and actioned in a timely manner.

An energy management system is in place in Ipswich, and this has resulted in efficiencies in energy usage and a resultant decrease in energy expenditure.

Mental health medical records are archived in a building adjacent to Dawson House known as the Dawson House Annexe. Whilst the building has suitable fire protection, the security of the building is minimal with unprotected glass windows and the records are exposed to sun. Steps should be taken to ensure that these records are stored so as to protect and preserve the records.

Part of the intent of this criterion is to ensure that all buildings (and utilities) owned or used by a health care organisation are managed and operated to support a safe health environment. The criterion addresses in a broader sense how the organisation maximises the safety, comfort and needs of the community it serves. The focus of this AC-60 recommendation and the accompanying subservient recommendations is the Barrett Adolescent Centre (BAC) located within The Park – Centre for Mental Health. Many of the patients admitted to the BAC have extensive histories of recurrent, severe self-harm and suicidal behaviours often associated with abuse and trauma. As a statewide service and the only facility capable of providing care for this high acuity group of patients, the BAC does not have a choice about the mix of patients they will admit. The surveyors noted that as the redevelopment of The Park site progressed BAC lost access to other buildings, eg nearby auditorium, high dependency unit and medical centre for the management of patients with eating disorders. This compounded the problems and placed greater strain on the patient accommodation, notably the ward environment.

The level of risk associated with the BAC patient accommodation and treatment areas has been identified over a long period of time, with reviews conducted in 2003-2004 and in 2006. In addition, internal reviews have been instigated following various critical incidents over the period from 2003 to the present time. Evidence in BAC and hospital records demonstrates an increasing level of incidents often associated with serious outcomes for both patients and staff. This has led to a high level reliance on continuous observation as a patient safety strategy. Recommendations to address the associated staffing issues are included under criterion 2.1.2 in the in-depth review report.

Whilst there has been a decision to rebuild the facility, the timeframe for this to occur remains unclear and is reported as not likely to be for another two or three years.

The current situation needs to be addressed immediately with interim measures to address and mitigate the risks associated with:
1. Requirement for containment for high acuity patients and to provide for protection from self-harm or harm to others;
2. Accommodating physically fit seriously ill adolescents in a non-purpose built environment which it has been agreed in various reports is entirely unsuitable to their needs.

A further comprehensive review was conducted in March 2007 and a range of improvements recommended to enable the unit to continue to provide a safe patient and staff environment, pending the capital works program to rebuild the facility. This report reiterated the findings of previous reports and could provide a useful basis for addressing the immediate risk issues.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Advanced Completion in 60 Days (AC-60)
An AC-60 was conducted on the following High Priority Recommendations from the In-Depth Review:
Stage 1:
(i) Written confirmation of approval be obtained (with necessary budget allocation) to immediately make the necessary environmental modifications to the Barrett Adolescent Unit to reduce risk to acceptable levels and improve patient and staff safety.
(ii) Documented evidence of approved plans and work schedule for the environmental modifications be provided, with designated timeframes for completion.

Action Taken by Organisation to Address Recommendation
Stage 1:
(i) Written approval with appropriate budget allocation has been obtained for the environmental modifications to Barrett Adolescent Unit to reduce risk and improve patient safety. The environmental modifications include:
* Removal and replacement of glass with Perspex in identified areas of the unit has been completed.
* The front entrance door will be replaced with an aluminium frame and toughened glass. Scope of work has been developed and installation of the new door is to be completed by 05 Dec 08.
* High Dependency Unit (HDU) plans have been drawn up and are progressing through the building approval process. Associated plans are currently being drafted in relation to the under slab, sewerage and drainage services and the ducted air conditioning. Once plans are finalised they will be submitted for approval through Project Services. Fixtures such as lighting, doors, door frames, hinges associated with the project have been ordered. Project scheduled to be completed April/May 2009.

(ii) The evidence of the documented plans and the work schedules of environmental modifications is available from Building and Engineering Maintenance Services. The Park Service Manager and Service Improvement Coordinator also have access to copies of the plans and work schedules. Timeframes for the completion of the environmental modifications project are scheduled to be completed April/May 2009. The scope of work for all of these modifications outlines the requirements/specifications of the work and the timeframes for the work to be completed.

Stage 2:
(ii) Corporately there has been a decision to relocate Barrett Adolescent Unit to another site. Negotiations are underway for the unit to be relocated and developed at Metro South Health Service District (Redlands). This is supported by documented evidence - "Report of the site evaluation sub-group" Site options paper for the redevelopment of the Barrett Adolescent Centre - October 2008 available through the District Chief Executive Officer's office.
Completion Due By: 15 December 2008
Responsibility: Executive Director Mental Health Service WMSBHSD

Surveyor's Comments
A budget allocation has been made for the temporary works. The design has been completed and final approval is awaited from Council for the plumbing works. In the meantime, some works have been completed and others are underway. Completion of the project is anticipated in April/May 2009. The rating remains at SA pending the completion of the Stage 1 works.

A site for the relocation of the unit has been agreed between the two relevant District Managers. Consultation with stakeholders is to be undertaken in the New Year. Funding is available and the project will proceed to the design stage as soon as the site is confirmed. The surveyors were encouraged by the progress to date.

The Conditional survey team will need to confirm the completion of the temporary building works to address the deficiencies in the building and will need to verify that continuing progress has been made towards the relocation of the facility. If both aspects are confirmed, the High Priority Recommendation can be closed and the criterion re-rated to MA.

Surveyor's Recommendation: **HPR:** Yes

(i) Action be taken to ensure that inpatients in the medical imaging waiting area at Ipswich are returned to the ward immediately after their procedures, or structural changes be made to ensure that comfort and dignity is maintained.
(ii) Signposting at Sacred Heart Oral Health (administration/dental records) be changed to reflect the changed role from clinic to administration building.
(iii) The decommissioning of Farr Home and the relocation of residents to a more suitable aged care residential facility be considered (Kingaroy).

(iv) Safe work practices/safety rules be readily available for workshop staff at Kingaroy to assist in the promotion of a safe workplace.
(v) The current workplace administration floor space at Wondai be reviewed with a view to increasing the workplace size.
(vi) Refrigerators/freezers at Boonah, Laidley and Esk be fitted with temperature monitoring capacity.
(vii) Archived medical records in the mental health and oral health services be stored in a safe manner, free from exposure to sunlight and security risks.
(viii) Signposting for access and entry to the emergency department at Kingaroy be reviewed.

Stage 2 (August 2009)
(i) The immediate works identified in Stage 1 to reduce risk to acceptable levels be completed.
(ii) The rebuilding of the Barrett Adolescent Unit be expedited to enable care and services to be provided for adolescent patients in a purpose-built facility which facilitates a safe health environment and maximises the safety, comfort and needs of the community.

Risk Rating: Extreme

Risk Comments:

The surveyors assessed the risk as in the extreme category ie (likelihood – almost certain and consequences high) based on the history of incidents, near misses and root cause analysis investigations, discussions with clinicians working in the unit and observation of the area first hand by surveyors from both the in-depth review and organisation-wide survey teams. The rating was subsequently reduced to SA and a High Priority Recommendation assigned.

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

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

Surveyor's Comments:

Waste management services across the District comply with industry standards and there are good initiatives at Ipswich with recycling of waste water. Recycling of packaging at Ipswich is limited to cardboard and given the extent of recyclable material from a facility of this size, a review should be undertaken to assess further opportunities to expand the recycling program. Improvement of waste management practices at The Park would benefit from inclusion in staff orientation and in-service packages.

Good signage for waste material storage is displayed throughout the facilities. Secure external storage facilities are in place with access to approved external waste contractors.

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

(i) The capacity to implement a comprehensive recycling program at Ipswich be reviewed.
(ii) Waste management procedures in the mental health service be included in staff orientation packages and in-service programs.
(iii) Action plans be developed in the mental health service for implementing improvements following routine waste management audits.

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

Surveyor's Comments:

The organisation provided evidence of full fire inspections of Esk, The Park, Boonah, Laidley, Kingaroy, Wondai, Nanango, Cherbourg and Murgon facilities. Action plans have been developed and identified works have been completed, or are progressing towards completion. Inspections and action plans of those facilities have been developed within the current EQuIP cycle. At the time of survey a fire inspection was underway at Ipswich Hospital and was due for completion in the coming months. There was no evidence of planned fire inspections for Oral Health facilities at Collingwood Park or Sacred Heart facilities.

Staff are trained in emergency preparedness and this is demonstrated by the sound knowledge that staff displayed during the survey period. New emergency exit plans have been developed at Ipswich Hospital.

Advanced Completion in 60 Days (AC-60)
An AC-60 was undertaken on the following recommendations from the Organisation-Wide Survey:
(i) Ipswich fire inspection be completed and there be a documented plan to implement the recommendations from that fire inspection.
(ii) Oral Health facilities at Collingwood Park and Sacred Heart undertake a full fire inspection by an authorised external provider and there be a documented plan to implement the recommendations of those fire inspections.

Action Taken by Organisation to Address Recommendations
Actions undertaken:
(i) Ipswich Hospital Building Survey report was received from Queensland Fire and Rescue Service (QFRS) on 20 October 2008. A documented action plan was developed to address all requirements to be addressed within 28 days as per Australian and Queensland legislation and standards. Key stakeholders at Ipswich Hospital met on 28 October 2008 and allocated tasks as identified in the Action Plan.
Tasks have been given a high priority to be completed by Building Engineering and Maintenance Services at Ipswich Hospital. All other recommendations have been given a priority to be completed. A follow-up compliance inspection is being arranged with QFRS between the 24 and 27 November 2008.

(ii) A Queensland Fire and Rescue Service (QFRS) Building Inspection was conducted on all West Moreton South Burnett Health Service District Oral Health facilities (including Collingwood Park and Sacred Heart). A report was subsequently received from QFRS for all facilities and the facilities which require actions to address identified issues from QFRS was placed into documented action plans. Documented action plans for Collingwood Park and Sacred Heart have been developed to address the identified issues. A follow-up compliance inspection is being arranged with QFRS between the 24 and 27 November 2008.
Completion Due By: 15 December 2008
Responsibility: District Director Clinical Support Services

Surveyor's Comments
The fire inspections for the Ipswich campus and the dental facilities have been completed and action plans were prepared and implemented.

All Queensland Fire and Rescue Service requirements have, subsequently, been completed and the Fire and Rescue Service has certified that all requirements have been met.

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

(i) Progress be hastened in replacing existing emergency exit plans with new exit plans in ward areas of Ipswich hospital.
(ii) The District fire training program be further developed to include site/unit specific content that reflects the uniqueness and needs of each work location.

EXHIBIT 75

Organisation Wide Survey - Survey Team Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

Surveyor's Comments:

Staff in at risk areas have access to monitoring equipment and security personnel as appropriate. Aggressive Behaviour Minimisation training is in place.

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

(i) The security risks facing staff when working alone at night in the emergency departments at Laidley and Esk be monitored to ensure that personal safety is maintained.
(ii) A safety review be undertaken of all non-hospital sites to ensure that staff working in small teams in isolated sites have a secure workplace with appropriate communication systems in place if needed in an emergency (Oral Health).
(iii) The security of staff working in the Laidley Oral Health facility be reviewed.
(iv) The personal duress alarm system at Wondai be reviewed with a view to determining its functionality and future use.
((v) General and master keys for the Kingaroy facility be located and maintained in a locked key cabinet with limited staff access.

Rating Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Clinical				
Criterion	Description	Organisation's self-rating	Surveyor Rating	HPR
Crit. 1.1.1	The assessment system ensures current and ongoing needs of the consumer / patient are identified.	MA	MA	
Crit. 1.1.2	Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.	MA	MA	
Crit. 1.1.3	Consumers / patients are informed of the consent process, understand and provide consent for their health care.	MA	MA	
Crit. 1.1.4	Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.	MA	MA	
Crit. 1.1.5	Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.	MA	MA	
Crit. 1.1.6	Systems for ongoing care of the consumer / patient are coordinated and effective.	MA	MA	
Crit. 1.1.7	Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.	MA	MA	
Crit. 1.1.8	The health record ensures comprehensive and accurate information is recorded and used in care delivery.	MA	MA	
Crit. 1.2.1	The community has information on, and access to, health services and care appropriate to its needs.	MA	MA	
Crit. 1.2.2	Access and admission to the system of care is prioritised according to clinical need.	MA	MA	
Crit. 1.3.1	Health care and services are appropriate and delivered in the most appropriate setting.	MA		
Crit. 1.4.1	Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.	MA	MA	
Crit. 1.5.1	Medications are managed to ensure safe and effective practice.	MA	SA	
Crit. 1.5.2	The infection control system supports safe practice and ensures a safe environment for consumers / patients and health care workers.	OA	MA	
Crit. 1.5.3	The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy.	MA	MA	
Crit. 1.5.4	The incidence of falls and fall injuries are minimised through a falls management program.	EA	MA	
Crit. 1.5.5	The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.	MA	SA	
Crit. 1.5.6	The organisation ensures that the correct patient receives the correct procedure on the correct site.	MA	MA	
Crit. 1.6.1	Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service	MA	MA	
Crit. 1.6.2	Consumers / patients are informed of their rights and responsibilities.	MA	MA	
Crit. 1.6.3	The organisation makes provision for consumers / patients from culturally and linguistically diverse backgrounds and consumers / patients with special needs.	MA	MA	

Rating Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Support				
Criterion	Description	Organisation's self-rating	Surveyor Rating	HPR
Crit. 2.1.1	The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.	EA	MA	
Crit. 2.1.2	The integrated organisation-wide risk management policy and system ensure that clinical and corporate risks are identified, minimised and managed.	EA	MA	
Crit. 2.1.3	Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.	MA	MA	
Crit. 2.2.1	Human resources planning supports the organisation's current and future ability to address needs.	MA	MA	
Crit. 2.2.2	The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.	MA	MA	
Crit. 2.2.3	The continuing employment and performance development system ensures the competence of staff and volunteers.	MA	SA	
Crit. 2.2.4	The learning and development system ensures the skill and competence of staff and volunteers.	MA	SA	
Crit. 2.2.5	Employee support systems and workplace relations assist the organisation to achieve its goals.	MA	MA	
Crit. 2.3.1	Records management systems support the collection of information and meet the organisation's needs.	MA	MA	
Crit. 2.3.2	Information and data management and collection systems are used to help meet the strategic and operational needs of the organisation.	MA	MA	
Crit. 2.3.3	Data and information are used effectively to support and improve care and services.	MA	MA	
Crit. 2.3.4	The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).	MA	MA	
Crit. 2.4.1	Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation.	MA	MA	
Crit. 2.5.1	The organisation's research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research	OA	MA	

Corporate				
Criterion	Description	Organisation's self-rating	Surveyor Rating	HPR
Crit. 3.1.1	The organisation provides quality, safe care through strategic and operational planning and development.	MA	MA	
Crit. 3.1.2	Governance is assisted by formal structures and delegation practices within the organisation.	MA	MA	
Crit. 3.1.3	Processes for credentialing and defining the scope of clinical practice support safe, quality health care.	MA	MA	
Crit. 3.1.4	External service providers are managed to maximise quality care and service delivery.	MA	MA	

Rating Summary Report

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Crit. 3.1.5	Documented corporate and clinical policies assist the organisation to provide quality care.	MA	MA	
Crit. 3.2.1	Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.	MA	MA	
Crit. 3.2.2	Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.	MA	SA	Y
Crit. 3.2.3	Waste and environmental management supports safe practice and a safe environment.	MA	MA	
Crit. 3.2.4	Emergency and disaster management supports safe practice and a safe environment.	MA	MA	
Crit. 3.2.5	Security management supports safe practice and a safe environment.	MA	MA	

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.1
Criterion: 1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.

High Priority: No

Recommendation:

(i) Compliance with the use of assessment documentation tools be improved.
(ii) Clearly documented, practical, easy reference admission and exclusion criteria be developed for each rural facility based on the site capability framework, so that front line staff can make consistent timely decisions about transfer out and that tertiary acceptance is more transparent.

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.

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

High Priority: No

Recommendation:

(i) All x-rays be reported for safe patient care and quality assurance.
(ii) Routine feedback be provided to rural hospitals regarding outcomes of care when patients are referred to Ipswich.

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.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

High Priority: No

Recommendation:

Consistent with Queensland Health policy and based on best practice, the timeliness of provision of documented informed consent be improved for all elective invasive procedures so that it is available for further discussion and confirmation, either at the pre-admission clinic or on admission (as appropriate to the particular patient journey).

Function: Clinical **Standard:** 1.1
Criterion: 1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.

High Priority: No

Recommendation:

(i) The analysis of aggregated data concerning outcomes of care be strengthened and the participation by medical officers in multidisciplinary review be increased, so that there is more effective development of strategies to improve patient outcomes.
(ii) A simple system for tracking the timeliness of Clinical Unit Director response to clinical indicator queries and other matters forwarded by the Patient Safety and Quality Unit be developed, with reporting at District safety and quality meetings where delays or failure to respond have occurred, so that appropriate clinical governance can be assured.

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.

Function: Clinical **Standard:** 1.1
Criterion: 1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.

High Priority: No

Recommendation:

Mental Health

Stage 2 (by August 2009)
(i) The effectiveness of the clinical record audit process implemented be evaluated.
(ii) West Moreton Health District complete an audit to ensure that all mental health services have a clinical record audit system in place and operational.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.2
Criterion: 1.2.2 Access and admission to the system of care is prioritised according to clinical need.

High Priority: No

Recommendation:

A review of the staffing/resource levels be undertaken and strategies implemented to address the waiting times involved with the outreach service provided by the Child and Family Health Service Young People's Health Team, Day Stay Centre and Occupational Therapy Service.

Function: Clinical **Standard:** 1.5
Criterion: 1.5.1 Medications are managed to ensure safe and effective practice.

High Priority: No

Recommendation:

(i) A pharmacy consulting service be provided to those rural facilities without a pharmacist and where the pharmacy service is provided by nursing staff.
(ii) The system for reviewing medication incidents and management practices be enhanced to ensure that there is always feedback to staff on outcomes of the reviews.
(iii) Specialist advice on appropriate protocols for the administration and ongoing clinical management of patients on opioid maintenance at Kingaroy be sought from Pharmacy or Alcohol, Tobacco and Other Drug Services.
(iv) Drug refrigerators be fitted with alarms to identify loss of temperature.

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.

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 health care workers.

High Priority: No

Recommendation:

Alarm systems for refrigerators in outlying hospitals to denote a power loss be implemented.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard:** 1.5
Criterion: 1.5.5 The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.

High Priority: No

Recommendation:

(i) A blood management system which monitors and reviews the prescribing of blood and blood products to ensure appropriate practice be developed.
(ii) An education program for clinical staff on appropriate practices for prescribing blood and blood products be developed and implemented.
(iii) The maximum blood ordering schedule (MBOS) dated 1995 be updated.

Function: Clinical **Standard:** 1.6
Criterion: 1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service

High Priority: No

Recommendation:

The current profile of consumer input be mapped to identify any gaps and, if necessary, an action plan be developed to guide further input from the community.

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.

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

High Priority: No

Recommendation:

Queensland Health be approached to review and republish its Rights and Responsibilities pamphlets and posters in order to ensure that the content is current.

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.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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.

High Priority: No

Recommendation:

(i) A standard, outcome-based template be developed for recording minutes of meetings, to improve the quality of minute taking across the District.
(ii) An analysis of the QASAR database be undertaken to identify users' perceptions, needs and level of satisfaction and make improvements as required.

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.

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

High Priority: No

Recommendation:

(i) The role of clinical leadership in peak committees which consider risk be reviewed to ensure that there is sound medical input into the risk management system.
(ii) A proactive, multidisciplinary approach be developed for the identification of risk to enhance the existing system, which relies heavily on incidents to identify risk.

Function: Support **Standard:** 2.1
Criterion: 2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.

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.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Support **Standard:** 2.2
Criterion: 2.2.1 Human resources planning supports the organisation's current and future ability to address needs.

High Priority: No

Recommendation:

The development of the workforce plan be expedited. (It is acknowledged that the District has made a significant commitment to achieving this objective and it is important that the imminent amalgamation with Toowoomba and Darling Downs Health Service District does not impede the progress of this development).

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

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.

Function: Support **Standard:** 2.2
Criterion: 2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.

High Priority: No

Recommendation:

(i) A strategy be developed to ensure that all employees participate in the new Performance and Development (PAD) system. The strategy could include enhanced promotion and training of PAD across the organisation and regular auditing of this requirement across all departments and facilities.
(ii) The supervision arrangements for junior medical staff undertaking rural relief duties be formalised to ensure that they receive adequate orientation, on-site teaching, supervision and general support.
(iii) The current registration status and scope of practice for all health professionals be readily accessible to rural managers.
(iv) Time be made available to ensure that there is adequate access to education and mandatory training for medical staff.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

High Priority: No

Recommendation:

(i) A comprehensive all-encompassing staff development plan be developed, based on a formal needs assessment of all departments and disciplines.
(ii) A proactive approach be developed to ensuring that there is optimal participation in mandatory training sessions. (It is suggested that auditing the implementation of the Policy and Procedure "Mandatory Training" across all sites could be a pivotal component of this approach).

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.

Function: Support **Standard:** 2.3
Criterion: 2.3.1 Records management systems support the collection of information and meet the organisation's needs.

High Priority: No

Recommendation:

(i) The work to date on the integration of patient records across services and the flagging of records held at other sites be continued across the District.
(ii) The District's standardisation of clinical forms project continue to be implemented.

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).

High Priority: No

Recommendation:

A District information technology plan (supporting the Queensland Health plan) be developed to address the local issues of information technology provision.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Support **Standard:** 2.4
Criterion: 2.4.1 Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation.

High Priority: No

Recommendation:

A suite of key performance indicators be established in consultation with relevant staff, to capture the outcomes of the health performance initiatives across the District and trend them over time.

Function: Corporate **Standard:** 3.1
Criterion: 3.1.2 Governance is assisted by formal structures and delegation practices within the organisation.

High Priority: No

Recommendation:

(i) A suitable mechanism for the evaluation of the effectiveness of committees be developed and appropriate measures for evaluation be included in each committee's terms of reference.
(ii) Minutes be recorded to a standard which provides a clearly identifiable decision trail and the status of issues under discussion.
(iii) The use of abbreviated names within minutes be eliminated and replaced with a system which ensures that individual participants are clearly identifiable.

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

High Priority: No

Recommendation:

The policy and procedure relating to home visiting by staff be reviewed to ensure that it adequately covers the needs of those working in rural and remote areas, for example, when outside mobile phone coverage.

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.

Function: Corporate **Standard:** 3.2
Criterion: 3.2.1 Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.

High Priority: No

Recommendation:

(i) A manual handling program be developed at Ipswich to address specific needs of administrative staff, ie lifting, moving clinical records, moving computers, lifting boxes of copy paper.

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

(ii) The storage facility for patient records at Sacred Heart oral health unit be evaluated for compliance with manual handling principles.
(iii) Resources be assigned at Laidley and Esk to prioritise actions to address issues in asbestos reports.
(iv) The Radiation Safety Officer provide professional development to local staff at Kingaroy to increase awareness of radiation safety issues.

Mental Health
(i) The bathroom 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.

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

High Priority: Yes

Recommendation:

(i) Action be taken to ensure that inpatients in the medical imaging waiting area at Ipswich are returned to the ward immediately after their procedures, or structural changes be made to ensure that comfort and dignity is maintained.
(ii) Signposting at Sacred Heart Oral Health (administration/dental records) be changed to reflect the changed role from clinic to administration building.
(iii) The decommissioning of Farr Home and the relocation of residents to a more suitable aged care residential facility be considered (Kingaroy).
(iv) Safe work practices/safety rules be readily available for workshop staff at Kingaroy to assist in the promotion of a safe workplace.
(v) The current workplace administration floor space at Wondai be reviewed with a view to increasing the workplace size.
(vi) Refrigerators/freezers at Boonah, Laidley and Esk be fitted with temperature monitoring capacity.
(vii) Archived medical records in the mental health and oral health services be stored in a safe manner, free from exposure to sunlight and security risks.
(viii) Signposting for access and entry to the emergency department at Kingaroy be reviewed.

Stage 2 (August 2009)
(i) The immediate works identified in Stage 1 to reduce risk to acceptable levels be completed.
(ii) The rebuilding of the Barrett Adolescent Unit be expedited to enable care and services to be provided for adolescent patients in a purpose-built facility which facilitates a safe health environment and maximises the safety, comfort and needs of the community.

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

High Priority: No

Recommendation:

(i) The capacity to implement a comprehensive recycling program at Ipswich be reviewed.
(ii) Waste management procedures in the mental health service be included in staff orientation packages and in-service programs.
(iii) Action plans be developed in the mental health service for implementing improvements following routine waste management audits.

EXHIBIT 75

Recommendations from Current Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Corporate **Standard:** 3.2
Criterion: 3.2.4 Emergency and disaster management supports safe practice and a safe environment.

High Priority: No

Recommendation:

(i) Progress be hastened in replacing existing emergency exit plans with new exit plans in ward areas of Ipswich hospital.
(ii) The District fire training program be further developed to include site/unit specific content that reflects the uniqueness and needs of each work location.

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

High Priority: No

Recommendation:

(i) The security risks facing staff when working alone at night in the emergency departments at Laidley and Esk be monitored to ensure that personal safety is maintained.
(ii) A safety review be undertaken of all non-hospital sites to ensure that staff working in small teams in isolated sites have a secure workplace with appropriate communication systems in place if needed in an emergency (Oral Health).
(iii) The security of staff working in the Laidley Oral Health facility be reviewed.
(iv) The personal duress alarm system at Wondai be reviewed with a view to determining its functionality and future use.
((v) General and master keys for the Kingaroy facility be located and maintained in a locked key cabinet with limited staff access.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.1.2.1
Function: Clinical **Standard:** 1.1
Criterion: 1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.

High Priority: No

Recommendation:

1. The Emergency Department when fully staffed implement a policy which requires authorisation for at least known high risk patients to be discharged by a senior doctor.

2. The timeliness of registrars attending the Emergency Department be monitored and reviewed.

3. The Health Service consider the formation of a Medical Emergency Team.

Mental Health

4. Formal processes be established to ensure that nursing handover (at The Park) occurs in an appropriate manner to facilitate the transition of clinical information which maximises and enhances consumer care.

Action:

1. Identified high risk patients (chest pain, abdo pain, headache, paediatrics) to be reviewed by a Senior Doctor before discharge by an intern or RMO from the Emergency Department Ipswich Hospital - completed.

2. The right of admission procedure circulated to all ED medical staff and hospital registrars which allows for patients who have not been reviewed within two hours to be admitted to the wards - completed.

3. Medical emergency team proposal on resus committee agenda - proposal considered at all levels - not proceeding - insufficient evidence that this achieves improved outcomes. Policy to be developed for patient criteria requiring medical/surgical registrar consultation. Currently researching the MEWS - Medical Emergency Warning System for possible application.
Mental Health

4. ET&R Clinical Project completed. WPG developed; Tool and process for transfer of information from clnical teams to staff developed; Entry and discharge processes reviewed; All processes and tools used in clinical handover reviewed - changes relating to content, responsibilities for, and roles; Project outcomes communicated to all staff. Electronic conveying of clinical information between Nurse Unit Managers and After Hours Nurse Managers on a daily basis - communication across all shifts in relation to changes to acuity. Joint policy developed between Ipswich Hospital and The Park for handover of information of patients assessed, treated or discharged at or from IH & The Park. (Nursing Executive / Clinical Program Areas - Completed) **Mental Health**

4. Clinical Program areas reviewing handover process and implementing practices. ET&R currently trialling intended changes. Work Practice Guidelines being established.

Completion Due By: June 2007

Responsibility: Nursing Executive / Clinical Program Areas

Organisation Completed:

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

1. The Director of the Emergency Department (ED) has implemented a policy which requires that all identified high risk patients (chest pain, abdominal pain, headache, paediatric) are reviewed by a senior medical officer prior to discharge by a junior medical officer. The policy is included in orientation for junior staff and monitored by reference to incident data. There have been no reported incidents of this nature since implementation of the policy.

2. The 2005 Right to Admission policy allows ED senior medical officers to transfer stable patients to the wards and the policy has been reinforced by orientation of registrars. The formation of the Medical Assessment and Planning Unit (MAPU) has had significant impact on the journey of medical patients through the hospital. Some delays still occur with surgical registrars having competing commitments in theatres or outpatients but the Right to Admission policy addresses this at least for stable patients.

3. The formation of a Medical Emergency Team has been considered with evidence explored and so the recommendation is closed. Alternate strategies to address identification and early management of deteriorating patients is currently being explored by the Resuscitation Committee.

Recommendation: OWS0206.1.3.1
Function: Clinical **Standard:** 1.1
Criterion: 1.1.2 Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.

High Priority: No

Recommendation:

1. The Pharmacy Department at Ipswich Hospital adopt rural support strategies that ensure regular visits to the Boonah, Esk and Laidley Health Services.

2. The newly implemented clinical practice guidelines be evaluated to ensure the effectiveness of this change and that the process is beneficial for both patient management and clinical outcomes.

3. A system be developed to track patient information documents that are developed in-house, and that all these be dated so that accurate up to date data is ensured. A process of formal review including level of language and understandability to the text be conducted.

4. The Patient Management process be looked at from a strategic view with policy development that allows those staff in charge of decisions to clearly understand the actions that are required when all available resources have been used.

5. There be a structured continuing education program in the Emergency Department and the wards of Ipswich Hospital with protected time for staff participation.

Mental Health

6. A review of the current (15 desk space) open office plan in the Extended Treatment & Rehabilitation Unit be undertaken, to ensure that there is lockable space for information, appropriate desk allocation and regard for the provision of confidential conversations and/or discussions.

7. A review of the workspaces at Goodna Community Health be undertaken to ensure that staff and clients are provided the safest environment.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Action:

Mental Health

6. Review undertaken and changes being implemented are:

New office on verandah of Gunnii House
Review of OT test room locations
WPH&S Environmental audit conducted
Office furniture and additional computers ordered.

1. Telepharmacy for rural sites & I-Pharmacy intervention implemented and completed across rural facilities - completed.

2. Evaluation of the efficacy of clinical guidelines be conducted and patient outcomes reflect effectiveness of the guidelines (June 2007 - DDON) in progress.

3. Completed and implemented policy and procedure for development, publication and evaluation of patient information. Audit results demonstrate compliance - completed.

4. MBU, CAFHS and SBU have established bed management strategies and have developed a formalised escalation process in times of crisis.

5. Nursing structured continuing education program has been actioned; training examples include: the nurses role in triage, communication, role and functions within ED, skill development and upskilling. Formalised medical structured continuing education and training program has been actioned; examples include upskilling, doctors are supernumerary for 10 weeks when converting from SHO to PHO level. An office within ED has been converted to a dedicated medical training room with scenario based training and real life simulations - completed.

Mental Health

6. Office space project completed - report finalised.

(ET&R Work Improvement Group / BU1 Management Committee - Completed)

7. Review work space for staff at Goodna in conjunction with Goodna Community Health (as per IMHS Strategic Plan 2006-2011) - June2007 Service Manager IMHS.

Completion Due By: December 2006

Responsibility: ET&R WIG / BU1 Management Committee

Organisation Completed:

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

1. Pharmacy services are in place at rural sites. The teleconference model at Laidley is working well there to increase clinical input. This model could be extended to other sites. The absence of on-site visits still has an impact on the risks for medication management being undertaken solely by nurses, and a new recommendation has been made under criterion 1.5.1 in the current report.

2. Clinical guidelines are progressively being implemented based on models of best practice from reputable sources. Local evaluation is also being undertaken in various indirect and direct ways sufficient to address the intent of the recommendation.

3. Processes for the introduction of patient forms have been formalised, with master templates of approved documents available on the intranet. Auditing of records by the Health Information Manager tracks compliance.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

4. Escalation processes have been developed using a traffic light system for the Emergency Department and Intensive Care Unit at Ipswich, with "pull" systems from the wards and transit/discharge lounge areas in each ward assisting patient flow along with other strategies such as the MAPU.

5. The Emergency Department now provides two education sessions per week plus teleconference to rural sites. Various nurse educator positions have been increased across all sites and opportunities for education in core competency increased. Junior medical officers report difficulty in accessing education at times, and this is the subject of comment under criterion 2.2.4 in the current report.

6&7. The organisation has demonstrated completion of review of these facilities with appropriate renovations completed.

Recommendation: OWS0206.2.4.2
Function: Clinical **Standard:** 1.1
Criterion: 1.1.3 Consumers / patients are informed of the consent process, understand and provide consent for their health care.

High Priority: No

Recommendation:

1. In the light of the outcomes of the Queensland Patient Satisfaction Survey a targeted audit be conducted of consumer awareness of the Patient Rights and Responsibilities information at Ipswich Hospital.

Mental Health

2. With the appointment of a consumer position for the Integrated Mental Health Service a similar model be implemented as currently exists at The Park with the ability for consumers to have access to information from consumers on their rights and responsibilities at all points of care.

Action:

1. Subsequent review of the Queensland Health Patient Satisfaction Survey. Latest survey specifically asks about patient rights and responsibilities (awaiting results). All area have patient rights and responsibilities brochures and posters in place.

Mental Health
2. Developed the role for Consumer Consultant around the recovery principles as per IMHS Strategic Plan 2006-2011; Established a Consumer & Carer Advisory Group - completed.

Completion Due By: Feb 2008

Responsibility: Quality and Safety Officer PSQU

Organisation Completed:

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

1. Further audit has taken place and thus this recommendation is closed. Results are not yet known, but the current information available was noted to be out of date and is the subject of a new recommendation under criterion 1.6.2.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.1.3.2
Function: Clinical **Standard:** 1.1
Criterion: 1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.

High Priority: No

Recommendation:

Mental Health

Ongoing review be undertaken of the level of seclusion within the Mental Health Service and strategies be implemented to ensure that the service performs at an industry standard based on best practice.

Action:

Mental Health
The Park

- Project and research commissioned to review issues related to seclusion use across all clinical programs at The Park. Priority areas in High Security, Medium Secure & Dual Diagnosis. The Park - Seclusion and Restraint Reduction Plan developed (2007)
- Benchmarking of seclusion use included in Statewide Benchmarking of Medium Secure services.
- Workgroup established in Medium Secure to identify and implement strategies to reduce seclusion use.
- Evaluation project has been established to assess the efficacy of these
- Beacon site for Prevention and Reduction of Seclusion and Restraint.
- Policies reviewed.

IMHS

- Seclusion review program implemented in IMHS by the CN for Clinical Risk Management. Significant decrease in seclusion rates has resulted through the implementation of the Seclusion Action Plan. There has been participation in the clinical collaborative for seclusion and restraint and the Seclusion Committee meets monthly

Completion Due By: Ongoing

Responsibility: Clinical Steering Committee / SERU / Seclusion & R

Organisation Completed:

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

The organisation has demonstrated review of its seclusion practices and implemented strategies to reduce the usage of seclusion.

EXHIBIT 75

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.1.4.1
Function: Clinical **Standard:** 1.1
Criterion: 1.1.5 Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.

High Priority: No

Recommendation:

1. An organisation-wide approach to discharge planning be developed including appropriate review of cases where there are problems.

2. At Laidley Hospital a record flagging or alert system be developed as a matter of priority to support effective discharge planning from the hospital to community and reduce the potential for miscommunication and/or unplanned clinical outcomes.

Action:

1. On hold until State Discharge Planning policy rollout. Hand to Home response team implemented at Ipswich Hospital which has integrated the roles of post acute wounds and health maintenance into a single service. This service manages the whole hospitalisation by case management from preadmission to up to 4 weeks post discharge. Ipswich Hospital is to be one of the pilot sites for Qld Health Enterprise Discharge Summary.

2. Address as part of District strategy to address the need for an integrated record across Ipswich Hospital, Rural Health Services and Community Health Service. Community Health Service dispatch the medical record to rural facility and upon completing admission or presentation, the medical record is returned to Community Health. Pilot site for electronic discharge summary to commence in 2008.

Completion Due By: Ongoing

Responsibility: Director HIM

Organisation Completed:

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

1. The organisation uses the Queensland Health Policy on Discharge Planning as the overarching guide to processes and practices across all sites. Systems are in place appropriate for each site for interdisciplinary review of patients who represent post discharge, or who have frequent readmissions. Identification of patients who are potentially at risk of delayed discharge occurs on admission and appropriate interventions are actioned. The Hand to Home program at Ipswich Hospital has been created in order to consolidate the range of resources dedicated to discharge support and to realign the acute/community interface. The survey team noted the commitment by the clinical staff across all sites to the review of patients where there are potential or actual problems with discharge.

2. All clinical services, including community health and diabetes education, now document in the patient medical records at Laidley Hospital rather than maintaining separate files as was the case at the previous survey. These practices have achieved consolidation of all patient information in one file and have obviated the need for the development of a flagging system to enhance communication.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.4.1.1
Function: Clinical **Standard:** 1.1
Criterion: 1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.

High Priority: No

Recommendation:

1. Priority be given to developing a system to ensure timeliness of access of all members of the health care team (acute care, mental health, community health) to all parts of the health record at the point of access of the patient / client to the service, to ensure comprehensive health assessments and improved clinical outcomes.

2. The process for reviewing the results and addressing the recommendations arising from the regular Medical Record Audits be more formalised and that there is clear documentation of the ways the recommendations are being addressed and the quality loop closed.

Action:

1. Review current medical records across the district and seek a streamlined approach to patient records (June 2007 - Director HIM).

2. Documentation audit is formally conducted as a clinical audit process with feedback loop. Results tabled Patient Safety and Quality Council on an annual basis - completed.

Completion Due By: June 2007

Responsibility: Director HIM

Organisation Completed:

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

A concerted effort has been made by the Medical Records Department to address the recommendations from the previous survey. Performance improvement is being monitored more effectively through the use of benchmarks and indicators There was evidence that there is an ongoing process for the integration of medical records and the flagging of other records for patients across the District.

Recommendation: OWS0206.1.1.1
Function: Clinical **Standard:** 1.2
Criterion: 1.2.1 The community has information on, and access to, health services and care appropriate to its needs.

High Priority: No

Recommendation:

1. A strategic approach be adopted to clinical service planning. This approach should reflect the needs of the community and projected service demands.

2. Podiatry resources be increased at Ipswich Hospital to address the foot health needs of diabetic patients.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

3. The resource levels of occupational therapy, speech pathology and nutrition and dietetics be increased at the Boonah, Esk, and Laidley Health Services.

Action:

1. Health Services Plan 2008-2012 developed and in progress. The Ipswich Hospital Demand Management Strategy is currently being developed - to identify how the facility will cope with the growth in demand over the next 10 years.

2. Appointment of Director of Podiatry – West Moreton South Burnett Health Service District. Increase of podiatry position 0.3FTE to 1.0FTE for Ipswich Hospital. New position and service created based at Kingaroy/Wondai to service South Burnett Area for district; development of new position description.

3. Current financial constraints prevent an increase in current resources - for review in next financial year.

Completion Due By: August 2007

Responsibility: DMS

Organisation Completed:

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

1. A Health Services Plan 2008-2012 has been developed for clinical service planning.

2. A Director of Podiatry appointment to Ipswich Hospital was made in 2007, an increase from 0.3. A high risk foot clinic has been established which runs concurrently with the diabetes clinic. It is noted that a podiatrist position has also been established at South Burnett.

3. A Rural Rehabilitation Outreach Service has recently been established, and has provided dedicated resources of an occupational therapist and a speech pathologist, in addition to a physiotherapist, to Boonah, Esk and Laidley Health Services. Whilst the primary focus is rehabilitation, the focus is not exclusively rehabilitation, and the service has enabled access to occupational therapy and speech pathology services, and has improved continuum of care, facilitated early discharge and integrated acute and rehabilitation care.

Recommendation: OWS0206.1.1.3
Function: Clinical **Standard:** 1.2
Criterion: 1.2.2 Access and admission to the system of care is prioritised according to clinical need.

High Priority: No

Recommendation:

1. Waiting lists for outpatient clinics be reviewed, and further strategies developed to help reduce waiting times for appointments.

2. Further consideration be given to the provision of an emergency operating room at Ipswich Hospital for urgent obstetric and surgical cases.

3. Consideration be given to designation of a separate waiting area for Emergency Department paediatric patients.

4. Develop an appropriate interim care diversional therapy / activity program at the Laidley Hospital that is appropriately resourced.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

5. Enhance the interim care program at Esk Hospital by furnishing and decorating the special support ward and allocating and training staff to deliver an appropriate diversional therapy program, consistent with residential aged care standards.

Action:

1. Review of OPD clinic processes for managing waiting lists and waiting times - in progress. Allocation of a NUM for 0.21 FTE to implement the Outpatient Referral Program.

2. Establish 6th Theatre - Business Case for a staffing establishment and equipment; Created a dedicated emergency session daily; Provided adequate elective list capacity to accommodate the increased community demand; Provided adequate elective lists without diminishing the private lists of the VMOs; Reduced number of cases performed after hours.

3. Refurbished current waiting environment and separate children's fenced area installed - completed.

4. Implementation of a diversional therapy program at this facility - Business case submitted to Ipswich community health NO6 through the hands to home project for funding for this position.

5. Seek support of District Executive to fund diversional therapy training; EOI for staff to undergo training; Implement training program; Review special support ward environment and implement recommendations - in progress.

Completion Due By: June 2008

Responsibility: DDON/DMS

Organisation Completed:

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

1. The outpatient booking processes have been reviewed and streamlined. An Outpatient Central Referral Centre has been established. All bookings are reviewed in conjunction with the relevant clinician and prioritised. Strategies adopted include the transferring of the management of patients with Type 2 diabetes to the community, the referral of diabetic eye reviews to local optometrists who would perform retinopathy screening, the establishment of a fast track endoscopy service and the consolidation of the Orthopaedic Physiotherapy Screening Clinic. There has been a resultant reduction in the waiting lists, particularly those who have had to wait longer than 12 months, and with the Faciomaxillary Clinic. Category One patients are usually seen within two weeks. The failure to attend rate has reduced. Waiting list audits are regularly performed to monitor the situation. Referral guidelines are being developed to expedite the prioritising and appropriate access of patients to the relevant clinics.

2. A dedicated emergency theatre session has been established daily.

3. A fenced off area with appropriate play equipment has been established in the waiting room of the Emergency Department.

4. Nurses at Laidley Hospital have implemented an activities program established by a diversional therapist.

5. A nurse at Esk Hospital has commenced an activities program and is undergoing formal training in diversional therapy, with a view to undertaking a dual role.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.2.4.1
Function: Clinical **Standard:** 1.6
Criterion: 1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service

High Priority: No

Recommendation:

1. A formal evaluation of all of the current consumer participation activities be undertaken and a district wide consumer plan be developed in consultation with consumers and staff of the various units of WMHSD.

Mental Health

2. Formal measures of consumer satisfaction be implemented consistently throughout the mental health services.

3. The level of consumer participation be increased in the Integrated Mental Health

Service through the allocation of dedicated resources to ensure consumers and carers have access to similar consumer services regardless of the entry point into services.

4. Consumer participation and representation at The Park have strong links with the establishment of consumer participation practice in the Integrated Mental Health Service.

Action:

1. Consumer Participation Toolkit completed and approved through District Executive.

Mental Health

2. Integrated Consumer Satisfaction Survey conducted Oct/Nov 07. Action plan to be developed from results of survey. Benchmarking between the 2 services. (Consumer Services - The Park / IMHS Consumer Consultant / CAG / SERU - April 08). Monthly surveys conducted in inpatient unit. Participation in trial of proposed national satisfaction measure (Consumer Perceptions of Care)

3. Consumer Consultant appointed. Consumer Liaison Officer position in the process of being established, currently filled in a temporary capacity. Established CAG. Consumer and Carer Representatives members of relevent management committees. Consumer Action Plan developed. Training program developed for volunteers. (Service Manager - Completed).

4. Communication strategies and supportive network developed between Consumer Consultant and Liaison Officer and IMHS Consumer Consultant to enable effective information sharing across services.. Proposal for integration of consumer services (The Park / IMHS) including Consumer & Carer Representative program, CAG, Consumer Consultant and Liaison roles. (Consumer Consultants The Park & IMHS - Ongoing)

Completion Due By: June 2007

Responsibility: Service Development / Consumer Services / SERU / C

Organisation Completed:

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

It would appear that no formal evaluation of consumer participation activities or a consumer plan have been developed as a result of the last recommendation. As a result of amalgamation with another District since the last Organisation-Wide Survey and its associated impact on realigning services, a new recommendation has been made.

Mental Health
The organisation has demonstrated measures for ongoing consumer satisfaction surveys, as well as increased level of consumer participation and representation within the mental health service.

Recommendation: OWS0206.2.3.1
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.

High Priority: No

Recommendation:

The District further extend and strengthen comprehensiveness of information reported to the District Council, Patient Safety and Quality Council and other areas within the organisation.

Action:

Development and implementation of the Clinical Governance Operational Plan which outlines reports for different forums across the district.

Completion Due By: March 2007

Responsibility: Director PSQU

Organisation Completed:

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

Actions taken have met the requirements of this recommendation.

Recommendation: OWS0206.2.3.1
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.

High Priority: No

Recommendation:

The District further extend and strengthen comprehensiveness of information reported to the District Council, Patient Safety and Quality Council and other areas within the organisation.

EXHIBIT 75

WMS.9000.0003.00731

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Actions taken have met the requirements of this recommendation.

Recommendation: OWS0206.6.1.1
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.

High Priority: No

Recommendation:

1. Implement a quality register and make information available to WMHSD staff via the intranet.

2. Explore increased opportunities for external benchmarking.

Action:

1. Developed quality activities register (QASAR) for multi- user access across the district. QASAR installed on server for multi user access. QASAR training in progress across district.

2. PCOC (Palliative Care Outcomes Collaborative) in progress, AROC (Australasian Rehabilitation Outcomes Collaborative) to be implemented, and APOP (Acute Pain Outcomes Project) in place. Venous Thrombo Embolism Prevention Program benchmarks with Princess Alexandra Hospital. Falls Prevention Program part of an action research program. Orthopaedic Physiotherapy Screening Clinic provides benchmarks for the statewide implementation.

Completion Due By: July 2007 - completed

Responsibility: PSQU

Organisation Completed:

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

Actions taken have met the requirements of this recommendation. The question of benchmarking is entirely a matter for the District as it pursues its quality journey.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.2.2.2
Function: Support **Standard:** 2.1
Criterion: 2.1.2 The integrated organisation-wide risk management policy and system ensure that clinical and corporate risks are identified, minimised and managed.

High Priority: No

Recommendation:

1. The organisation ensure that all recommendations arising from root cause analyses are addressed and that a register of outcomes of actions arising from these recommendations is maintained.

2. The reporting and follow-up of adverse events and incidents be expanded to include "near misses".

Action:

1. Further development of the Queensland Health PRIME incident reporting system now captures all RCA recommendations. Reports available from QHERS - Queensland Health Electronic Reporting System. Overdue reports now tabled at Patient Safety & Quality Council.

2. Implemented District Wide HEAPS training that emphasises near miss reporting and established patient safety walk rounds- completed.

Completion Due By: Completed

Responsibility: Completed

Organisation Completed:

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

Whilst near misses are now reported and actioned, the follow-up of root cause analyses in mental health is still not undertaken to an appropriate standard, and there is a further recommendation in relation to this within the current report. This recommendation is therefore closed.

Recommendation: OWS0206.3.1.1
Function: Support **Standard:** 2.2
Criterion: 2.2.1 Human resources planning supports the organisation's current and future ability to address needs.

High Priority: No

Recommendation:

Develop an organisational wide workforce plan that addresses the projected staffing requirements across disciplines of WMHSD.

Action:

District Wide Workforce Plan - WMSBHSD in progress.

Completion Due By: Dec 2008

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Responsibility: Director HRM

Organisation Completed:

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

This recommendation has been addressed in part by the development of an interim workforce plan. A Project Officer has been employed to coordinate the development of a comprehensive workforce plan that includes projected staffing. The timeframe for achieving this objective is two years. A new recommendation will be made in the current report which subsumes this recommendation , which is now closed.

Recommendation: OWS0206.3.1.2
Function: Support **Standard:** 2.2
Criterion: 2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.

High Priority: No

Recommendation:

1. The District develop and implement a system to confirm identification of staff being appointed to the District Services. Proof of ID may include an original passport, drivers license, medicare card being sighted and copied with the signed copy being kept in the employee's personnel file.

2. The system of reviewing credentials and granting privileges be further refined in the areas of registrar and GP clinical practice.

Action:

1. Criminal History checks have been implemented for all new employees with documents used to confirm identification, such as a birth certificate, drivers licence or passport - completed.

2. Division of General Practice conduct a credentialling for GPs within private sector. Obstetric and Gynaecology registrars are credentialled for conducting unsupervised after hours LUSCS - completed. Credentialling policy updated to meet HQCC standards.

Completion Due By: June 2007

Responsibility: Director HRM

Organisation Completed:

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

1. This recommendation has been appropriately addressed by the introduction of mandatory criminal record checks for all new staff appointments. These checks involve confirmation of identification via a birth certificate, passport or Medicare card, and the recommendation is now closed.

2. This recommendation has not yet been fully addressed and will be reframed and included in the current report, and accordingly is now closed.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.3.1.3
Function: Support **Standard:** 2.2
Criterion: 2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.

High Priority: No

Recommendation:

The District Performance and Development process be actively implemented in all sites in the organisation to increase the level of compliance across the organisation.

Action:

Evaluated current system for recording of PAD. Current difficulties in capturing and reporting of data - awaiting a state-wide solution - to be rolled out in the near future (SABA).
District Wide policy on requirements of each manager/ supervisor to conduct PADs. PAD process simplified and circulated - training sessions provided for revised process.

Completion Due By: June 2007

Responsibility: Director HRM

Organisation Completed:

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

A new Performance and Development (PAD) system has been developed by the Human Resources Department and this is being progressively rolled out across the organisation. The surveyors noted that compliance was still not 100% or near it, and a new recommendation to address this issue is included in the current report. This recommendation is now closed.

Recommendation: OWS0206.2.1.1
Function: Corporate **Standard:** 3.1
Criterion: 3.1.1 The organisation provides quality, safe care through strategic and operational planning and development.

High Priority: No

Recommendation:

Mental Health

1. The Mental Health strategic plans be developed and implemented across sites, with clear review mechanisms in place. To ensure accountability a reporting structure on progress at a District level continue to be developed.

2. There be a clear focus and subsequent articulation on the desired level of integration of services for The Park and the Integrated Mental Health Service.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Action:

Mental Health
1. Strategic & Operational Planning complete. First review proposed early 2007. Organisational Structure and reporting framework reviewed. Amendments made to The Park's Governance Document reflecting outcome of review.

2. West Moreton Health Service Patient Safety and Quality Committee established. The DMHES has been established and is progressing the integration of aspects of mental health education, orientation, mandatory training & rotation of graduate placements.**Mental Health**

1. Strategic & Operational Planning completed. Business Planning 2008-09 commenced - incorporated into District Plan. Organisational structure and reporting framework reviewed. Amendments made to The Park's Governance Document reflecting outcome of review.

2. West Moreton South Burnett Mental Health Service Patient Safety & Quality Committee reviewed. The District Mental Health Education Service established and is progressing the integration of aspects of mental health education, orientation, mandatory training and rotation of graduate placements. Proposal for integration of consumer services (The Park / IMHS) including Consumer & Carer Representative program, CAG, Consumer Consultant and Liaison roles. (Completion Date: Feb 07 / Responsibility of: DD WMSBMHS.

Completion Due By: April 2007

Responsibility: EMC / Service Development / Business Units

Organisation Completed:

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

The organisation has demonstrated the development and implementation of mental health strategic plans across all sites and an articulation of the level of integration of services for The Park and integrated mental health service.

Recommendation: OWS0206.2.1.3
Function: Corporate **Standard:** 3.1
Criterion: 3.1.2 Governance is assisted by formal structures and delegation practices within the organisation.

High Priority: No

Recommendation:

1. Allied Health Seniors meeting should identify ways to collectively address pressing issues including rural health model of care, workforce planning, resource allocations in the rural health services, workload management, supervision models, clinical risk management and competency assessment.

2. Review the position of allied health chairperson to improve credibility and sustainability at District Executive level, and fund the incumbent at minimum 0.2 EFT so that appropriate leadership and clinical backfill can be provided.

3. The District research and develop a rural and primary health model to ensure consistency and equity of resources, especially for allied health, at the Boonah, Esk and Laidley Health Services.

Action:

1. Evaluation of Allied Health Meeting and Terms of Reference to address pressing issues. Meeting for Allied Health

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Seniors has commenced with Terms of Reference drawn up to reflect recommendations - completed.

2. Position of Allied Health Chairperson reviewed and time allocated to meet the demands of the role. A new position of District Director of Allied Health Services is currently under consideration.

3. Addressed as part of Health Services Plan 2008-2012.

Completion Due By: Completed

Responsibility: Completed

Organisation Completed:

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

1. In addition to the development of Terms of Reference for the reconstituted allied health seniors Meeting, this recommendation has been further addressed by the temporary appointment of an Allied Health Workforce Development Officer, who has not only mapped the resource base of allied health staff across the District, identified issues of inequality of access and reinforced the need for the appointment of the position of Director of Allied Health Services at the District Executive, but also developed a business case for funds to establish a rehabilitation outreach service as an alternative service delivery model to address the inequities of access.

2. The establishment of a position of Director of Allied Health has been endorsed by the District Executive but recruitment has been delayed during the negotiations for a statewide industrial agreement for allied health staff, and will now be further delayed by the staff freeze pending the amalgamation with the Toowoomba and Darling Downs Health Service District.

3. The District has established a multidisciplinary Allied Health Outreach Team based at both Ipswich and Kingaroy Hospitals, as a new model of service delivery to better address the needs of the rural communities.

Recommendation: OWS0206.2.1.5
Function: Corporate **Standard:** 3.1
Criterion: 3.1.5 Documented corporate and clinical policies assist the organisation to provide quality care.

High Priority: No

Recommendation:

1. There be a system for monitoring staff access to and compliance with policies and procedures.

Mental Health

2. Policies and procedures be reviewed to ensure consistency within the Mental Health Services.

3. A system be developed to provide back-up policy and procedure documentation in the event of the electronic system being unavailable.

Action:

1. Reviewed Doc Cube system and developed a district wide strategy for a user friendly and efficient system through the development of district website for improved access for staff - in progress (Marketing - June 2008). All policies and procedure identified across the newly amalgamated district. Merging and archiving of no longer relevant or

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

duplicitous documents has commenced. A structure for managing policies across the district has been drafted and is currently awaiting executive approval.

Mental Health

2. All Policy documents being reviewed and where practicable, integrated across both services. Review of process for development and review of policies completed. (August 08 - Service Development The Park / PS&Q Officer IMHS)
3. Policy documents in the form of hard copy and CD held by Service Development at The Park. Hard copy access provided to AH Nurse Managers. As Policies & Procedures are reviewed also being published to the WMSBHSD Intranet site. (Service Development - Completed)

Completion Due By: Ongoing

Responsibility: Service Development

Organisation Completed:

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

1. A project officer has been appointed to implement a revised policy and procedure framework following the amalgamation of the Districts. This is a work in progress and will need to be reviewed at the next Periodic Review. An improved system for monitoring compliance with policies and with legislation was suggested to staff during the Organisation-Wide Survey.

Mental Health
2&3. The organisation has demonstrated consistency of its policies and procedures within mental health services. There is now a system to provide backup of policy and procedure documentation to the electronic system.

Recommendation: OWS0206.5.1.1
Function: Corporate **Standard:** 3.2
Criterion: 3.2.1 Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.

High Priority: No

Recommendation:

1. District Management review and evaluate the current Risk Register and Balanced Scorecard to ensure they meet not only the needs of Queensland Health, but of all the facilities within the District Health Service.

2. District Management extend the monitoring and evaluation of the delivery of support services through the Queensland Health Shared Service arrangements, particularly with respect to financial management, procurement, workplace health & safety and injury management.

3. Expertise within the Ipswich Hospital workplace health & safety team and injury management team be more accessible to all hospitals / services within the District.

4. A review of policies / procedures be initiated to more effectively support safe practice and a safe environment at The Park, with appropriate emphasis to be placed in identifying risks and preventing injuries to staff and clients.

5. District Management ensure that policies related to child protection, particularly at the Barrett Adolescent Unit be reviewed to confirm that there are appropriate protocols to protect children against abuse from children, as well as staff or visitors.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

6. IMHS staff be regularly reminded of the need to carefully assess and manage clients who are potentially suicidal or who self harm.

7. Where at risk clients are not deemed sufficiently at risk to be placed in the High Dependency Unit, close observation of these clients be maintained and documented evidence be provided to demonstrate practices.

8. Management at The Park more strongly support and encourage staff participation in the Workplace Safety Committee.

9. A workplace health and safety officer, be nominated for Laidley Hospital.

10. Maintenance delegations (expenditure levels) be reviewed to ensure managers have sufficient authority to efficiently and effectively manage safety issues at the local level.

Action:

1. Reviewed risk register. Undertaken a district wide strategic planning process for the balanced scorecard. Implementation of QH Risk Management System provides access for directors across the district to lodge and manage their own risks.

2. Restructure of Shared Service Providers with return to the district of OHS, HRM with remaining functions to held offisite (whole of government initiatives).

3. O H & S structure reviewed and more resources applied to better meet district needs.

4. Policies, Procedures and Work Practice Guidelines continue to be monitored and reviewed in line with National, State and District risk management and child safety guidelines and requirements. Manual Handling (Object Handling) training conducted and competency assessments undertaken for all operational staff . (Service Development / WPH&S Officer / Business Units - Ongoing)

5. All staff in Barrett Adolescent Unit have undertaken Child Safety Legislation training. All staff are required to have a blue card prior to commencing employment in the unit. Child Safety mandatory reporting DVD shown to all staff and new staff captured at orientation; attendance is recorded. Children's Commission representative visits regularly for consumer feedback. Written report of visit provided. (Completion Date: Dec 06 / Responsibility of: Adolescent Unit / Service Development / PEP

6. Strengthened service capacity to deal with patients who are potentially suicidal or who self harm & ensure appropriate follow up for those people who are identified as having an increased risk. Reviewed handover to review risk. Review processes in clinical reviews. Failure to Attend Policy developed and implemented.

7. Maintain current management practices for high risk clients on the open ward (Ongoing - Nurse Unit Manger, Mental Health Unit).

8. Election of WPH&S Representatives across the District. Training provided to newly elected representatives and will be provided continuously. Attendance at meetings has increased. Meetings provide an opportunity for problem solving to occur between experienced members and new members. Flyers identifying OH&S Representatives in areas displayed in all units. (WPH&S Officer / Service Manager - Completed)

9. Manager Operational Services is the Laidley hospital WHSO.

10. Financial delegations have been reviewed.

Completion Due By: Ongoing

Responsibility: Service Development / WPH&S Officer / Business Uni

Organisation Completed:

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

1. The risk register and balanced scorecard have been reviewed and evaluated. These documents form the basis of a Queensland whole of state approach to risk management and there is evidence that District risks are identified, and action plans developed within the statewide framework.

2. Queensland Health Shared Service arrangements have been reviewed and consistent with that review, occupational health and safety and human resource management functions are now located within the District structure. This has seen an improvement in service support to operational areas.

3. The outcome of action from recommendation 2 (above) for occupational health and safety has seen the formation of a District unit, which has provided sound support to hospital operational units. Comments within this current survey report will identify the need to further support non-hospital sites within the district.

4. Policies and procedures within The Park unit have been reviewed within a risk reduction framework.

5. Policies are now in place to reduce the risk of child abuse within the unit. Redevelopment of the unit to provide a more appropriate setting for the adolescents is the subject of a High Priority Recommendation in this report.

6. Assessment and client management of at risk clients is in place.

7. Completed.

8. Staff actively participate in the Workplace Safety Committee.

9. Workplace health and safety officers have been trained and are in place throughout the District, inclusive of Laidley.

10. Delegations schedules throughout the District have been implemented and staff education has been completed to ensure that Managers are aware of their delegated authority.

Recommendation: OWS0206.5.1.2
Function: Corporate **Standard:** 3.2
Criterion: 3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

High Priority: No

Recommendation:

1. The planned relocation of the generator and the completion of electrical upgrades at Esk Hospital be expedited.

2. The completion of the planned renovations of the toilet / bathroom facilities at Boonah Hospital be expedited.

3. A review of the facilities / infrastructure at Laidley Hospital be initiated to assess safety and security risks and meet modern service delivery needs.

4. District Management pursue the redevelopment of the Barrett Adolescent Unit at The Park so that care can be provided in a modern facility designed to meet service delivery needs and support safe practice and a safe environment.

5. A review be conducted on current systems for testing of electronic detection devices, pagers, radios to confirm that they are fully functional; and report results to the workplace safety committee.

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

6. The waiting area available for both inpatients and outpatients in the Medical Imaging Services, Ipswich Hospital be reviewed with respect to the comfort and privacy of patients, and action be taken for improvements needed.

7. Appropriate consultation be undertaken with the Rurals with respect to the planning of any refurbishments, the prioritisation of refurbishments (and any subsequent delays), and the procurement of goods and services.

Action:

1. Installed generator and switchboard upgraded.
2. Renovations completed.
3. Annual Security audit conducted and completed. Submission to Capital Assets committee for Duress and ED Alarms funding. ED Plan to upgrade security and duress submitted. Upgrade to backdoor entry completed.
4. Redevelopment of Barret Adolescent Unit remains a priority. Funding identified as part of the new Mental Health Plan. User Group established and meeting. Feasibility on a location for redevelopment is progressing through the Area Managers. Interim actions undertaken to enhance service delivery include:
: All hanging points identified and rectified.
: Sensory room created
: Improved quiet room
: Created a bedroom to suit need of a specialised client.
Identified improvements are prioritised and will progress.
5. Radios and pagers are repaired on request from the users. Duresses - aged mental care unit, adult mental health unit tested daily; special care nursery tested weekly; all duresses tested monthly; Duress system at The Park tested by random selection at every shift.
6. Some improvement made from review of waiting room area conducted with consumer input, awaiting additional funding and re-structure as part of the Demand Management Strategy.
7. Reviewed to reflect needs of rural facilities with BEMS manager. Boonah Hospital currently undergoing structural changes to improve aged care facilities.

Completion Due By: Completed

Responsibility: Completed

Organisation Completed:

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

1. Generator and associated electrical work has been completed.

2. Toilet/bathroom facilities at Boonah have been completed.

3. Security audit has been completed. This recommendation has been closed and will be replaced with a recommendation focused on the safety of staff working alone at night . This new recommendation will be reported under criterion 3.2.5.

4. The recommendation in its current form has been closed and replaced by a new recommendation within the main body of this report, to better reflect the current circumstances.

5. Systems for testing and maintenance work on duress devices are appropriate.

6. The recommendation in its current form has been closed and replaced by a new recommendation within the main body of this report, to better reflect the current circumstances.

7. Rural facilities are consulted on refurbishment projects and remain active throughout the process.

EXHIBIT 75

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.1.1.2
Function: Corporate **Standard:** 3.2
Criterion: 3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

High Priority: No

Recommendation:

1. Signage at Esk from Brisbane Valley Highway be improved to ensure that those who are not familiar with the area can more easily locate the hospital.

2. Signs at the front of the Esk Hospital be upgraded.

Mental Health

3. Signage at the entrances to The Park be amended to include information on the nearest facility for hospital emergency services.

Action:

1. Reviewing current signage using consumer input (Apr 2007 - DRHS Esk).
2. Upgraded current signage.

Mental Health

3. Major road works have commenced at both entrances to The Park and redevelopment by QPS of the old facility. Erecting / replacing signage at this time would be ill-advised. Review at completion of roadworks. (Completion of roadworks - Service Manager)

Completion Due By: Review at completion of road works

Responsibility: Service Manager

Organisation Completed:

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

1. Public road signage has been improved.

2. Signage at Esk Hospital has been upgraded.

3. Signage at The Park will be upgraded when the new traffic works are completed.

EXHIBIT 75

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Recommendation: OWS0206.5.1.4
Function: Corporate **Standard:** 3.2
Criterion: 3.2.4 Emergency and disaster management supports safe practice and a safe environment.

High Priority: No

Recommendation:

1. The practical lessons from the fire emergency at Ipswich Hospital be documented and shared across all facilities.

2. Outstanding fire safety works commenced at The Park be completed.

3. The current no smoking policy in residential units at The Park be enforced and any relevant client/staff education be undertaken.

4. Staff at Goodna participate in fire safety training and conduct an annual mock evacuation.

5. The workplace layout for community services at Goodna be reviewed and the egress routes made clear/accessible.

6. The fire safety audit tool designed by the Fire Safety Officer at Ipswich be implemented District-wide.

7. Evacuation signs at Laidley be reviewed and replaced, as required, to facilitate safety.

Action:

1. Sent to all facilities to share with their staff and requested they save on shared drives. Included Mock purple and Code Purple action plans.

2. Works from the Bourne Report progressing with all required documentation related to amendments to the Fire & Engineering report forwarded for sign off. (Service Manager / Coordinator Fire Prevention & Security / District Fire, Security & Safety Advisor - Jun 08)

3. Anti-Smoking Legislaton reveiwed by the Smoking Committee. Facility policy reviewed. Nominated smoking areas created in all clinical areas. Staff trained in smoking cessation guidelines. Signage displayed in all areas. NRT implemented for staff and consumers. Inhalers, lozenges and patches available to consumers. Physical environments reviewed in all clinical areas and changes made to conform with policy requirements. Line Manager responsible for ongoing monitoring and compliance. Smoking inlcuded in assessment areas for benchmarking in ETR, Dual Diagnosis, and Medium Secure. (Smoking Committee / Clnical Business Units / DMHES - Completed.

4. Completed and now included on annual timetable within district.

5. Bins were removed from the rear stairwell and evacuation egress routes have been erected. A mock evacuation was conducted on 29.11.06.

6. Fire safety audit tool implemented and in place.

7. Replacement of evacuation signs at Laidley Hospital has been completed.

Completion Due By: Completed

Responsibility: Completed

Organisation Completed:

EXHIBIT 75

Recommendations from Previous Survey

Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

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

1. This has been done and the Ipswich unit shares information across the District as emergency exercises are completed.

2. The Park has undergone a fire inspection, an action plan has been developed and works completed.

3. No smoking policy is consistent with Queensland Health policy.

4. Goodna staff participate in fire training and evacuation exercises.

5. Workplace safety has been reviewed and action taken to address egress concerns.

6. Ipswich unit shares information and audit tools.

7. Signage at Laidley has been upgraded.

From: Avis macdonald
Sent: 23 Jul 2009 11:32:38 +1000
To: Terry Hughes
Cc: Pam Lane
Subject: Fwd: Demolition Work pictures from Barrett Adolescent HDU
Attachments: DSCF0512.JPG, DSCF0513.JPG, DSCF0516.JPG, DSCF0517.JPG

Hi Terry - a progress update on HDU. Regards Avis

Avis Macdonald,
District Director Patient Safety and Quality
(West Moreton South Burnett Health Service District)
Darling Downs West Moreton Health Service District
Ipswich Hospital,
PO Box 73, Ipswich Qld 4305

>>> Robert Wood 23/07/2009 11:08 am >>>
FYI

Work Day 3.

See Ya,
Robert

Robert Wood
Acting Manager
Building, Engineering and Maintenance Services
Ipswich Hospital

EXHIBIT 75

WMS.9000.0003.00745

EXHIBIT 75

WMS.9000.0003.00746

EXHIBIT 75

WMS.9000.0003.00747

EXHIBIT 75

WMS.9000.0003.00748

Report of the Conditional Survey for the ACHS Evaluation and Quality Improvement Program

West Moreton South Burnett Health Service District

Ipswich, QLD

Organisation Code: 71 51 30

Survey Date: 13 July 2009

ACHS Accreditation Status: **ACCREDITED**

Table of Contents

About The Australian Council on Healthcare Standards

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 by a health care organisation, of requirements of national health care standards.

How to Use this Conditional 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 Conditional Survey 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.

1- Surveyor Team Summary Report
2 - Ratings Summary Report
3 - Summary of Recommendations from the Current Survey relevant to this Conditional Survey
4- Recommendations from the Previous Survey relevant to this Conditional 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 (except criterion 1.3.1 which is a developmental
criterion)

- 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 need to be implemented but may have only basic systems in place. At this level there will be compliance with legislation and policy that relates to the criterion.

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 very little or no monitoring of outcomes or efforts at continuous improvement.

MA –Moderate Achievement- An MA rating requires that all the elements of LA and SA have been achieved and that efficient systems in collecting relevant outcome data, monitoring, evaluation procedures and methods of improvement are in place.

EA – Extensive Achievement- In the EQuIP 4 program, all the elements in LA, SA and MA must be achieved. Also organisations will be able to demonstrate extensive achievement in a criterion if they satisfy one or more of the following requirements:
- internal or external benchmarking and subsequent system improvement, and / or
- the conduct of research that relates to that particular criterion, and / or
- the implementation of what would be considered to be advanced systems that relate to that criterion, and / or
- proven, excellent outcomes in that particular criterion.

Some organisations may be able to demonstrate achievement in more than one of these elements.

OA- Outstanding Achievement- The 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 that organisation is the best in Australia. It may mean that the organisation can demonstrate that it is one of the best or is outstanding amongst its peers.

Developmental Criterion (1.3.1) -
A developmental criterion is one that the ACHS has introduced to organisations for the purpose of creating awareness and for commencing collaborative national action in a specific area of health care. There is one developmental criterion that has been introduced in EQuIP 4 – criterion 1.3.1 - Health care and services are appropriate and delivered in the most appropriate setting.

When a developmental criterion is introduced:
• organisations will work towards achieving the elements of the criterion
• progress towards achievement of the criterion will be discussed during survey but will not be taken into account when determining the accreditation status of the organisation
• a progressive evaluation of the implementation of the standard / criterion will be undertaken by the ACHS

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)-
These are applied to a particular criterion where
• 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 High Priority Recommendation. A HPR should be addressed by the organisation in the shortest time possible.

2 Conditional Survey 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 Conditional Survey-
Recommendations are highlighted areas for improvement due to a need to improve performance under a particular criterion.
Recommendations are structured as follows:
The criterion numbering relates to the month and year of survey and the criterion number. For example recommendation number OWS 0106.1.1.1 is a recommendation from an OWS conducted in January 2006 with a criterion number of 1.1.1

4 Recommendations from Previous Survey relevant to this Conditional 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 following recommendations were made at the Organisation-Wide Survey held 18-22 August 2008 and is one of the recommendations being surveyed as part of the Conditional Survey on 13 July 2009:

Stage 2 (by August 2009)
(i) The effectiveness of the clinical record audit process implemented be evaluated.
(ii) West Moreton Health District complete an audit to ensure that all mental health services have a clinical record audit system in place and operational.

At the Conditional Survey it was noted that:

The organisation has established a comprehensive clinical audit system that monitors and evaluates administrative, clinical, care plan and community treatment charts. A flowchart guides the transfer of audit information upwards to executive management and downwards to clinical teams for actioning of any recommendations. Strong leadership is encouraging compliance with health record requirements. Internal benchmarking between teams is undertaken. Whilst it is early days yet, in regard to data collection, analysis of variation between teams is likely to yield useful information that may assist improvement in outcomes, for example, the roles of clinical leader/champion and continuing professional development. It is clear to the survey team that an enormous amount of work has been undertaken leading to a successful outcome. The organisation is to be congratulated on this achievement.

EXHIBIT 75 WMS.9000.0003.00755

Conditional Survey - Survey Team Summary Report
Organisation: West Moreton South Burnett Health Service District
Orgcode: 715130

Function: Clinical **Standard: 1.1**

Criterion: 1.1.8

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

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

Surveyor's Comments:
There is a clinical record audit system across the whole of the mental health service and the system has been evaluated. Now that adequate data are now available from the audits, the Service Evaluation and Research Unit has been commissioned to undertake an evaluation of outcomes flowing from the audit process to verify its effectiveness.

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

FUNCTION SUMMARY: SUPPORT

The following recommendations were made at the Organisation-Wide Survey held 18-22 August 2008 and is one of the recommendations being surveyed as part of the Conditional Survey on 13 July 2009:

(i) An audit of the current control and tracking of the progress of the recommendations from root cause analysis and HEAPS be undertaken in the mental health service, and the focus be on ownership by site staff and leaders as well as the District system with the development of an identified pathway of open, two-way communication.
(ii) A formal and inclusive home visiting risk assessment process be put in place in the mental health service and evaluated.

At the Conditional Survey it was noted that:

(i) All recommendations from Root Cause Analyses and Human Error and Patient Safety (HEAPS) reviews for the four years prior to the Organisation-Wide Survey were identified and tabulated and the actions on the recommendations have been traced and implementation of the recommendations has been verified or instituted and subsequently evaluated. There rest now only a very small number of recommendations from 2007 and 2008 which have still to be completely evaluated. A very satisfactory system is now in place to ensure that all recommendations are monitored for implementation and evaluated in a timely manner. In fact there are no outstanding recommendations from 2009, all having been promptly addressed, demonstrating the effectiveness of the system.

(ii) The home visiting policy which was in place at the AC60 survey has been evaluated for compliance and effectiveness, demonstrating that it is being followed by staff and is effective in ensuring their safety.

Function: Support **Standard: 2.1**

Criterion: 2.1.2

The integrated organisation-wide risk management policy and system ensure that clinical and corporate risks are identified, minimised and managed.

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

Surveyor's Comments:
There are now very sound arrangements in place to ensure that recommendations arising from serious incidents are implemented and evaluated.

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

FUNCTION SUMMARY: CORPORATE

The following recommendations were made at the Organisation-Wide Survey held 18-22 August 2008 and are two of the recommendations being surveyed as part of the Conditional Survey on 13 July 2009:

3.1.3
1. Demonstrate that the scope of clinical practice and performance management systems developed in Stage 1 have been implemented across the whole District.

3.2.2
(i) The immediate works identified in Stage 1 to reduce risk to acceptable levels be completed.
(ii) The rebuilding of the Barrett Adolescent Unit be expedited to enable care and services to be provided for adolescent patients in a purpose-built facility which facilitates a safe health environment and maximises the safety, comfort and needs of the community.

At the Conditional Survey it was noted that:

3.1.3
The organisation has revised its medical credentialling and scoping of clinical practice policies and processes to fully reflect current good practice expectations. A database of allocated scope of clinical practice has been developed and an intranet site has been created with access available to all staff. The system allows linkage with performance development and continuing professional development. The Post Graduate Medical Council of Queensland is about to undertake (July 2009) an accreditation survey of the organisation's management of junior medical officers. Accordingly, all policies and processes relating to the management, supervision and education of junior medical officers have been reviewed. Procedural capabilities for registrars have been identified and implemented in obstetrics and gynaecology, psychiatry and anaesthetics. Requirements in general surgery and orthopaedics are currently being addressed as part of an ongoing roll out across all specialty areas. Based on Queensland Health guidelines for credentialling and defining the scope of clinical practice (2009) the Clinical Governance Unit is developing a training program for Credentialling Committee members. Surveyors noted that three audits have been undertaken, with all demonstrating 100% compliance with credentialling issues. Performance indicators have been developed in order to assist the monitoring and ongoing evaluation of credentialling processes. These include (a) 100% credentialling and (b) professional development completion - 100% for staff specialists and 50% for VMOs.

3.2.2
(i) Building works for the establishment of a new High Dependency Unit at the Barrett Adolescent Unit to address the safety issues identified during the Organisation-Wide Survey have commenced and have an estimated completion date of 28 August 2009. The site was visited on 13 August and building works were observed to be almost complete. The High Priority Recommendation is, therefore, satisfied and the SA rating can be amended to MA.

Pending completion of the building works, issues surrounding staffing, environment and admission criteria have been addressed to improve the existing conditions, and the surveyors were impressed to note the dramatic reduction in incidents in the Unit since these interventions.

(ii) Agreement has been reached with the Southern Metropolitan Health Service District and the Director of Mental Health for the relocation of the Barrett Adolescent Unit to Redlands Hospital with a planned completion in 2011 and documentation of this agreement was sighted.

Function: Corporate **Standard: 3.1**

Criterion: 3.1.3

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

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

Surveyor's Comments:
Credentialling and scoping of practice are now undertaken to an appropriate standard and scoping is continuing to be rolled out across the disciplines. A system for performance review has been developed and is being rolled out. It will be necessary, at the next survey, to demonstrate that the roll out is complete and that the systems are sustained.

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

Function: Corporate **Standard: 3.2**

Criterion: 3.2.2

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

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

Surveyor's Comments:
As the replacement for the Barrett Adolescent Unit at Redlands Hospital will not be available until 2011 or later, it is essential to continue with risk minimisation strategies in the interim to ensure the safety of the residents.

Surveyor's Recommendation: **HPR:No**
Risks to residents in the Barrett Adolescent Unit continue to be monitored and actively managed pending the relocation of the unit to Redlands Hospital.

Risk Rating:

Risk Comments:

Rating Summary

Clinical

Criterion	Organisation's self-rating	Surveyor Rating	HPR
Crit. 1.1.8	MA	MA	

Support

Criterion	Organisation's self-rating	Surveyor Rating	HPR
Crit. 2.1.2	MA	MA	

Corporate

Criterion	Organisation's self-rating	Surveyor Rating	HPR
Crit. 3.1.3	MA	MA	
Crit. 3.2.2	MA	MA	

Recommendations from Current Survey

Function: Corporate **Standard:3.2**

Criterion: 3.2.2

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

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.

Recommendations from Previous Survey

Recommendation: OWS08081.1.1
Function:Clinical Standard:1.1
Criterion: 1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.

High Priority: No

Recommendation:

(i) Compliance with the use of assessment documentation tools be improved.
(ii) Clearly documented, practical, easy reference admission and exclusion criteria be developed for each rural facility based on the site capability framework, so that front line staff can make consistent timely decisions about transfer out and that tertiary acceptance is more transparent.

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:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08081.1.2
Function:Clinical **Standard:1.1**
Criterion: 1.1.2 Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.

High Priority: No

Recommendation:

(i) All x-rays be reported for safe patient care and quality assurance.
(ii) Routine feedback be provided to rural hospitals regarding outcomes of care when patients are referred to Ipswich.

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:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08081.1.3
Function:Clinical **Standard:1.1**
Criterion: 1.1.3 Consumers / patients are informed of the consent process, understand and provide consent for their health care.

High Priority: No

Recommendation:

Consistent with Queensland Health policy and based on best practice, the timeliness of provision of documented informed consent be improved for all elective invasive procedures so that it is available for further discussion and confirmation, either at the pre-admission clinic or on admission (as appropriate to the particular patient journey).

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08081.1.4
Function:Clinical **Standard:1.1**
Criterion: 1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.

High Priority: No

Recommendation:

(i) The analysis of aggregated data concerning outcomes of care be strengthened and the participation by medical officers in multidisciplinary review be increased, so that there is more effective development of strategies to improve patient outcomes.
(ii) A simple system for tracking the timeliness of Clinical Unit Director response to clinical indicator queries and other matters forwarded by the Patient Safety and Quality Unit be developed, with reporting at District safety and quality meetings where delays or failure to respond have occurred, so that appropriate clinical governance can be assured.

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:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08081.1.8
Function:Clinical **Standard:1.1**
Criterion: 1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.

High Priority: No

Recommendation:

Mental Health

Stage 2 (by August 2009)
(i) The effectiveness of the clinical record audit process implemented be evaluated.
(ii) West Moreton Health District complete an audit to ensure that all mental health services have a clinical record audit system in place and operational.

Action:

Criterion 1.1.8 Mental Health (AC60) Stage 1 Actions:

(i) Audit processes & tools reviewed & a linking system is in place for collection of data. (Revised Audit Tool and Audit Report Spreadsheet.)
Reporting findings / recommendations system developed and formalised for the following clinical chart audits:
- HIM – Area Admin Officer Clinical Chart Audit. Compliance looks at the administrative components of the medical record
- Clinical Programs Clinical Chart Audit. To ensure clinicians, by discipline, comply with facility policy and professional standards regarding clinical charts.
- Clinical Initiatives – Care Plan Audit. Compliance measures the Individual Care Plan in the Medical Record
- Medical Services – Limited Community Treatment Audit. Compliance with MHA 2000 and other legislation & standards.
(Documentation includes audit tool, flowchart, audit report and action plans).

(ii) Flowchart developed which incorporates each clinical chart audit. Process links audit tools and outlines the process for reviewing any trends or patterns identified in the findings of each audit. Communication / feedback flow process included in flowchart.
(iii) An audit of the quality of clinical notes has been implemented in the audit tool and report contains action plan for each discipline. *(Evidence through flowchart, findings and audit summary report for each clinical chart audit).*

Criterion 1.1.8 Mental Health (AC60) Stage 2 Recommendations:

(i) The effectiveness of the clinical record audit process implemented be evaluated. District develop and collect some relevant performance indicators to demonstrate the effectiveness and sustainability of the changes.
(ii) West Moreton Health District complete an audit to ensure that all mental health services have a clinical record audit system in place and operational.

Criterion 1.1.8 Mental Health (AC60) Stage 2 Actions:
(i) & (ii) Considerable work has been undertaken in relation to processes for improving the documentation in clinical charts (audit reports, feedback to staff, reports discussed at Strategic Committee meetings). An audit summary report has been completed to ensure that all mental health services at The Park - Centre for Mental Health and Integrated Mental Health Service have clinical record audit system in place and operational. From the completed audit summary an action plan was developed from the recommendations identify the areas of improvement. Service Evaluation and Research Unit (SERU) has developed a Brief to evaluate outcomes which will be completed by December 2009.
Relevant Performance Indicators have been developed, these include:
1. Reduction of 10% each year in missing data;
2. Reduction of 10% each year in errors;
3. Benchmarking with other mental health services to monitor variation in the proportion of errors.
These performance indicators are to be collected by SERU as part of the evaluation of the effectivenss of the audit process. Outcomes will be reported at Clinical Records Committee and Clinical Steering Committee.

Completion Due By: 01/12/2009

Responsibility: Clinical Director - The Park

Organisation Completed:

Surveyor's Comments: **Recomm. Closed: Yes**
Stage 2
The recommendation has been implemented to a high standard and is closed. Please refer to the Function Summary for detailed comments.

Recommendation: OWS08081.2.2
Function:Clinical **Standard:1.2**
Criterion: 1.2.2 Access and admission to the system of care is prioritised according to clinical need.

High Priority: No

Recommendation:

A review of the staffing/resource levels be undertaken and strategies implemented to address the waiting times involved with the outreach service provided by the Child and Family Health Service Young People's Health Team, Day Stay Centre and Occupational Therapy Service.

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08081.5.1
Function:Clinical **Standard:1.5**
Criterion: 1.5.1 Medications are managed to ensure safe and effective practice.

High Priority: No

Recommendation:

(i) A pharmacy consulting service be provided to those rural facilities without a pharmacist and where the pharmacy service is provided by nursing staff.
(ii) The system for reviewing medication incidents and management practices be enhanced to ensure that there is always feedback to staff on outcomes of the reviews.
(iii) Specialist advice on appropriate protocols for the administration and ongoing clinical management of patients on opioid maintenance at Kingaroy be sought from Pharmacy or Alcohol, Tobacco and Other Drug Services.
(iv) Drug refrigerators be fitted with alarms to identify loss of temperature.

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:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08081.5.2
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 health care workers.

High Priority: No

Recommendation:

Alarm systems for refrigerators in outlying hospitals to denote a power loss be implemented.

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08081.5.5
Function:Clinical **Standard:1.5**
Criterion: 1.5.5 The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.

High Priority: No

Recommendation:

(i) A blood management system which monitors and reviews the prescribing of blood and blood products to ensure appropriate practice be developed.
(ii) An education program for clinical staff on appropriate practices for prescribing blood and blood products be developed and implemented.
(iii) The maximum blood ordering schedule (MBOS) dated 1995 be updated.

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08081.6.1
Function:Clinical **Standard:1.6**
Criterion: 1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service

High Priority: No

Recommendation:

The current profile of consumer input be mapped to identify any gaps and, if necessary, an action plan be developed to guide further input from the community.

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:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08081.6.2
Function:Clinical **Standard:1.6**
Criterion: 1.6.2 Consumers / patients are informed of their rights and responsibilities.

High Priority: No

Recommendation:

Queensland Health be approached to review and republish its Rights and Responsibilities pamphlets and posters in order to ensure that the content is current.

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:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08082.1.1
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.

High Priority: No

Recommendation:

(i) A standard, outcome-based template be developed for recording minutes of meetings, to improve the quality of minute taking across the District.
(ii) An analysis of the QASAR database be undertaken to identify users' perceptions, needs and level of satisfaction and make improvements as required.

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:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08082.1.2
Function:Support Standard:2.1
Criterion: 2.1.2 The integrated organisation-wide risk management policy and system ensure that clinical and corporate risks are identified, minimised and managed.

High Priority: No

Recommendation:

(i) The role of clinical leadership in peak committees which consider risk be reviewed to ensure that there is sound medical input into the risk management system.
(ii) A proactive, multidisciplinary approach be developed for the identification of risk to enhance the existing system, which relies heavily on incidents to identify risk.

Action:
Criterion 2.1.2 Mental Health (AC60) Stage 1 Recommendations:

(i) An audit of the current control and tracking of the progress of the recommendations from root cause analysis and HEAPS be undertaken in the mental health service, and the focus be on ownership by site staff and leaders as well as the District system with the development of an identified pathway of open, two-way communication. Audit undertaken and process for progressing recommendations from reviews (RCA / HEAPS) be developed. Process to include feedback mechanisms (two-way communication).

(ii) A formal and inclusive home visiting risk assessment process be put in place in the mental health service and evaluated. Review *Home Visiting in the Community* policy and develop audit tool to evaluate.

Criterion 2.1.2 Mental Health (AC60) Stage 1 Actions:
(i) Audit completed in relation to monitoring & progress of RCA & HEAPS recommendations. Audit identified deficits in the process.
Process revised and includes:
- Flowchart includes defined sequence of events & reporting processes and improved flow of communication
- Electronic & paper checklist implemented to monitor progress of each recommendation for completion and closure of incident
- Feedback mechanisms to clinical teams revised
- Appointment of Mental Health Patient Safety Officer.

(ii) Policy reviewed and revised version endorsed by 14 Nov 08. Risk Assessment tool reviewed to include environmental risks (cigarette smoke / dogs / weapons).
Audit tool developed to evaluate policy with audit findings being evaluated to produce compliance report. Audit summary report completed. Workgroup established and action plan developed to progress the recommendations from the audit. Action Plan defines *Responsibility and timeframes* for completion and finalisation of recommendations. *Home Visiting in the Community* policy reviewed and accessible on district intranet site. Re-audit on risk assessment tool for home visiting in the community will continue on a quarterly basis until there is an achievement of zero (0) occurrences of visits when assessed as being unacceptable.

Criterion 2.1.2 Mental Health (AC60) Stage 2 Recommendations:
Conditional Survey team to confirm that the changes have been sustained. District develop and collect some relevant performance indicators to demonstrate the effectiveness and sustainability of the changes.

Criterion 2.1.2 Mental Health (AC60) Stage 2 Actions:
Relevant performance indicators have been developed, these include:
All high level recommendations are completed within allocated timeframe.
1. All staff members who report the clinical incident are informed of the recommendations.
2. All recommendations are tabled on a report for the applicable business units patient safety round.
These performance indicators are to be collected by Patient Safety Officers and are scheduled to be tabled at the Patient Safety and Quality Council in late June 2009.

Completion Due By: 31 July 2009

Responsibility:A/Executive Director Strategy, Performance and Ser

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** **No**

Recommendation: OWS08082.1.3
Function:Support **Standard:2.1**
Criterion: 2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.

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:**

Recommendation: OWS08082.2.1
Function:Support **Standard:2.2**
Criterion: 2.2.1 Human resources planning supports the organisation's current and future ability to address needs.

High Priority: No

Recommendation:

The development of the workforce plan be expedited. (It is acknowledged that the District has made a significant commitment to achieving this objective and it is important that the imminent amalgamation with Toowoomba and Darling Downs Health Service District does not impede the progress of this development).

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08082.2.2
Function:Support **Standard:2.2**
Criterion: 2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.

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:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08082.2.3
Function:Support **Standard:2.2**
Criterion: 2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.

High Priority: No

Recommendation:

(i) A strategy be developed to ensure that all employees participate in the new Performance and Development (PAD) system. The strategy could include enhanced promotion and training of PAD across the organisation and regular auditing of this requirement across all departments and facilities.
(ii) The supervision arrangements for junior medical staff undertaking rural relief duties be formalised to ensure that they receive adequate orientation, on-site teaching, supervision and general support.
(iii) The current registration status and scope of practice for all health professionals be readily accessible to rural managers.
(iv) Time be made available to ensure that there is adequate access to education and mandatory training for medical staff.

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08082.2.4
Function:Support **Standard:2.2**
Criterion: 2.2.4 The learning and development system ensures the skill and competence of staff and volunteers.

High Priority: No

Recommendation:

(i) A comprehensive all-encompassing staff development plan be developed, based on a formal needs assessment of all departments and disciplines.
(ii) A proactive approach be developed to ensuring that there is optimal participation in mandatory training sessions. (It is suggested that auditing the implementation of the Policy and Procedure "Mandatory Training" across all sites could be a pivotal component of this approach).

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:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08082.3.1
Function:Support **Standard:2.3**
Criterion: 2.3.1 Records management systems support the collection of information and meet the organisation's needs.

High Priority: No

Recommendation:

(i) The work to date on the integration of patient records across services and the flagging of records held at other sites be continued across the District.
(ii) The District's standardisation of clinical forms project continue to be implemented.

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08082.3.4
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).

High Priority: No

Recommendation:

A District information technology plan (supporting the Queensland Health plan) be developed to address the local issues of information technology provision.

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08082.4.1
Function:Support **Standard:2.4**
Criterion: 2.4.1 Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation.

High Priority: No

Recommendation:

A suite of key performance indicators be established in consultation with relevant staff, to capture the outcomes of the health performance initiatives across the District and trend them over time.

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08083.1.2
Function:Corporate **Standard:3.1**
Criterion: 3.1.2 Governance is assisted by formal structures and delegation practices within the organisation.

High Priority: No

Recommendation:

(i) A suitable mechanism for the evaluation of the effectiveness of committees be developed and appropriate measures for evaluation be included in each committee's terms of reference.
(ii) Minutes be recorded to a standard which provides a clearly identifiable decision trail and the status of issues under discussion.
(iii) The use of abbreviated names within minutes be eliminated and replaced with a system which ensures that individual participants are clearly identifiable.

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08083.1.3
Function:Corporate Standard:3.1
Criterion: 3.1.3 Processes for credentialing and defining the scope of clinical practice support safe, quality health care.

High Priority: No

Recommendation:

Stage 1 (AC60)

1. Implement a system for defining, monitoring and communicating the scope of clinical practice for all consultant, GP-VMO, registrars and senior medical officers in the District, which specifically includes medical staff working in the Park Centre for Mental Health and registrars performing electro-convulsive therapy procedures.
2. Implement a system of performance management for junior medical staff, and consultant and GP-VMO medical staff, which is linked to the system of credentialing and defining scope of clinical practice, and ensures that all consultant and GP-VMO medical staff have an annual performance appraisal.
3. Implement a system of performance management for junior medical staff, which is linked to the system of credentialing and defining scope of clinical practice.
4. Develop a policy and implement a system for the safe introduction of new interventions, which includes review of a clinician's scope of clinical practice prior to the introduction of new interventions.
5. Implement the systems developed in response to recommendations 1 and 2 in at least two clinical services and develop an action plan for their implementation across the whole District.

Stage 2 (by August 2009)

1. Demonstrate that the scope of clinical practice and performance management systems developed in Stage 1 have been implemented across the whole District.

Action:

Criterion 3.1.3 (Credentialing) Stage 1 Recommendations:
(i) A system be implemented for defining, monitoring and communicating the scope of clinical practice for all consultant, general practitioner/visiting medical officer, registrars and senior medical officers in the District, which specifically includes medical staff working in The Park Centre for Mental Health and registrars performing electro-convulsive therapy procedures.
(ii) A system of performance management for junior medical staff, and consultant and general practitioner/visiting medical officer medical staff be implemented, which is linked to the system of credentialling and defining the scope of clinical practice, and ensures that all consultant and general practitioner/visiting medical officer medical staff have an annual performance appraisal.
(iii) A system of performance management for junior medical staff be implemented, which is linked to the system of credentialling and defining the scope of clinical practice.
(iv) A policy be developed and a system implemented for the safe introduction of new interventions, which includes review of a clinician?s scope of clinical practice prior to the introduction of new interventions.
(v) The systems developed in response to recommendations (i) and (ii) in at least two clinical services be implemented and an action plan developed for their implementation across the whole District.

Criterion 3.1.3 (Credentialing) Stage 1 Actions:

(i) The WSMB District Credentials and Clinical Privileges for Medical Practitioners Policy / Procedure has been revised to fully reflect the requirements in the Credentialing and defining the Scope of Clinical Practice for medical practitioners in Queensland – a policy and resource handbook). v1.0 April 2008. Credentialing application forms have been revised to reflect the current Credentialing and defining the Scope of Clinical Practice for medical practitioners in Queensland – a policy and resource handbook). v1.0 April 2008 and all new applications and reapplications are using this new form. A database has been developed which monitors and identifies all Senior Medical Officers and Visiting Medical Officers in the district and outlines their credentialing status. A district credentialing and clinical privileges intranet site has been created and published for all credentialing resources and to communicate the process for credentialing. The WMSB District Service Capability Framework has been revised and links with the district and Queensland Health credentialing policy and is accessible on the WMSB District intranet site. Registrars (except Psychiatric Registrars who perform ECT) have been excluded from the credentialing process as supported and referenced in the ACHS EQuIP 4 Update (No.4, October 2008) which states on page four of this document that credentialing of junior medical officers / registrars in training programs is not required by the ACHS standards, however organisations must provide evidence that junior medical officers are provided with appropriate levels of supervision at all times, by either the organisation or a college and that their scope of practice is defined, with inclusion and exclusion criteria readily available to other members of staff and clearly displayed. Please refer to Rec. No. 3 below. Mental Health Medical Officer Consultants and Registrars that perform ECT have applied for credentialing. These applications are for review at the Credentialing committee meeting on the 9 December 2008.

(ii) The Senior Medical Officer Performance Appraisal and Development (PAD) form has been revised to incorporate additional credentials and clinical privileges sought in the coming 12 months. The PAD also incorporates additional complex / interventional procedures or equipment that a medical officer may wish to conduct / use in the coming 12 months at their current facility. The PAD links with the revised WMSB District Credentialing policy / procedure and the revised WMSB District New Interventional policy / procedure. All three documents are now linked and appropriately make reference to each other. A referee report form and supervisors report form have been implemented to ensure all medical officers are subject to ongoing performance management. These reports may be called on if there are concerns about a clinician. The Terms of Reference for the Credentialing and Clinical Privileges committee have been revised to ensure a system of credentialing for medical officers is more robust and aligns itself with state and federal credentialing standards. The committee now allows for performance management of Senior Medical Officers as access to reports such as complaints, surgical complications and concerns about a clinician are able to be discussed in this forum.

(iii) In accordance with state and national directives, the Ipswich Hospital Junior Doctor Medical Education program will undergo a full accreditation survey in March 2009 (date to be confirmed). The accreditation will be undertaken by the Postgraduate Medical Education Council of Queensland (PMCQ), who are the accreditation authority for the Medical Board of Queensland. PMCQ are responsible for ensuring that all healthcare facilities employing junior medical officers (PGY1, PGY2, and PGY3 and above not involved in a vocational training program) adhere to set standards in relation to supervision, assessment, evaluation, education provision, and general working conditions. In accordance with the requirements of the recently released new state and nationally supported accreditation standards, Ipswich Hospital is currently undertaking a comprehensive review of all policies, processes, and practices relating to these standards. This process will ensure that all junior doctors employed within Ipswich Hospital are appropriately supported, supervised, assessed, and educated. The draft policies and guidelines will form the basis for junior doctor education, supervision and assessment in Ipswich Hospital and will be implemented at the beginning of 2009, for review by PMCQ in March 2009 as part of the full accreditation process. These include: Assessment Interview Process flow sheet, Guidelines for Junior Medical Officers Assessment handbook, Clinical Supervisors handbook for supervising Junior Medical Officers, End Term Assessment form management flow chart for Junior Medical Officers, Guidelines for completing Junior Medical Officer Assessment forms, Junior Doctor Assessment Policy, Protected Learning Time Policy for

Junior Medical Officer, Supervision of International Medical Graduates, Supervision of Junior Medical Officers.
(iv) District policy / procedure on New Interventional Procedures has been reviewed. The revised policy / procedure has been approved by District Executive and is accessible on the district intranet site. This policy / procedure links and references the revised WSMB District Credentials and Clinical Privileges for Medical Practitioners Policy / Procedure.
(v) Recommendation 1 has been implemented across the district. This can be demonstrated through an up to date credentials database for Senior Medical Officers and Visiting Medical Officers for the district. Recommendation 2 has been addressed through all new medical officer applicants and re-applicants now completing the new application form as documented through a revised credentialing process flowchart. Terms of reference for credentialing committee have been revised to ensure a system of credentialing for medical officers is more robust and aligns itself with state and federal credentialing standards.

Criterion 3.1.3 (Credentialing) Stage 2 Recommendations:
(i) The organisation demonstrate that the scope of clinical practice and performance management systems developed in Stage 1 have been implemented across the whole District.
The District is in the process of undertaking a review of all policies, processes and practices relating to the supervision, management and education of junior medical staff. This will culminate with an accreditation review by the Postgraduate Medical Education Council of Queensland in early 2009, at which time these policies and practices will be finally reviewed and implemented. The Conditional survey team will need to confirm that the changes have been sustained, and this process will be facilitated if the District develops and collects some relevant performance indicators to demonstrate the effectiveness and sustainability of the changes.

Criterion 3.1.3 (Credentialing) Stage 2 Actions:

All policies, processes and practices in relation to the supervision, management and education of junior medical staff have been revised and updated to be consistent with the Postgraduate Medical Education Council of Queensland requirements; the district is awaiting PMCQ accreditation survey visit on the 20 July 2009. The delay for PMCQ accreditation is due to the strong demand from increased numbers of interns coming into Queensland, with PMCQ changing survey accreditation visit from March 2009 to 20 July 2009.
A statewide process for Senior Medical Officer PAD is to be rolled out from the Princess Alexandra Hospital over the next 12 months. The district will continue with the current process until the statewide process has been implemented. A revised Performance Appraisal and Development (PAD) form has been trialled on several clinicians. From this trial, a PAD schedule has been developed to complete Senior Medical Officers (SMO)/ Staff Specialists PADs by the end of 2009-10 financial year. The Administration Officer (AO) for the District Medical Superintendent (West Moreton South Burnett Sector for Darling Downs – West Moreton Health Service District) coordinates and manages the credentialing database. The credentialing database is to be accessible on District Resources page on the District intranet site for all staff to access. Database for WMSB sector is transitioning to be merged with the new district (Darling Downs – West Moreton Health Service District) over the next six months. The credentialling database will continue to be developed with Information Technology (IT) to assist the Administration Officer in its development. The Qld Health Guidelines for Credentialing and Defining the Scope of Clinical Practice was released in April 2009. The Clinical Governance Unit is developing and is to implement a training package for Credentialing committee members by 01 September 2009. All forms and information on the district intranet site for Medical Administration are in the process of being reviewed and revised which has coincided with the release of the Qld Health Guidelines for Credentialing and Defining the Scope of Clinical Practice in April 2009. Procedural capabilities have been identified by the Clinical Director for Medical Officer Registrars in the specialty of Obstetrics and Gynaecology; this has been extended from the specialties of Psychiatry and Anaesthetics. The previous external process has transitioned to an internal departmental process for Mental Health Registrars in completing their core training and ECT. Orthopaedics and General Surgery have been identified as the next two specialties for Registrars that are to have their procedural capability identified by their Clinical Director with

accompanying photographs attached. West Moreton South Burnett sector in Darling Downs – West Moreton Health Service District has developed Credentialing performance indicators. These performance indicators include:
1. All SMO/ Staff Specialists/ VMOs are credentialed within West Moreton South Burnett sector;
2. By the end of 2009-10 financial year, 100% of Staff Specialists/ Senior Medical Officers, and 50% of Visiting Medical Officers (VMO) have a PAD completed.
All performance indicators are reported monthly to the credentialing committee for WMSB sector as a part of Darling Downs – West Moreton Health Service District.
3. By July 2010, all surgical specialties will have a process for identifying procedural capabilities.

Completion Due By: 31 July 2009

Responsibility: District Medical Superintendent

Organisation Completed:

Surveyor's Comments: **Recomm. Closed: Yes**
Stage 2
The recommendation has been implemented to a high standard and is closed. Please refer to the Function Summary for detailed comments.

Recommendation: OWS08083.1.5
Function:Corporate **Standard:3.1**
Criterion: 3.1.5 Documented corporate and clinical policies assist the organisation to provide quality care.

High Priority: No

Recommendation:

The policy and procedure relating to home visiting by staff be reviewed to ensure that it adequately covers the needs of those working in rural and remote areas, for example, when outside mobile phone coverage.

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:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08083.2.1
Function:Corporate **Standard:3.2**
Criterion: 3.2.1 Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.

High Priority: No

Recommendation:

(i) A manual handling program be developed at Ipswich to address specific needs of administrative staff, ie lifting, moving clinical records, moving computers, lifting boxes of copy paper.
(ii) The storage facility for patient records at Sacred Heart oral health unit be evaluated for compliance with manual handling principles.
(iii) Resources be assigned at Laidley and Esk to prioritise actions to address issues in asbestos reports.
(iv) The Radiation Safety Officer provide professional development to local staff at Kingaroy to increase awareness of radiation safety issues.

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:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08083.2.2
Function:Corporate Standard:3.2
Criterion: 3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

High Priority: Yes

Recommendation:

(i) Action be taken to ensure that inpatients in the medical imaging waiting area at Ipswich are returned to the ward immediately after their procedures, or structural changes be made to ensure that comfort and dignity is maintained.
(ii) Signposting at Sacred Heart Oral Health (administration/dental records) be changed to reflect the changed role from clinic to administration building.
(iii) The decommissioning of Farr Home and the relocation of residents to a more suitable aged care residential facility be considered (Kingaroy).
(iv) Safe work practices/safety rules be readily available for workshop staff at Kingaroy to assist in the promotion of a safe workplace.
(v) The current workplace administration floor space at Wondai be reviewed with a view to increasing the workplace size.
(vi) Refrigerators/freezers at Boonah, Laidley and Esk be fitted with temperature monitoring capacity.
(vii) Archived medical records in the mental health and oral health services be stored in a safe manner, free from exposure to sunlight and security risks.
(viii) Signposting for access and entry to the emergency department at Kingaroy be reviewed.

Stage 2 (August 2009)
(i) The immediate works identified in Stage 1 to reduce risk to acceptable levels be completed.
(ii) The rebuilding of the Barrett Adolescent Unit be expedited to enable care and services to be provided for adolescent patients in a purpose-built facility which facilitates a safe health environment and maximises the safety, comfort and needs of the community.

Action:
Criterion 3.2.2 Mental Health (AC60) Stage 1 Recommendations:

(i) Written confirmation of approval be obtained (with necessary budget allocation) to immediately make the necessary environmental modifications to the Barrett Adolescent Unit to reduce risk to acceptable levels and improve patient and staff safety. Progress environmental modifications to Barrett Adolescent Unit.

(ii) Documented evidence of approved plans and work schedule for the environmental modifications be provided, with designated timeframes for completion. Collation of documented evidence of plans and designated timeframes for completion.

Criterion 3.2.2 Mental Health (AC60) Stage 1 Actions:

(i) Written approval with appropriate budget allocation has been obtained for modifications. Modification progress:
- Removal & replacement of glass with Perspex in identified areas completed
- Front door entrance – scope of work developed. Door replaced with aluminium frame and toughened glass
- HDU – plans drawn up and progressing through building approval process. Associated plans drafted in relation to under slab, sewerage & drainage services and ducted air conditioning. Finalised plans will be submitted to Project Services.

(ii) Building & Engineering Maintenance Services maintain the documented plans and work schedules for the modifications.
Timeframe for completion is April/May 09
Scope of Work outlines the requirements / specifications of the work and the timeframes for work to be completed.

Criterion 3.2.2 Mental Health (AC60) Stage 2 Recommendations:
(i) The immediate works identified in Stage 1 to reduce risk to acceptable levels be completed. The Conditional survey team will need to confirm the completion of the temporary building works to address the deficiencies in the building and will need to verify that continuing progress has been made towards the relocation of the facility. If both aspects are confirmed, the High Priority Recommendation can be closed and the criterion re-rated to MA.
(ii) The rebuilding of the Barrett Adolescent Unit be expedited to enable care and services to be provided for adolescent patients in a purpose-built facility which facilitates a safe health environment and maximises the safety, comfort and needs of the community.

Criterion 3.2.2 Mental Health (AC60) Stage 2 Actions:

(i) Written approval with appropriate budget allocation has been obtained for modifications at Barrett Adolescent Unit. Modification progress includes:
: removal & replacement of glass with Perspex in identified areas is completed.
: front door entrance – door has been replaced (aluminium frame and toughened glass) – completed.
: High Dependency Unit – associated plans drafted in relation to under slab, sewerage & drainage services and ducted air conditioning plans drawn up. Finalised plans submitted to private certifier for approval. Building & Engineering Maintenance Services maintain the documented plans and work schedules for the modifications. Scope of work outlines the requirements / specifications of the work and the timeframes for work to be completed. Once plan approval has been received from private certifier, construction will begin with an estimated time of construction of six weeks.
(ii) Final decision on the redevelopment of the unit has been signed off and the unit will be relocated to Redlands Hospital site. A new User Group is being established by Metro South to progress the redevelopment and staffing profile of the Adolescent Extended Treatment Unit. The Park will be responsible for interim service delivery and the transition of services to the new site. Commissioning of the new unit is scheduled for March 2011.

Completion Due By:

Responsibility:

Organisation Completed:

Surveyor's Comments: **Recomm. Closed:** **Yes**
Stage 2
The recommendation has been implemented and is closed. Please refer to the Function Summary for detailed comments.

Recommendation: OWS08083.2.3
Function:Corporate **Standard:3.2**
Criterion: 3.2.3 Waste and environmental management supports safe practice and a safe environment.

High Priority: No

Recommendation:

(i) The capacity to implement a comprehensive recycling program at Ipswich be reviewed.
(ii) Waste management procedures in the mental health service be included in staff orientation packages and in-service programs.
(iii) Action plans be developed in the mental health service for implementing improvements following routine waste management audits.

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08083.2.4
Function:Corporate **Standard:3.2**
Criterion: 3.2.4 Emergency and disaster management supports safe practice and a safe environment.

High Priority: No

Recommendation:

(i) Progress be hastened in replacing existing emergency exit plans with new exit plans in ward areas of Ipswich hospital.
(ii) The District fire training program be further developed to include site/unit specific content that reflects the uniqueness and needs of each work location.

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

Recommendation: OWS08083.2.5
Function:Corporate **Standard:3.2**
Criterion: 3.2.5 Security management supports safe practice and a safe environment.

High Priority: No

Recommendation:

(i) The security risks facing staff when working alone at night in the emergency departments at Laidley and Esk be monitored to ensure that personal safety is maintained.
3. (ii) A safety review be undertaken of all non-hospital sites to ensure that staff working in small teams in isolated sites have a secure workplace with appropriate communication systems in place if needed in an emergency (Oral Health).
4. (iii) The security of staff working in the Laidley Oral Health facility be reviewed.
5. (iv) The personal duress alarm system at Wondai be reviewed with a view to determining its functionality and future use.
6. ((v) General and master keys for the Kingaroy facility be located and maintained in a locked key cabinet with limited staff access.

Action:

Completion Due By:

Responsibility:

Organisation Completed:

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

– Copy to Kim Fuhrer

18/3/03

QUEENSLAND HEALTH
DIRECTOR-GENERAL CORRESPONDENCE ACTION SLIP

NUMBER: DG 035239 DATE: 11.3.03

ORIGINAL TO: 1. DHSS 2. 3. 4.

COPIES TO: 1. MO33 2. MO38 3. MO34 4. MO14

☑ Please prepare a response for DG/GMHS/DDGPO signature by - 25.3.03

☐ Please prepare response for signature of GMHS/DDGPO over DG's signature block by _____

☐ Please prepare response for signature of Branch Director/State Manager etc by _____

NB: The green signed file copy of the response must be forwarded to the Executive Support Unit – 19th Floor – QEB

Note: If a substantive response has not been prepared by the above date an interim response must be provided and forwarded to the Executive Support Unit.

☐ Please coordinate your response with _____ by close of business on _____

☐ For discussion at a meeting scheduled for _____

☐ Briefing Note required by _____

☐ For appropriate action direct

☐ For information only. (NEEDS NO REPLY)

☑ Advance Copy 12.3.03 FAXED 12.3.03

☐ Acknowledgment and ☐ thanks (All acknowledgment letters are completed in the Executive Support Unit)

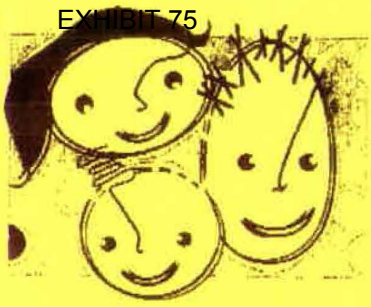
Further Comments.

Letters to districts to be prepared for signing by DG.

RECEIVED
11 MAR 2003
DG'S OFFICE

Please return completed documents to the Executive Support Unit, 19th Floor, Queensland Health Building

EXHIBIT 75



Commission for Children and Young People
14th Floor, T&G Building, 141 Queen Street, Brisbane, Qld, 4000
PO Box 12671, Brisbane, George Street, Qld, 4003
[redacted]
www.childcomm.qld.gov.au

Ref:...\MH DG 030224.doc

(07) 3247 5525

4 March 2003

Dr Robert Stable
Director-General
Queensland Health
PO Box 48
BRISBANE QLD 4001

Dear Dr Stable

Attached please find a copy of the most recent Community Visitor reports in relation to mental health facilities relevant to Queensland Health.

The reports are generally very positive and indicate that these mental health facilities provide appropriate services to meet the needs of young people visited. The reports further indicate that there are no significant issues at the sites, or that only minor issues exist that can be addressed at the local level by the service providers. I commend these reports to your attention.

Copies of the reports have been forwarded to the relevant service providers. If you have any queries regarding these reports, please do not hesitate to contact Mr Dennis Palmer, Manager (Community Visitors) on 3247 5155.

Yours sincerely

[redacted]

Robin Sullivan
Commissioner for Children and Young People

Enc. 1. List of facilities visited and relevant date.
2. Individual reports by Community Visitors.

Commission for
Children & Young People
Queensland Government

EXHIBIT 75

Community Visits to Queensland Health locations

9.1.03	Townsville Hospital - Acute Mental Health	Douglas
23.1.03	Royal Brisbane Hospital - Adolescent Unit	Herston
23.1.03	Barrett Adolescent Unit	Wacol
29.1.03	Fraser Coast Mental Health Service	Maryborough