QSA
QUALITY SYSTEMS ASSESSMENT

Quality Systems Assessment
December 2008

Justice Health NSW

Summary of findings for Justice Health NSW

Data submitted February – April 2008

CLINICAL EXCELLENCE COMMISSION

ABN 79 172 068 820
GPO Box 1614, SYDNEY NSW 2001
Tel: 61 2 93827600
Fax: 61 2 93827615

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Foreword

The development of a Quality Systems Assessment Program (QSA) was one of the key recommendations of the NSW Patient Safety and Clinical Quality Program originating from the Walker report into Camden and Campbelltown hospitals. A key function of the Clinical Excellence Commission (CEC) outlined in the NSW Patient Safety and Clinical Quality Program was to develop and conduct quality system assessments of public health organisations (PHOs) and recommend improvements to the NSW health system.

The aim of the QSA is to provide assurance about the quality and safety of health care provided by public health services in NSW and compliance with standards and policy requirements developed by NSW Department of Health. The QSA has been specifically developed for the eight area health services (AHS), the Children's Hospital at Westmead, Ambulance Service of NSW and Justice Health. The QSA provides a focus on current and future risks and has identified areas for continuous improvement of clinical quality and safety. It also highlights areas of exemplary practice relating to clinical quality and patient safety. The QSA complements current accreditation activities without replacing or duplicating them.

This report represents the first census of the quality and safety policies and their level of implementation for Justice Health, NSW. There was a one hundred percent response from all levels of the service.

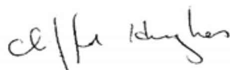
This report clearly identifies areas of exemplary performance, particularly in relation to the implementation of incident management policy and well-defined procedures for communication and follow-up of patient safety alerts. The report also identifies areas for improvement, such as continuity of care when patients are transferred throughout the NSW correctional system.

We commend this report to you and encourage you to engage actively with the clinicians in your service to develop improvement plans for patients in NSW.

We congratulate the staff of the Governance Unit of Justice Health who worked closely with the CEC QSA development team to achieve a successful implementation and data acquisition from the self-assessment process.

We strongly urge Justice Health to participate in further QSA self-assessments throughout 2009.

Sincerely,



Clifford Hughes
Chief Executive Officer
Clinical Excellence Commission

Bernie Harrison
Director, Organisational Development and Education
Program Director, QSA
Clinical Excellence Commission

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1 Executive Summary

This report presents the results of the first QSA survey of Justice Health which was undertaken between February and April 2008. The survey covered three levels of the Justice Health system – the statewide administrative level, the stream level and the cluster / service level. There was a one hundred percent response for the first QSA, with all of the nominated services at each system level completing the survey. The results provide a baseline measure of these services' performance in the implementation of various quality and safety programs and policies.

Justice Health provides health care for those people in contact with the criminal justice system. This includes individuals in adult and juvenile correctional institutions as well as individuals awaiting sentence in police cells and reception centres.

It should be noted that all inmates in correctional institutions come under the direct responsibility and control of the Department of Corrective Services (DCS) or for young people the Department of Juvenile Justice (DJJ). Justice Health operates independently from these departments but their access to patients is determined by them.

A key challenge for Justice Health is the provision of effective health care to patients in correctional centres where the window of opportunity is constrained by:

- The short length of stay (27% of inmates stay less than eight days and 44% stay less than 30 days)
- Frequent movement of inmates as few individuals spend their entire sentence within the same correctional centre and
- The ability to gain regular access to patients as provided by the DCS and DJJ.

The survey has demonstrated that key clinical quality and patient safety governance structures and processes for identifying and reporting risks to quality and safety have been established. There is ongoing review and improvement of service quality within the Justice Health system, including:

- The establishment of a Quality Council chaired by a Justice Health Board member
- The establishment of a Governance unit at state level
- Implementation of the Incident Information Management System (IIMS)
- Well-defined procedures for communication and follow-up of patient safety alerts
- Process for credentialing of medical staff
- Monthly collection and reporting of key clinical performance indicators
- Regular performance review of clinical staff

- Clear and well communicated processes for receipt and analysis of patient complaints
- Quality review meetings held monthly in all streams, clusters and services
- Clinical audit within operational units.

From the self-assessments Justice Health has identified areas where there are potential vulnerabilities and opportunities for improving the quality of clinical care and patient safety. They include:

- Gaining timely access to patients in custody for both accurate diagnosis and effective treatment
- Medication management
- The ability to provide continuity of care to patients and
- Patient factors such as non-compliance in treatment, recidivism and self harm.

There is consensus across the service that the issue of timely patient access to services presents a major risk. The provision of routine and regular healthcare is constrained by the hours during which DCS permits patients to access Justice Health clinics. There are also frequent situations where access may be prevented altogether as a result of DCS staff shortages, training days and correctional centre lockdowns. Facilitating continuity of care for patients is a major challenge given the short length of stay and frequent movement of inmates between correctional centres.

Patient factors present a key risk to patient safety and clinical quality in the criminal justice system environment. There is a high prevalence of mental illness and drug addiction or dependence leading to high levels of patient morbidity. In addition there is a high risk for aggression, non compliance with prescribed treatment protocols and self harm including suicide.

Over the past five years Justice Health has implemented the foundations of a system for monitoring and improving patient safety and clinical quality. The next steps involve building on these foundations, including the development of risk registers in all service streams and policies and guidelines to guide the routine conduct of quality review activities.

As in the broader NSW health system, the use of quality review activities such as clinical audit, medical record review and peer review is occurring but in an ad hoc fashion.

This initial census of clinical quality and safety systems has been undertaken to identify what is currently in place in the statewide administrative, stream and cluster levels of Justice Health. Subsequent QSA surveys will be tailored specifically to look at the level of implementation and effectiveness of the policy initiatives.

2 Key Recommendations

The key recommendations are based on analysis of responses to the Quality Systems Assessment at the statewide administrative, stream and cluster/sector level of Justice Health.

2.1 Governance

All findings from any review of incidents, such as death reviews and clinical indicator performance must be routinely reported to the Quality Council (page 25).

2.2 Risk Management and Patient Safety

Justice Health must ensure that integrated risk management systems are developed and in place in all streams (page 29).

2.3 Clinician Performance Review

Justice Health must ensure the provision of ongoing performance review of all professional groups throughout the organisation (page 33).

2.4 Development of Improvement Programs

Justice Health must ensure all cluster/services undertake improvement work in patient care and services based on clinical need and identified patient safety issues (page 38).

2.5 Incident Management

Justice Health must ensure that the findings of any review of critical incidents, for example: death review; root cause analysis; Health Care Complaints Commission / Coroner's findings; are fed back to the relevant clinical teams in a prompt manner (page 41).

2.6 Quality Review Activities

Working in partnership with NSW health, Justice Health must establish 'best practice' models for staff to undertake clinical audit, medical record review, peer review or other quality review activities (page 47).

2.7 Infection Control

Justice Health must continue to adapt current NSW health policies on infection control that meet the specific needs and challenges of Justice Health. Observation studies of compliance with hand washing protocols should be performed with outcomes reviewed by the quality committee (page 53).

2.8 Risk Identification

2.8.1 Justice Health must work with the Department of Corrective Services and Department of Juvenile Justice to ensure that procedures are in place to allow Justice Health staff timely and reliable access to patients for the provision of effective healthcare interventions (page 56).

2.8.2 Justice Health must to develop and implement improved systems for the transfer of clinical information when there is a transfer of care between correctional facilities (page 56).

2.9 Quality Systems Assessment (QSA)

The CEC needs to develop a targeted assessment for the 2008/09 QSA based on the issues identified from this report (page 57).

Expectations from the QSA report

The Clinical Excellence Commission (CEC) has developed an overall report of Justice Health which provides an assessment of the state of safety and quality management systems. All Justice Health data collected through the self-assessment has been returned to the Governance unit in an Excel spreadsheet format.

It is expected that these resources will be used by the service to review their data and respond to issues raised to identify areas with greatest risk and vulnerability and develop improvement plans to address them.

The expectation of the CEC is that each level will:

- Develop an improvement plan based on the information provided by the QSA. This would include:
  - Statewide recommendations
  - Statewide themes identified in the risks to patient safety
- Develop the improvement plan with involvement of the state senior executive
- Regularly monitor and report on the progress of the development and implementation of the improvement plan to Justice Health's peak Quality Committee and the CEC
- Ensure individual streams and clusters review their own responses to the QSA. If they have identified patient safety risks not included in the state improvement plan they need to put in place actions to minimise these risks
- Send an initial copy of the improvement plan to the CEC **three months** after the release of this report.

The improvement plans will be reviewed as part of the onsite verification program and a formal written report will be provided to the CEC at **12 months** on the progress of implementation.

3 Background

The Patient Safety and Clinical Quality Program (PSCQP) was launched in 2005, following the Inquiry into Campbelltown and Camden hospitals (Walker, 2004). The cornerstones of the PSCQP are:

- Provision of a standardised system for managing, reporting and investigating incidents to ensure that risks are identified and steps are taken to prevent recurrence
- Provision of an electronic Incident Information Management System (IIMS) to support centralised reporting and recording of incidents
- Establishment of clinical governance units in each area health service
- Development of a Quality Systems Assessment (QSA) framework and
- Establishment of the Clinical Excellence Commission (CEC) in 2005 (replacing the Institute for Clinical Excellence) to support and promote systemic improvements.

A key responsibility of the CEC outlined in the NSW PSCQP was to develop and undertake a QSA for all public health organisations (PHOs) in New South Wales.

In 2005, NSW Health produced the *QSA– framework* for the assessment of quality systems in all health services (NSW Health, 2005). The framework was based on the seven standards in the PSCQP, with which all public health organisations (PHOs) were required to comply. Following an unsuccessful open tender process in May 2005 to contract a suitable proponent to provide the QSA, the CEC decided on a different approach to developing a workable methodology for the QSA. An extensive international literature review of quality and safety assessment systems in both health and non-health settings were undertaken. It identified the utility of self-assessment models in use in non-health settings such as tax, mining, petroleum and the financial sector. A decision was made to develop a tailored self-reporting QSA for use in NSW.

In March 2006 KPMG, Risk Advisory Services, were contracted to work with the QSA Development Team to develop a suitable methodology. As a result of this work, an assessment methodology that relies on self-assessment through the completion of a web-based activity statement by all PHOs in NSW was developed. This first stage development included key stakeholder consultations and provided the framework, methodology and Area Health Service (AHS) level self-assessment tool for the QSA. The methodology is described in detail in Section 4 of this report.

In July 2006 a ‘proof of concept’ exercise was undertaken through a pilot program involving three AHSs. It indicated a positive result, with the feasibility and validity of the model endorsed by the participating services.

Following a subsequent tender process KPMG was engaged in December 2006 to further develop the methodology. The focus of this second stage development from December 2006-September 2007 was on developing assessment criteria and tools for health services at the facility and department /clinical unit level as well as for Justice Health and the Ambulance Service of NSW. Substantial consultation with AHSs occurred through a series of workshops. All tools were piloted.

The QSA methodology allows for development of reporting that will provide meaningful comparison and address issues of relative risk while allowing the CEC and Justice Health to identify themes, trends, key issues and opportunities for improvement

4 The Quality Systems Assessment (QSA) program

4.1 The QSA methodology

The methodology underlying the QSA is based on a risk management framework and draws experiences from other industries, including mining, petroleum and finance. In those industries there has been a shift to a risk-based approach to management of safety and quality. The international evidence supports an approach to safety improvement based on the identification and assessment of risks, followed by proportionate action to reduce those risks.

There are four components of the QSA:

- Completion of a self-assessment survey at three levels of the organisation (the activity statement)
- Verification of the activity statements
- Feedback and reporting to respondents, the health system and the community
- Development of improvement plans at each level of the organisation to respond to the issues identified in the self-assessment process. The improvement plan will be subject to review in subsequent QSA assessments.

4.1.1 Activity statements

The QSA activity statements have been designed to enable public health organisations to respond to a series of open and closed questions in a web-based module. The online format facilitates the speed of distribution and significantly lessens the burden of data collection and collation.

The activity statements consist of a series of specific open and closed questions under the six domains described and presented in their totality in the QSA report.

The NSW PSCQP identifies seven quality and safety standards with which all area health services are required to comply (NSW Health, 2005). These standards outline requirements for:

- Systems to monitor and review patient safety
- Effective clinical governance
- Incident management systems
- Complaints management systems and their use to improve patient care
- Systems to assess core adverse event rates by periodical medical record review
- Processes for performance review of clinicians by their peers to maintain best practice and improve patient care
- Audits of clinical practice.

These standards guide the development of the QSA activity statements and the development of its six domains:

- Governance
- Risk management
- Clinical indicators
- Incident management
- Review activities
- Complaints management.

Some of these standards lack any policy framework, or the existing policies and guidelines are either out of date, or do not provide sufficient clarity on key elements which can be assessed (KPMG, QSA Program Final Report 2007, p23). These standards include the areas of peer review, medical record audit and clinical audit. The QSA has addressed this shortfall by identifying associated key elements as developmental and by asking more open-ended questions as a means of assessment.

The relevant statewide policies and Justice Health policies governing these domains are listed in Appendix One of this report.

4.1.2 Verification process

The verification process includes five methods to confirm the activity statements responses. They are:

- Same level
- Between level
- Source of evidence
- Desktop review
- Targeted interview verification, which may consist of telephone consultation and site visits.

4.1.3 Feedback process

A key element of the QSA process is the reporting-back to stakeholders of findings from the assessment activities. The methodology provides for the development of reporting which enables meaningful comparison between organisations and addresses issues of relative risk. This includes:

- A high-level statewide report to the health system and the public, such as contained in this report, providing an assessment of the overall state of safety and quality management systems in Justice Health.
- All data collected at each service level will be returned to the service. This will enable Justice Health to continue to analysis, generate ad hoc reports and utilise results to develop improvement plans.

4.1.4 Improvement plans

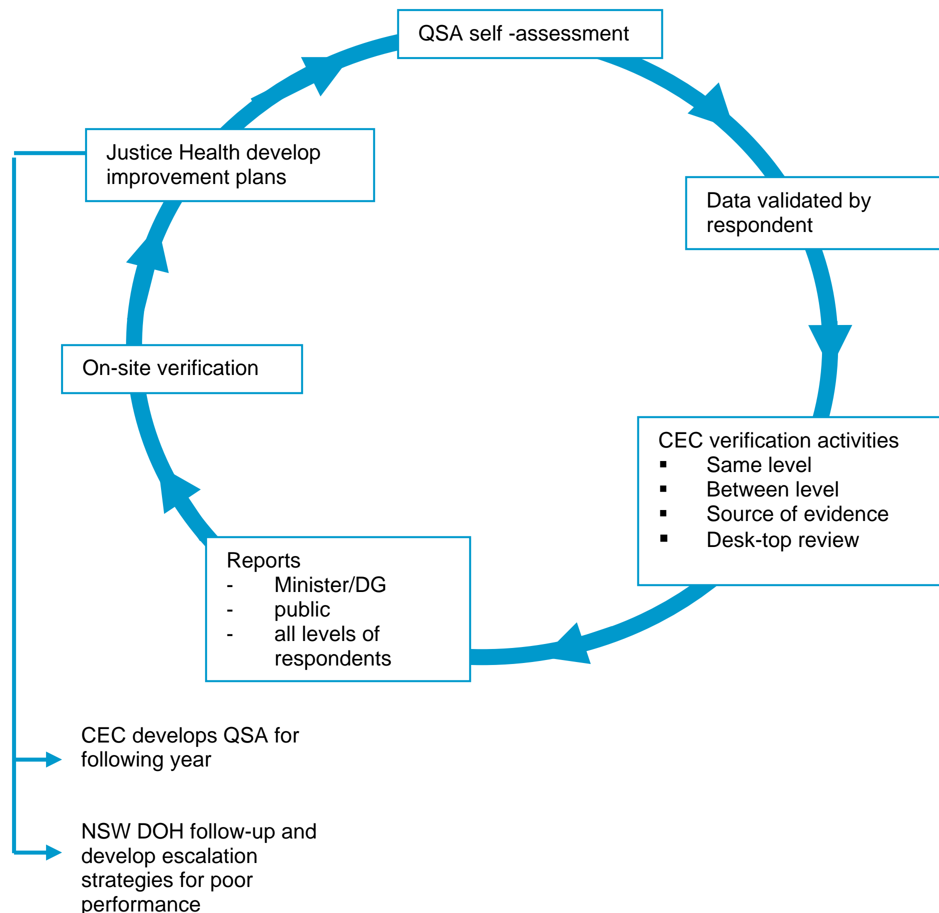
One of the critical elements of the QSA is the focus on identifying opportunities for improvement. Rather than assigning a pass or fail, the aim is to identify areas of poor or inconsistent performance.

Once these have been identified, educational materials and practice improvement tools can by provided to assist services to make the required changes. Where performance is inconsistent, exemplar health services demonstrating good practice can be identified and their approach disseminated across the system.

It is expected that Justice Health will develop its own improvement plan from the results of the QSA and that it will be designed with specific timeframes. The NSW Health Department will have oversight of its development.

The CEC will undertake a formal review of the outcomes of the plans with identified areas requiring improvement assessed in the following year's QSA as illustrated in Figure 1.

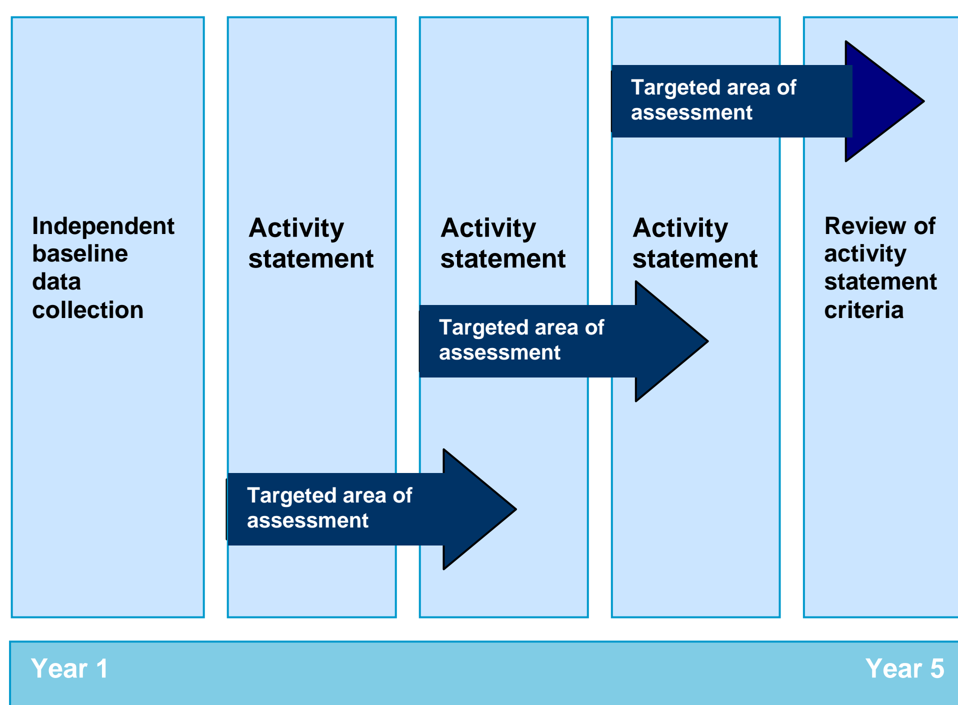
Figure 1 The Quality Systems Assessment model



4.2 Frequency of Assessment

Assessment of quality and safety systems using the QSA methodology will occur on an annual basis. The first survey will provide baseline measures for a comprehensive range of clinical quality and safety elements with the data re-assessed regularly, every five to seven years. In the intervening years, it is anticipated the surveys will have a thematic approach to targeted areas of assessment. These themes are expected to emerge from the analysis of the first baseline survey results presented in this report. The proposed approach is illustrated in Figure 2.

Figure 2 The overarching framework of the QSA



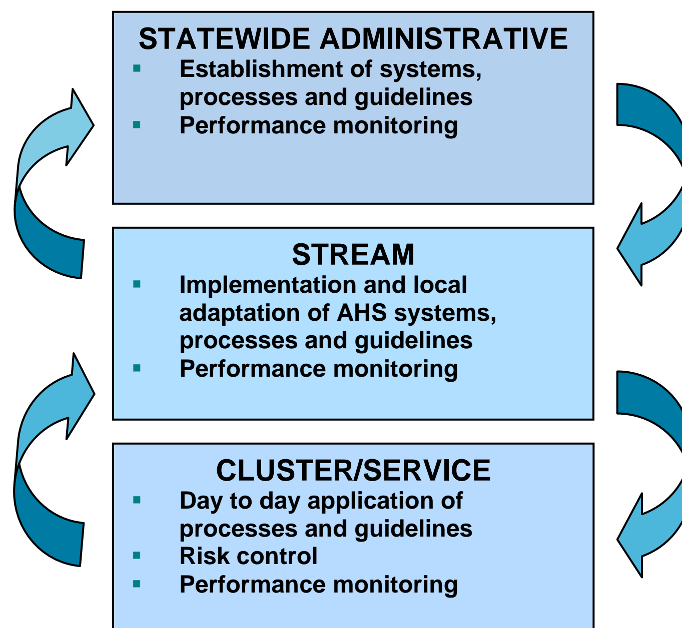
4.3 Program Scope

The QSA encompasses the whole of the NSW public health system which comprises eight area health services, the Children's Hospital at Westmead, Ambulance Service of NSW and Justice Health.

4.3.1 A multi-level approach to assessment

The QSA features a multi-level approach to quality systems assessment, with activity statements tailored to the different levels within Justice Health, as illustrated in Figure 3.

Figure 3 Multi-level assessment and correlation of findings to evaluate the governance system



The multi-level approach allows for responses at different levels of the organisation to be correlated, to assess the effectiveness of governing and reporting structures. It is anticipated that this will assist in:

- Identifying statewide policy and program gaps
- Providing a source of verification of self-assessment responses
- Estimating the degree of effectiveness in the implementation of policy performance monitoring and risk controls.

4.3.2 Justice Health system levels

Following consultation with Justice Health Governance staff it was agreed that the 2007 QSA would be undertaken at three levels, these were:

- Statewide administrative
- Stream
- Cluster/service.

The statewide administrative office of Justice Health is based at Long Bay Complex in Sydney. Functions provided at this organisation level include Executive Management, Governance, Corporate Services and Finance. At the **statewide administrative** level, the Director of Governance is responsible for the coordination of patient safety and quality improvement within Justice Health.

Justice Health operates a matrix organisation structure with six horizontal service **streams.** The streams provide statewide strategic focus on the key target groups and vertical reporting structures for the operational management of clinical units.
The six streams are:

- Population Health
- Primary Health
- Drug and Alcohol
- Mental Health
- Adolescent Health
- Women's Health.

The six streams primarily provide strategic review and policy functions such as the development of clinical standards and audit systems and the development and review of key performance indicators. Streams such as Mental Health, Primary Health, Women's Health and Adolescent Health also have direct operational responsibility for service units.

At an operational level, Justice Health services are administered by a number of **clusters** or **services**. Clusters are either geographic groupings of services e.g. Parklea Complex, Western Region, Cessnock Cluster, or statewide services which are based on population or service groupings e.g. Aboriginal Health, Radiology, Community Forensic Mental Health Service.

The 20 clusters / services are:

- Northern Region
- Cessnock Cluster
- Western Region
- Bathurst Cluster
- John Morony Cluster
- Parklea Complex
- Long Bay Health Centres
- Inpatient Mental Health – Long Bay
- Ambulatory Mental Health
- Southern Region
- Aboriginal Health
- Metropolitan Remand & Reception Centre
- Police Cells
- Community Forensic Mental Health Service
- Medical Appointments Unit
- Oral Health
- Radiology
- Physiotherapy
- Pharmacy
- Connections Project – provides post release drug & alcohol care.

4.4 Program Context

The QSA is designed to complement the broad range of activities which are already in place to assess, improve or provide assurance on the safety and quality of patient care in NSW. They include:

- Clinical practice improvement (CPI) initiatives (e.g. collaborative projects)
- Accreditation processes
- Policy development
- Credentialing procedures
- Regulation of
  - health service provider organisations
  - health professionals.

The QSA is based on a risk and improvement framework which complements an accreditation framework which has a regulatory and compliance focus. The CEC views accreditation as having a defined role within this quality framework as part of a continuum of options.

Justice Health currently undertakes the Australian Council on Healthcare Standards (ACHS) EQuIP accreditation. It is expected that the QSA program will complement the current accreditation processes.

5 Justice Health

Justice Health is a Statutory Health Corporation established under the Health Services Act (NSW) 1997. Annually Justice Health cares for over 28,500 inmates and detainees. Justice Health is responsible for the provision of health services to adults and young people in:

- 32 correctional centres
- 11 periodic detention centres
- 2 transitional centres
- 10 police cell complexes
- 8 Juvenile Justice centres
- 1 Juvenile Detention centre.

In the provision of health services to an average daily population of around 9700 full-time inmates who are characterised by poor health status including general physical and nutritional neglect, substance abuse and mental illness, Justice Health faces some key challenges (Justice Health Annual Report, 2007). These include:

- Provision of services in a array of locations including relatively remote parts of NSW
- Limited access to patients
- Limited window of opportunity to provide healthcare with 44% of inmates staying fewer than 30 days and only 10% staying longer than six months
- Frequent relocation of inmates with approximately 250,000 inmate movements between correctional centres, police cells and courts per annum, and
- A 5.5% per annum increase in the inmate population over the past five years.

While drug and mental health are over represented in the morbidity of the patient population, patients have a range of health needs including but not limited to:

- Chronic and complex conditions such as coronary heart disease, cancer treatment and screening
- Chronic respiratory conditions and
- Diabetes.

Justice Health provides a comprehensive range of clinical services. Those specialist services not provided by Justice Health are sourced externally through Area Health Services (AHS).

It should be noted that all inmates in correctional institutions come under the direct responsibility and control of the DCS, or DJJ for young people. Justice Health operates independently from these departments but their access to patients is influenced by the activities of staff from these departments.

6 Justice Health 2007 Survey

The QSA self-assessment was undertaken by Justice Health between February and April 2008. The aim was to establish a baseline picture of the safety and quality systems and activities.

The survey guided respondents to provide responses based on activity from January to December 2007. The results provided herein reflect the status of the organisation at that time, and do not include changes that have occurred since.

It is expected that the baseline measures obtained through the first QSA survey have:

- Identified characteristics of the existing patient safety management system and differences in approach between organisations and levels
- Identified, where possible, key elements of a robust patient safety quality system and response chains where they exist
- Established improvement aims
- Identified key areas of risk which will be used to inform targeted areas of assessment in later years
- Provided data that can be used to further develop criteria and questions for subsequent activity statements
- Identified existing risk control points.

6.1 QSA Response Rate

The QSA program conducted surveys at three levels of Justice Health to evaluate the status of quality systems. All assessments were returned completed (Table 1).

Table 1 Justice Health QSA survey response rate

Level of assessment	Surveys sent	Total returned	Response rate
Statewide administrative	1	1	100%
Stream	6	6	100%
Cluster/service	20	20	100%

Many of the domains assessed have questions asked at one level of the organisation as well as the same or similar question asked at another level. This approach assists in the verification of the responses provided and shows the extent to which an issue has been implemented. Table 2 shows the topics covered by each level.

Table 2 Self-assessment topics covered by Justice Health survey

Domains assessed	Statewide administrative	Stream	Cluster/service
Quality governance	✔	✔	
Clinical indicators	✔	✔	✔
Risk management	✔	✔	✔
Incident management	✔	✔	✔
Mortality review	✔	✔	✔
Complaints review	✔	✔	✔
New procedures	✔	✔	✔
Peer review	✔	✔	
Clinical audit	✔	✔	✔
Credentialing and performance review	✔	✔	✔
Health care record review		✔	
Infection control	✔		✔
Correct Patient/site/procedure	✔		✔

6.2 Data analysis

Data was collected through an online internet self assessment which was managed by Strategic Data: the data was then provided to the CEC for collation, in an Excel spreadsheet.

Analysis of the quantitative and qualitative data collected at all levels of the self assessment was undertaken by the QSA project team and an independent consultant with expertise in statistical analysis.

Further clarification and verification of the data was gained by telephone and face to face interviews with the Director of the Governance Unit and staff.

7 Assessment of survey domains – summary of results

7.1 Clinical Governance and Committee Structures

Relevant Policy Framework

The NSW Framework for Managing the Quality of Health Services (NSW Health, 1999) indicates that an essential component of a quality framework is an appropriate structure to monitor and manage the quality of health care being delivered in an area health service. The Framework recommends the establishment of a peak committee such as an "Area Quality Council" as part of this structure.

Justice Health clinical governance committee structure

In accordance with area health service model by-laws, the Board of Justice Health has established two key committees, the Quality Council (QC) and the Audit and Risk Management Committee (ARMC). These committees provide advice in relation to quality assurance and risk management. The Board receives regular reports from these two committees as well as reports from the incident information management system (IIMS).

The ARMC is responsible for: maintaining an effective internal control framework; reviewing and ensuring the effectiveness of the internal and external audit functions and overseeing the risk management functions and responsibilities of the organisation.

The QC performs the role of the peak committee for clinical governance in Justice Health and is chaired by a member of the Justice Health Board. The Chief Executive (CE) is a member of this committee and is responsible for the operations and conduct of the organisation. The QC provides the link between executive, the Board and, ultimately, the Minister for Health.

The Justice Health Clinical Council is an Executive committee which reports to the CE and receives reports on operational patient safety and clinical quality issues which may be referred to the QC. The role of the Clinical Council is to:

- Provide leadership on clinical risk management
- Develop indicators to monitor performance
- Monitor and review incidents and complaints
- Report performance to the Senior Executive and Board.

Results

Statewide administrative level

The **statewide administrative** level response identified the role of the Quality Council in relation to the review of various quality activities (Table 3).

Table 3 Role of Justice Health Quality Council

	Almost always	Often	Sometimes	Rarely	Never
Reports on SAC1* incident investigations	✔				
Trended data or other information regarding SAC2, SAC3 or SAC4 incidents	✔				
Complaints management performance	✔				
Clinical indicator performance				✔	
Outcomes of death reviews			✔		
Progress on implementation of safety and quality policies			✔		

*Severity Assessment Code

The results show outcomes of death review and clinical indicator performance are not consistently reviewed by the Quality Council. Reports on SAC 1, trended data on SAC 2, 3, and 4 incidents and complaints performance are almost always reported to the committee.

Recommendation:

All findings from any review of incidents, such as death reviews and clinical indicator performance must be routinely reported to the Quality Council.

Stream level

Five of the six **streams** responded that they did refer safety issues to the Clinical Council with one stream responding that issues are usually managed within the stream.

> *Stream level response*
> *The Nurse Unit Managers provide a monthly report to the Cluster Nurse Manager in regard to their local incident management using the IIMs system. The Women's Health Cluster nurse manager (NM) then provides a monthly IIMs incident trend analysis report to the Patient Safety Meeting chaired by the Director Adult, Clinical and Nursing Operations (DACNO). A six monthly trend report is also submitted by the NM. The reports from this meeting are then presented to the Clinical Council by the DACNO. The Service Director Women's Health and NM may also provide information to the Clinical Council indirectly as participants in the RCA process. Complaints are also reviewed at this meeting.*

The information the streams regularly report to the clinical council include:

- Patient Safety and Clinical Quality meeting minutes
- Briefs on identified organisational risks
- Reports on clinical audit processes and outcomes
- Practice improvement project reports
- Monthly IIMS reports/reviews/action sheets
- Tabulated annual IIMS data trends
- Updates on identification, planning and implementation of clinical protocols.

An example of how the Quality Council responds to patient safety and clinical quality issues was given:

> *Stream level response*
> *All Clinical Streams report activity through the Clinical Council to the Quality Council. Selected issues based on incident and clinical stream reports are monitored. A review of adolescent health medication safety trends resulted in the development of an integrated governance model to reduce the incidence of medication safety issues.*

In response to the statement "The Clinical Council responds to patient/client safety and clinical quality issues which are reported to it", four streams strongly agreed, one agreed and one replied that it was not sure.

Cluster/service level

At the **cluster/service** level, 100% of operational units reported that a staff meeting or management meeting was the forum for discussion of patient safety and quality issues such as indicator performance, incidents and complaints, and that this occurred at least monthly. All cluster / services responded that if an issue was unable to be managed locally there was a process available for referral to management as described in the example below.

> *Issues are referred through the Justice Health line management process. Safety issues that require immediate attention are dealt with in a timely manner.*

The cluster/service level response to the question: who attends these meetings and the frequency which each level of staff attends is shown in Table 4.

Table 4 Cluster/service level - Attendance at safety and quality meetings (n=20)

Classification	Almost always	Often	Sometimes	Rarely	Almost never
Nursing	18 (90%)				2 (10%)
Allied health	6 (30%)	1 (5%)		2 (10%)	11 (55%)
Registrar	2 (10%)	1 (5%)		2 (10%)	15 (75%)
CMO, VMO or staff specialist	6 (30%)	2 (10%)		2 (10%)	10 (50%)
Management	19 (95%)	1 (5%)			
Other	5 (25%)		1 (5%)		

While there is a high representation of nursing and management staff at these meetings, medical staff are in attendance less than 30% of the time. This may be an area for future review.

7.1.1 Governance Unit

The NSW Patient Safety and Clinical Quality Program [PSCQP; (2005)] required each area health service to establish an area clinical governance unit (CGU). The focus of the CGU is to oversee the risk management of patient safety and clinical quality through the implementation of the PSCQP.

Justice Health has established a Governance unit (GU), as recommended in the PSCQP. A business plan has been developed and implemented and a monitoring system has been established, as described.

> *All objectives in the business plan have been assigned an action officer and progress is reported via individual and team meetings. Identified actions are reviewed as part of the annual Governance Unit Staff Performance Review.*

7.2 Risk Management

Relevant Policy Framework

Risk management in Justice Health is guided by the risk management framework policy 2.155 and overseen by the Audit and Risk Management Committee and the Quality Council. Implementation of audit and improvement recommendations is facilitated by the GU.

The Justice Health risk management framework provides the process whereby identified and assessed risks are reported and managed through line managers. Risks may be escalated to executive management where appropriate. The role of the Governance Unit is to report identified risks to executive management, the Chief Executive (CE) and Justice Health Board. If required, risks are notified up to the level of Director General or Minister. The Governance Unit's role is to facilitate the flow of information, it does not manage the risk this is the role of line management.

The **statewide administrative** level agreed with the statement "overall, the governance of clinical, corporate, and environmental risk is integrated at Justice Health level." At this level the Quality Council has the lead role in overseeing the processes for identification, communication and management of risks to patient safety. The Audit and Risk Management Committee also oversees clinical risks, particularly where these form a component of the audit program, such as medication management. Examples of clinical risks reviewed by the committee include:

- Clozapine management
- Olanzapine (Zyprexa) prescribing
- Drug storage
- Medication administration
- Consent – release of information and for surgery.

7.2.1 Identification of risks to patient safety

Four of the six **streams** indicated that they kept a risk register that included patient/clinical safety and clinical quality risks. Although two streams responded they did not have a risk register all were able to describe a process (usually through IIMS) for monitoring and analysis of clinical risks.

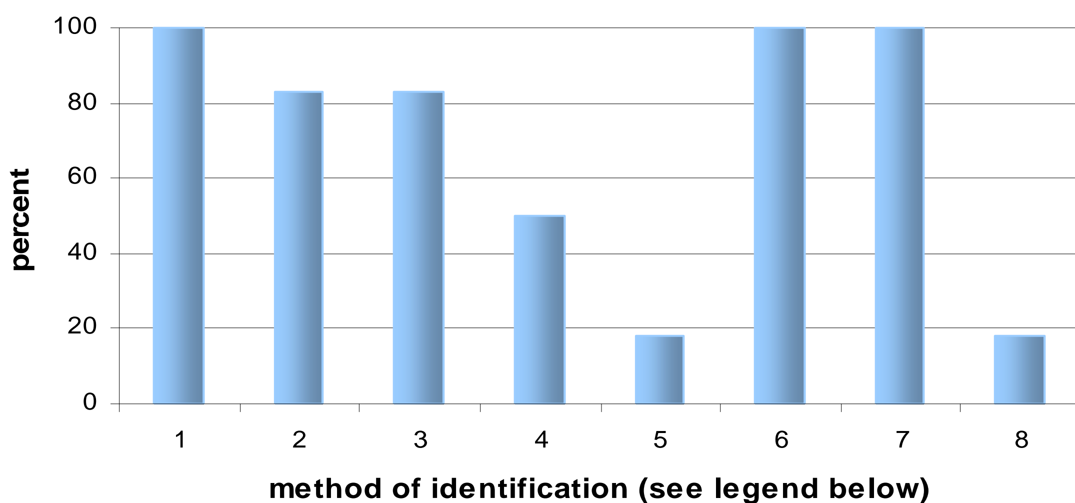
> *Stream level response*
> *The stream reports on all incidents to the statewide Patient Safety meeting. This occurs on a monthly basis through the Patient Safety report prepared by the nurse manager. The incident management process highlights deficits and the stream utilises all recourses available across the organisation in the resolution of these incidents. The Women's Health Clinical Stream has produced a medical appointments flow chart in an effort to address complaints from patients in regard to medical appointments.*

Three of the streams strongly agreed that there was an integrated approach to risk management. Two agreed and one disagreed.

> *The risk management system is currently not formalised and collated as a single register for each unit or stream, although key risks are identified and actioned using the available evidence and recorded and monitored through Patient Safety meetings. In addition, risks are escalated through bi-lateral discussion with the Director of Clinical and Nursing Services, providing a conduit to the Justice Health Executive.*

At the **stream** level respondents indicated that risks are identified from a wide number of sources as shown in Figure 4.

Figure 4 Stream level response - Methods of identifying safety & quality issues or clinical risks



Methods used to identify safety and quality issues

1 Review of incidents or IIMS data
2 Review of clinical indicator data
3 Patient/client survey
4 Patient/client interview
5 Peer review
6 Patient/client complaints
7 Stream meetings
8 Other

Recommendation:

Justice Health must ensure that integrated risk management systems are developed and in place in all streams.

7.2.2 Communication of Risks to Patient Safety

At the **statewide administrative** level communication to staff regarding changes in patient safety and clinical quality policies and protocols is achieved via the intranet and email. Each stream or unit has a designated person responsible for acknowledgement of receipt and follow up of non compliance.

The response at **stream** level described multiple processes to communicate patient safety alerts across their services. These processes appear to be well defined with procedures to ensure any changes made were notified to staff. Modes of communication include the intranet as well as it being included as a standing item on the agenda of weekly staff meetings.

> *Response from stream level*
> *Patient safety alerts are entered on the Patient Administration System (PAS) by a Justice Health clinician, the alert is then automatically sent via the intranet to the Department of Juvenile Justice (DJJ) client information management system and is registered on their alert system. Additionally any alerts entered on the DJJ system is automatically sent to the Justice Health alert system. All clinicians have access to the system and can check alerts at any time; a print out of current alerts is made at each clinic on a daily basis and the alerts are discussed by the clinicians at the weekly or bi weekly interagency, multidisciplinary team meetings.*

Streams also nominated a variety of processes that ensure changes are made in response to patient safety alerts. These include:

- Local clinical audits
- Use of health problem notification forms
- Progress recorded and actioned in patient safety minutes and
- Reports from clinical areas.

> *Response from stream level*
> *The changes are made at the local clinic level and any issues requiring escalation are reported to the nursing unit manager (NUM). The NUM will then co-ordinate with the appropriate service provider.*

The responses to the QSA survey at statewide administrative and stream levels indicate that Justice Health has good systems in place, both to communicate and act on patient safety alerts.

Risks to patient safety

As part of the self-assessment the streams and cluster/service level respondents were asked to list (in no particular order) what they considered were the three main risks to patient safety. The qualitative analysis of these risks was undertaken by the QSA project team and through the analysis common themes at each level were identified. The findings of the analysis are in section 8 (page 55) of this report.

7.2.3 Credentialing and Role Delineation

Relevant Policy Framework

The requirements of delineation of clinical privileges are outlined in NSW Health policy PD2005_497 which applies to all public health organisations (PHOs). This policy describes the process required for aligning the competence of a medical practitioner with the competence of a health care facility, to ensure that the right clinicians are providing the right services in the right public health organisations. All PHOs in NSW are required to have properly constituted credentials committees that comprehensively review and make recommendations in regard to the clinical privileges for all medical staff, excluding junior medical officers.

In relation to credentialing and role delineation in Justice Health the **statewide administrative** level responded that they have:

- A policy or guideline outlining roles and responsibilities in defining an individual clinician's clinical privileges
- A process for the review of clinical privileges throughout the period of appointment / employment of VMOs or staff specialists
- A process for delineation of clinical privileges for all medical practitioners
- A process for delineation of clinical privileges for all dentists.

These processes are governed through the Medical and Dental Appointments Advisory Committee (MADDAC). Clinical staff are not permitted to practice until privileges are approved.

This response was supported by all **streams** answering that these processes were in place.

> *Stream level response*
> *At the appointment of medical staff, delineation of clinical privileges is undertaken with the advice of MADDAC. Any revisions would be the subject of performance review. Applications made by the clinician and supported by the Clinical Director, through the Medical Director, are again endorsed by MADDAC. Any concerns that are raised through complaints, peers, IIMs etc would inform any suspension of procedures and review of the delineation of clinical privileges. Review of specific or non-routine procedures would be undertaken in collaboration with the Medical Director and other stakeholders to ensure that there was adequate capacity and resource to support the competence of the practitioner. Through the annual performance review, the position description of individual clinicians is also reviewed.*

In relation to credentialing and role delineation the responses from the QSA self-assessments indicate that Justice Health has defined processes in place.

7.2.4 Clinician Performance Review

Periodic performance review of medical staff was reported to be undertaken in four of the six streams. Women's Health responded that a performance review framework was not applicable to their stream; no further explanation was given. Population Health answered that the stream did not undertake periodic performance reviews. Its medical staff are Visiting Medical Officers (VMOs) and it is likely that performance review in Population Health is occurring as part of the VMO re-appointment process.

> *Stream level response*
> *Credentials and registrations are routinely checked on an annual basis and at appointment. The quality of the performance review is largely academic and dislocated from observed practice and undertaken often by telephone conversation for rural and remote practitioners. There is no current system for formally recording the review or the outcomes, together with the recommended action. Work is required to provide the necessary framework to ensure consistency and full engagement in the process.*

All responses from the **stream** level described processes where issues regarding practice and competence were addressed in a timely manner and were inclusive of medical, nursing and allied health staff.

> *Stream level responses*
> *The performance review is an opportunity to identify issues relating to individual clinicians and through dialogue, other significant issues that compromise quality of care may be identified at this time. The outcomes are passed to the Service Director by the Clinical Director or raised in the Population Health Stream meeting. A more formal procedure/process is required to identify training /development requirements, specific issues, strengths and weaknesses and also synergy with the Population Health Business Plan and Justice Health strategy for service development.*
>
> *The performance review process involves discussion of issues of professional practice that may compromise the quality of care. A number of strategies are set in place to rectify and monitor professional practice. These include; clinical supervision, performance management and further education.*
>
> *Any nursing staff identified as having clinical practice issues is placed on performance management until the cluster manager is confident that the issue is resolved. Performance management usually requires the health professional to work in a supported role with direct supervision by the Nurse Unit Manager. Training is provided if a specific need or skill deficit is identified. If there is an issues associated with a medical staff member in respect to performance then this is managed conjointly by the Clinical Director and Medical Director.*

Streams were asked to indicate the frequency of performance review of all staff (Table 4).

Table 4 Stream level response - Frequency of clinician performance review (n=6)

Classification	6 mthly	Yearly	> 2 years	Almost never
CMO		3		3
Registrar		2		4
Staff specialist		4		2
VMOs		4		2
RNs		4		2
NUMs		3		3
Other nursing		6		
Allied health		6		
Other		4		2

The above table shows that three of the streams “almost never” undertake performance review of nursing unit managers and two streams “almost never” review registered nurse performance. All streams review allied health and other nursing staff performance annually. Performance review of medical staff is also variable across the streams. These results indicate potential to implement regular performance review for all staff.

Recommendation:

Justice Health must ensure the provision of ongoing performance review of all professional groups throughout the organisation.

7.3 Clinical Indicators/Performance Management

Relevant Policy Framework

The Clinician's Toolkit (NSW Health, 2001) describes how clinical indicators can be used as 'flags' which can alert clinicians and managers to possible problems and/or opportunities for improvement in patient care.

Performance Management in Justice Health is governed by policy 3.132.

7.3.1 Use of Clinical Indicators/Key Performance Indicators (KPIs)

Justice Health has a good range of clinical indicators across all its programs and levels. They include screening/health assessment, access, treatment rates, adverse events, patient satisfaction and aspects of follow-up care.

The **statewide administrative** level was asked to list the top ten clinical indicators considered to be the most important in monitoring safety and quality systems which are regularly collected and reported by streams. These included:

- Women's health – cervical screening; pregnancy testing and mammography indicators
- Inmate health survey indicators
- Mental health – MH-OAT (Mental Health Outcome & Assessment Tools) audit
- Drug and alcohol – opiate treatment program; commencing and finishing detoxification program
- Population health – Hepatitis C assessment and treatment; Hepatitis B vaccination course
- Primary health – long term health plan completion; surgery and appointment waiting times
- Adolescent health – health assessment indicators
- Patient satisfaction.

The clinical indicators collected at the **stream** or **cluster/service** level reflect the clinical program or stream structure.

7.3.2 Analysis and Performance Management

The **statewide administrative** and **stream** level were asked how they responded to poor performance in clinical indicators. Both responded that a specific process was in place where incidents were reviewed, results continually monitored and if action was required the issue escalated. The process includes review of results at the clinical quality committee where trends are reviewed and assessed against benchmarks. Senior management are involved in developing and monitoring outcomes.

> *Statewide administrative level response*
> *The KPIs are reported to and monitored through the line management system. Key issues are raised at Clinical Council where risks are identified, escalated and reported / monitored against action plans.*
>
> *Stream level responses*
> *Action taken to improve unsatisfactory performance includes direct reporting to the statewide Director, senior and front line management. The clinical streams meeting is the venue where incidents are collectively discussed, including ways to mitigate identified risks.*
>
> *The clinical indicator benchmark is reviewed, the reasons why it has fallen below targets are identified and solutions to improve the targets are discussed. If necessary the issue would be raised at a higher level: solutions may include additional education or developing a timeframe to improve the targets.*

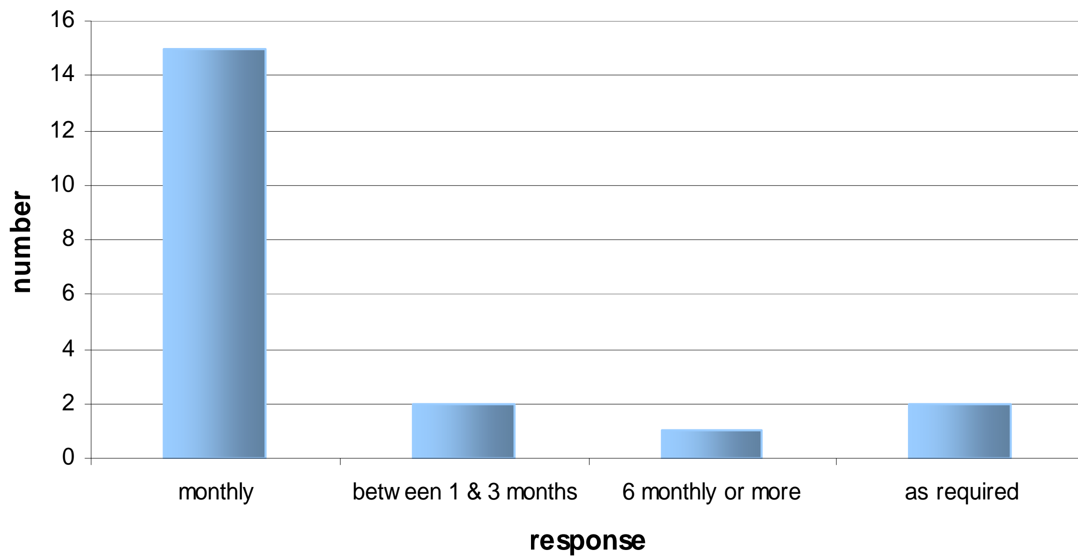
Stream responses indicated that some level of benchmarking was undertaken using relevant NSW Health benchmarks. An example is the participation in National Forensic Mental Health Benchmarking Forum and some interstate benchmarking against other forensic health services.

> *Stream level responses*
> *KPIs are submitted to NSW Health in respect to breast and cervical screening and pregnancy rates. We do not necessarily benchmark with other organisations in a formal manner but there are research endeavours that occur which allow us to benchmark utilising comparative data obtained as part of the research project. The Mothers and Gestation in Custody (MAGIC) study is currently underway and reviews mothers and gestation in custody outcomes across the country. This study is being conducted by UNSW.*

Only one stream does not benchmark with other organisations, however the unique nature of many of the Justice Health services would make it difficult to find services for a valid comparison.

At the **cluster/service** level when asked whether they compared performance using clinical indicators twelve (60%) responded that they compared the indicators with other clinical services.

Figure 5 Cluster/service level response - Frequency of clinical indicator reports to next level of management.



At the **cluster / services** level, 85% reported that clinical indicators were reported between one and three monthly to the next level of management, while two responded that indicators were reported as required (Figure 5).

The responses from all levels of self-assessment indicate that Justice Health has a well-organised system in place for the collection, monitoring and analysis of performance.

7.3.3 Practice Improvement Projects (PIPs)

Relevant Policy Framework

The undertaking of Practice Improvement Projects in response to clinical incidents is governed by the Practice Improvement Projects policy (2.137).

Throughout Justice Health PIPs have been undertaken in response to clinical incidents, or in response to RCA investigations. All **streams** are undertaking PIPs either as part of statewide Justice Health initiatives or at individual stream level. PIPs are identified and prioritised according to clinical need and patient safety.

Stream level response

The process for deciding to undertake any new project begins with an initial discussion between the unit head, clinician and the Primary health Service Director. Various points are considered and include:

1. *Significance and risk of issue identified related to patient need professional integrity and risk to the organisation*
2. *Unit/stream capacity to plan and implement the PIP, within the resource allocation and potential availability for additional resource/support to be identified*
3. *NSW Health Policy and learning from other organisations*
4. *Current administrative/clinical workload within the unit/area*
5. *Likely and desired impact of undertaking the PIP*
6. *Determination of priorities by other Justice Health functions e.g. Governance unit, Clinical Council and Clinical Nursing Committee.*

Each level was asked to provide an example of how a safety and quality improvement project has improved the safety of patient care.

Statewide administrative level:

Project aim:
The aim of the project was to reduce the number of medication related incidents.

Outcomes and achievements:
Medication guidelines and a pharmacy advice line were developed and implemented to address medication issues and incidents. All Justice Health staff have access to the medication guidelines via hard and electronic copy. The medication guidelines comprises legal and procedural guidelines.
This project is currently undergoing further evaluation.

Stream level:

Mental health

Project aim:
Reduce the number of patient on patient incidents of aggression in the acute inpatient setting.

Timeframe:
Six months.

Performance measures:
Reduced number of incidents; time and day of week of incidents and reduced medication incidents.

Outcomes and achievements:
Review of incident data showed that incidents of aggression were occurring, particularly on Mondays and Thursdays, mid morning and early evening. Thursday was the day where doctors' rounds took place, and subsequently there was little in the way of structured activities occurring. Structured activities were subsequently implemented and led to reduction in amount of aggressive behaviour.

Cluster/service level:

Medical Appointments Unit

Project aim:
Reduce cancellations of scheduled doctor appointments due to transfer of patients from location of original booking.

Project activities:
Appointments for female patients were cancelled as patients were no longer in centre where original appointments were made (Reception goal). Department of Corrective Services (DCS) could not facilitate appointments at centre where patients were transferred to (Goal of classification).

Referrals from centre of reception were minimised and only urgent referrals were actioned. All other referrals were entered on PAS and activated only when patient was transferred to goal of classification. This was achieved by Health centre staff cross referencing DCS reception list with referrals in PAS and informing the Medical Appointments Unit (MAU) to activate referral.

Results achieved:
Comparing cancellation data pre and post implementation demonstrated a marked reduction in numbers of cancellations from 123 pre implementation of improvement strategy to 53 post implementation.

Half (10/20) of the **clusters/services** indicated that they had undertaken PIPs in the past 12 months as a result of clinical indicator or clinical incident data.

Recommendation:

Justice Health must ensure all cluster / services undertake improvement work in patient care and services based on clinical need and identified patient safety issues.

7.4 Incident Management

Relevant Policy Framework

The NSW Health Incident Management Policy (PD2006_030) mandates the actions of all public health organisations in response to clinical incidents that occur in the NSW health system. The policy details requirements for submission of reportable incident briefs, notification of incidents in the Incident Information Management System (IIMS), for open disclosure in the incident management process and for privileged Root Cause Analysis (RCA.) It provides relevant timeframes for providing the required reports to the NSW Health Department.

All levels of Justice Health are using the incident information management system (IIMS) for reporting and collecting information about clinical incidents.

At the **statewide administrative level** Justice Health has a policy framework for the management of clinical incidents (Information Management System Policy). Clinical incident data (SAC 1, 2, 3 and 4 incidents) are grouped and trended for analysis and disseminated to all levels of management in the system. This response was supported by:

- All six **streams** reporting that there were processes for reporting incidents
- All streams received information on the outcomes of Root Cause Analysis (RCAs)
- All twenty **cluster / service** surveys indicated that there was a forum or meeting that included discussion of safety and quality issues including incidents and complaints.

Nineteen indicated that such meetings were held monthly and one responded meetings were held at least three monthly.

The **statewide administrative** level response indicated that trended data for SAC 1, 2, 3 and 4 incidents are analysed at least three monthly or less. At the **stream** level all six indicated that trended data for SAC 2, 3 and 4 incidents is reviewed and analysed.

Stream level responses

- *Usually the only SAC 2 clinical incidents that occur within the Women's Stream are self harm incidents. This has resulted in the review and modification of existing safe work practices and completion of risk assessments and management plans for patients. This is done in consultation with DCS.*

- *Review of SAC 2, 3 or 4 data is instigated by the stream director and is dependent upon the nature of the issue, the identified risks and the extent of the near miss. The review will be led by the Unit head to review the incident and provide recommendations to prevent further recurrence.*

- *Unit Heads are invited to report on their IIMs SAC 3 / 4 incidents during the Patient Safety Meeting. The whole management team participates and consideration is given to patterns and informal trends to inform necessary action.*

The **cluster/service** activity statement asked a number of questions on the frequency of various activities relating to incident management, as outlined in Figure 6.

Figure 6 Cluster/service level response to activities related to incident management

Questions relating to incident reporting & investigation – cluster/service level

1 SAC 1 and SAC 2 incidents are reported within 24 hours

2 IIMS is used to enter data on clinical incidents

3 IIMS is used to enter data on complications of care such as adverse reaction to drug therapy

4 Information regarding outcomes of death review, RCAs and analysis of incidents is fed back to staff *

5 SAC 3 & 4 incident data reports are provided to the cluster / service

* This question requires verification as it is possible the self assessment respondents answered "almost never" and "rarely" because deaths or complications rarely or almost never occur rather than indicating a lack of compliance with the policy.

The responses demonstrate compliance with activities where there is a clear policy directive, such as reporting of SAC 1 and SAC 2 incidents. Eighteen of the twenty cluster/services indicated that they receive information on SAC 3 and 4 incidents "almost always" with two responding "rarely" or "almost never". As Justice Health publishes reports on SAC incident trends there may be an issue of awareness of these reports in some cluster/services.

The results indicate that 35 % of cluster/services "almost always" feed-back information to staff regarding the outcomes of death review, RCAs and analysis of incidents. As well 50% "almost always" use IIMS to enter data on clinical incidents or complications of care. These

responses provide an opportunity to review and improve current practice around feedback and reporting around incidents.

Recommendation:

Justice Health must ensure that the findings of any review of critical incidents, for example: death review; root cause analysis; Health Care Complaints Commission/Coroner's findings is fed back to the relevant clinical teams in a prompt manner.

7.4.1 Mortality Review

The review of deaths in Justice Health is guided by the Death in Custody (DIC) policy.

All deaths that occur in custody (DICs) are subject to a Coroner's investigation, and all deaths whether expected (due to chronic conditions) or unexpected (suicide, homicide or suspected overdose) are reported to NSW Health via Reportable Incident Briefs (RIBs). They are given an initial SAC 1 rating. All unexpected deaths undergo a Root Cause Analysis (RCA) investigation. The DCS have their own internal systems for investigation of DIC; the Justice Health RCA team may consult with them in their review of an incident.

If a patient's death is expected a medical record review will be undertaken. This is usually performed by the Patient Safety Manager and a Medical Officer, and if necessary another clinician. If no clinical concerns are identified regarding healthcare provision, this is stated in the internal file review report. If concerns are identified, either a RCA or an internal investigation will be undertaken. If no concerns are identified at this stage, the SAC rating placed on the RIB is downgraded.

All deaths in custody expected or not are reported as an incident on the IIMS system.

Fifteen of the clinical **cluster/services** responded "almost always" to the question "are deaths reviewed?" One responded "sometimes" and four responded "almost never". Telephone verification confirmed that the response of "almost never" reflected that deaths did not occur in the respondent's service rather than review of actual deaths almost never occurred, for example, pharmacy and medical appointment unit.

Guided by clear procedures outlined in policy documents Justice Health has defined processes for review of all deaths in the service.

7.4.2 Open Disclosure

Relevant Policy Framework

The NSW Health policy on open disclosure (PD2007_040) aims to establish a standard, direct approach to communication with patients, families and carers after incidents involving potential injury or other harm to patients. The aims of the policy are to ensure that health services have established consistent processes in place for open disclosure including a standard approach for communication after such incidents and to ensure that this occurs in an empathetic and timely manner.

At the **statewide administrative** level, Justice Health responded that it follows the NSW Health Policy Directive for open disclosure following an adverse event. Draft Justice Health policy and guidelines on open disclosure has been developed and sent to key stakeholders for consultation. The open disclosure process is co-ordinated by the Director of Governance.

The QSA activity statements did not ask questions at the stream or cluster/service level regarding open disclosure. Future QSA surveys will address this.

7.5 Complaints Management

Relevant Policy Framework

Complaints management in Justice Health is guided by two policies - Complaints Handling (2.015) and Management of a Complaint or Concern about a Clinician (2.016).

At the **statewide administrative** level, Justice Health referred to the presence of two policies (2.015; 2.016) which outline the process for clinicians and managers to respond effectively to clinical and corporate complaints. The complaints data is analysed and reported to the senior executive and reviewed at least monthly.

Statewide administrative response
Quantitative data such as number of complaints, categories, outcomes and trends are reviewed. Justice Health currently meets and exceeds the NSW Health benchmark for complaints management.

All **streams** were able to describe a process for the management of complaints in relation to receipt and response to the complaint, and the review of this information in a systematic way.

Population health
Complaints regarding Population Health are received from patient liaison officer. They are investigated and responded to by Service Director Population Health and reported via IIMS report at the monthly Patient Safety meeting.

Primary health
Complaints are routinely reviewed by the unit head a function that is integral to their role. They are invited to disseminate their findings in their reports to the Population Health stream meeting, where there is relevance or opportunity for shared learning with other colleagues.

Drug & Alcohol
Complaints received by the stream are investigated and provided with a response. Complaints can by received from the clinic /Justice Health patient representative and Ministers Office.

Mental health
All complaints are investigated by the Governance Unit. All complaints are logged on the IIMS database and are reported and reviewed monthly in clinical stream meetings.

Adolescent health
All complaints are logged on the IIMS system, the unit manager is notified via an email that an incident has been reported and is then required to check the incident within 24 hours. Formal review of the complaints occurs at the monthly patient safety meetings as with all other patient safety incidents.

Women's health
Complaints are addressed as a cluster at the monthly Women's Health management meetings as each NUM presents a site report to the meeting and complaints are included in this report.

Justice Health has a wide variety of information available to inform consumers about how to make a complaint about their healthcare including:

- Brochure
- Information given as part of the reception process
- Inmate Development Committees - these committees provide a forum to discuss and resolve local issues relating to the treatment and care of inmates
- Client liaison officer and
- 1800 Helpline.

The QSA survey responses by the statewide administrative and stream levels indicate that there are good systems in place both to receive and respond to complaints. Questions regarding complaint management were not asked at the cluster / service level. This will be addressed in future QSA self assessments.

7.5.1 Complaints against Clinicians

Relevant Policy Framework

NSW Health guideline (GL2006_002) sets out an operational framework for dealing with a complaint or concern about an individual clinician and the policy PD2006_007 describes the mandatory principles for action in managing these complaints, including the legislative responsibility and the roles and responsibilities of the Public Heath Organisations.

At the **statewide administrative** level a series of questions was asked regarding the management of complaints or concerns about a clinician. The response indicated that Justice Health has a policy around the issue of complaints about a clinician and information regarding those complaints is received. This could include:

- Information on the number of complaints against a clinician
- Complaints that lead to disciplinary action
- Complaints involving industrial associations.

Information regarding complaints against a clinician is held in confidence by the Workforce Director.

7.6 Review Activities

Relevant Policy Framework

Clinical audit is a quality improvement process which seeks to improve patient care and outcomes. It does this by systematic review of care against explicit criteria and the implementation of any changes to care delivery that may be required. There is no prescribed statewide policy or guideline for undertaking clinical audit.

7.6.1 Clinical Audit

At the **statewide administrative** level Justice Health indicated there was a formal process for conducting internal audits. The conduct of clinical audits system wide appeared to be occurring on an ad hoc basis. The response indicated an intention to develop a framework for integrating clinical audit processes into the broader audit activities of the service.

Four **streams** indicated that clinical audit occurred while two indicated that it occurred only in some sites. All streams were able to describe how clinical audit information is used to improve the safety and quality of patient care.

Population health
Following the audit, improvements in patient safety and quality of care are assessed through evidence of implementation of recommendations (either from previous audit or RCAs) and follow-up audit.

Primary health
Clinical audit is used to identify patterns and trends in practice, together with any individual areas that have specific strengths or are apparent outliers. Results and feedback are used for focussed intervention, education programs at individual sites, priorities for practice improvement or revisions to policies and procedures as a whole. The results of audits are examined to identify the potential shortcoming and necessary resource, establish reasonable targets and to increase performance/compliance.

Drug and alcohol
To improve practice and develop systems to support the changes.

Mental health
Data collected is analysed by team members and where possible trended. From this analysis, priorities are identified and actions agreed and implemented. The outcomes are then measured using the baseline data collected.

Adolescent health
In the event that the audit identifies areas that need to improve, a management plan is developed and reported on as required to the Adolescent Health Clinical Governance meeting.

Women's health
Issues identified are reported back through the cluster to the nurse unit managers and then to the clinical staff at the local staff meetings thus impacting directly in improving patient care.

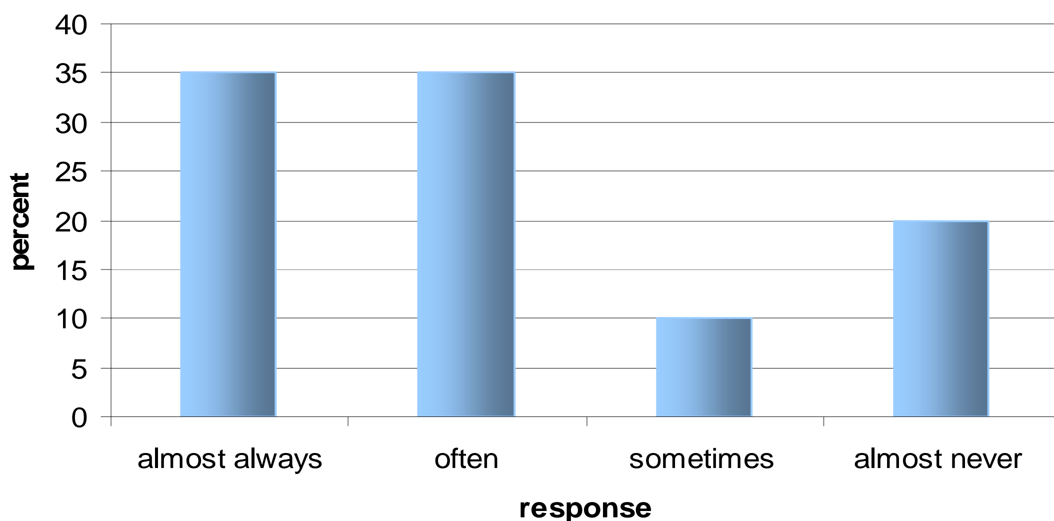
The **stream** self-assessment asked respondents to provide details of the clinical audit process and how it is used to improve patient care. Some stream level responses are shown below.

> *The scope and dimensions of the audit (and sampling technique) are defined in collaboration with the Service Director, together with consideration of the administrative requirement for undertaking the activity. Key Performance targets are usually defined by both practitioners in the area, in collaboration with the Unit Head and the Service Director; with an expectation of performance improvement or milestones over time.*
>
> *An agreed timeframe is established and arrangements made for the review of the findings, which may include dissemination of the data to other stakeholders outside of the stream. Additional expertise, guidance and assistance may well be called upon from the Governance unit if required. The findings are generally reviewed by a number of professional groups within the stream.*
>
> *Recommendations and proposals for development are then prepared for wider endorsement if required. Dissemination is considered together with any consideration for replication at a later date or used to evaluate implementation of change.*

The detail presented in the responses relating to the clinical audit processes reflects an effective clinical audit program across all streams.

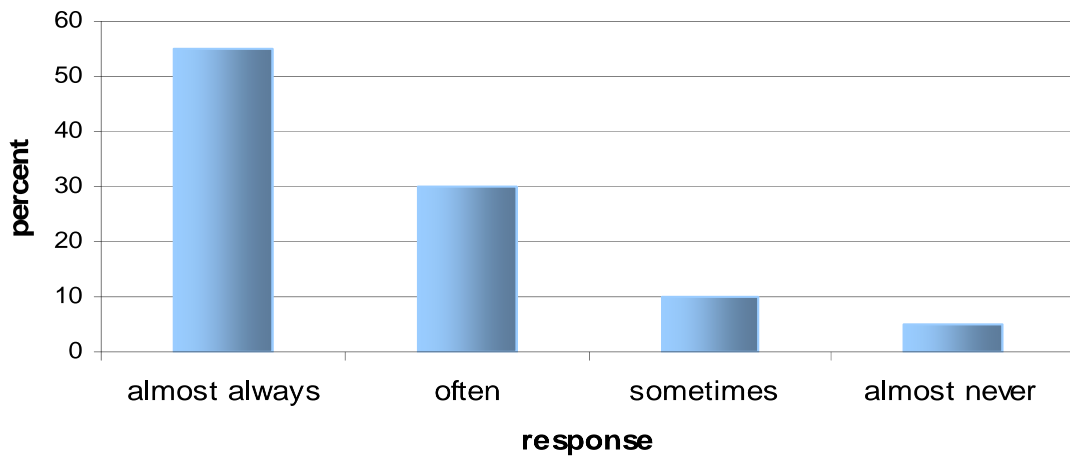
At the **cluster / service** level the question “Periodic audits of clinical practice of high risk processes and procedures occur” (Figure 7).

Figure 7 Cluster/service response to question: “Do periodic audits of clinical practice for high risk processes and procedures occur?



The results demonstrate that fourteen (70%) out of the twenty respondents undertake periodic audits almost always or often.

Figure 8 Cluster/service response to question: “Does feedback to staff of clinical audit results occur?”



In response to the question regarding the frequency of feedback from results of clinical audits the results show that 85% of staff almost always or often receives results of clinical audit (Figure 8).

Recommendation:

Working in partnership with NSW Health, Justice Health must establish ‘best practice’ models for staff to undertake clinical audit, patient health care record review, peer review or other quality review activities.

7.6.2 Medical Record Review

Relevant Policy Framework

The Clinician's Toolkit (NSW Health, 2001) describes the process of retrospective chart review which is a continuous medical record review involving the use of selected outcome criteria for screening purposes. It is followed by peer review to determine whether an adverse event occurred and the possibility of this event being prevented. The conduct of regular reviews of medical records is one of the standards set by the NSW Patient Safety and Clinical Quality Program that is not governed by a specific system-wide policy.

The QSA survey defined patient health care record review as ***"..a continuous process which involves the use of selected outcome criteria for screening purposes followed by some form of peer review to determine whether an adverse event occurred. This does not include review of a medical record as part of an incident investigation".***

Justice Health indicated in the **statewide administrative** survey that they do have a policy framework for medical record review but there is no formal medical record review program within the system. Information around the findings of medical record review is only sometimes received at the statewide administrative level. The type of information received includes:

- Ad hoc medical record reports
- Results of routine audits completed by clinical streams
- Results of compliance audits specifically related to projects.

Findings of activities around medical record review are almost never reported to the quality council.

At the **cluster/service** level, twelve indicated that medical record review was used as a source of information for identification of clinical indicators.

Recommendation as per 7.6.1:

Working in partnership with NSW Health, Justice Health must establish 'best practice' models for staff to undertake clinical audit, patient health care record review, peer review or other quality review activities.

7.6.3 Peer Review

The QSA survey defined peer review as ***"…the evaluation of work or performance by other people in the same field in order to maintain or enhance the quality of the work or performance in that field."***

At the **statewide administrative level** Justice Health indicated that there was no policy framework for peer review.

Two **streams** indicated that peer review occurs across the stream and three indicated that peer review occurs only in some sites.

> *The peer review process ensures that clinicians are not operating as sole practitioners and making decisions in isolation. It also ensures that treatment is evidence based, and where evidence is not available, the most appropriate options are reached by consensus.*

One stream responded that peer review did not occur however they were still able to define how issues of concern are identified and managed.

> *There is no current formal mechanism or procedure within the stream for peer review. Routine performance management of clinicians remains an intrinsic weakness that is being addressed. Most issues are identified as a clinical concern and appropriate action is determined in partnership with a number of stakeholders and key managers, reflecting the identified issues or key risks.*

A variety of processes were described in response to the question on how peer review was used to improve the safety and quality of patient care, including the process for individual staff competency appraisal such as medication administration.

Recommendation as per 7.6.1:

Working in partnership with NSW Health, Justice Health must establish 'best practice' models for staff to undertake clinical audit, patient health care record review, peer review or other quality review activities.

7.6.4 New Interventional Procedures

The QSA survey defined an interventional procedure as ***"An interventional procedure is a procedure used for diagnosis or treatment involving an invasive contact with the patient".***

At the **statewide administrative** level, Justice Health indicated that there was a policy for the introduction of new interventional procedures and drug therapies (Safe Introduction of New Interventional Procedures into Clinical Practice (5.123)). This policy defines a process for gaining formal approval before a new interventional procedure is introduced and the follow up required to monitor outcomes.

The introduction of new drug therapy is monitored by the Medical and Dental Appointment Advisory Committee (MADAAC). A risk assessment is completed before all new interventional procedures or drug therapies are introduced. In response to the question "was information on new procedures received at the organisation level?" the response was "rarely". This response, when qualified, reflects that very few new interventions are introduced into Justice Health.

A series of questions were asked at **stream** level regarding the introduction of new procedures/drug therapy. The responses are outlined in Table 5.

Table 5 Stream level response - Process for introduction of new procedures / drugs (n=6)

Question	Almost always	Often	Sometimes	Rarely	Almost never
A risk assessment completed before a new interventional procedure is introduced	2	1			3
How often is a credentialing process used for clinicians who will be performing the new interventional procedure	5				1
When training/new skills are required does the stream require evidence of training be provided for credentialing	5				1
How often does the stream review outcomes subsequent to the introduction of new interventional procedure	4				2
A risk assessment completed before a new drug therapy introduced	4	1			1

There is concordance between the stream and the statewide administrative level in relation to the introduction of new procedures. An example of a response is as follows:

Drug and Alcohol stream

Current definition of new interventional procedure does not apply to the interventions drug & alcohol provides, as we primarily provide pharmacotherapies. For these, medical officers are accredited and authorised. They are credentialed and given specific clinical privileges to deliver these interventions. This stream never introduces a new procedure/intervention unless it has been trialled in the community first, and is evidence based.

Credentialing of prescribers and addition to the formulary was monitored by the Drugs and Therapeutic Committee.

Response from stream level
Following the endorsement of a statewide formulary by Justice Health a risk assessment of any new therapy will be undertaken. When the therapy is not accepted in the formulary, a procedure is available to allow clinicians to prescribe. Prior to dispensing the approval of a clinical director is sought; clearly identifying both the potential risks to patient, alternatives and the impact on health outcome of not prescribing the requested therapy. Any new therapy is peer reviewed prior to inclusion in the formulary, with the appropriate recommendation/endorsement of the pharmacist.

7.6.5 Infection Control

Relevant Policy Framework

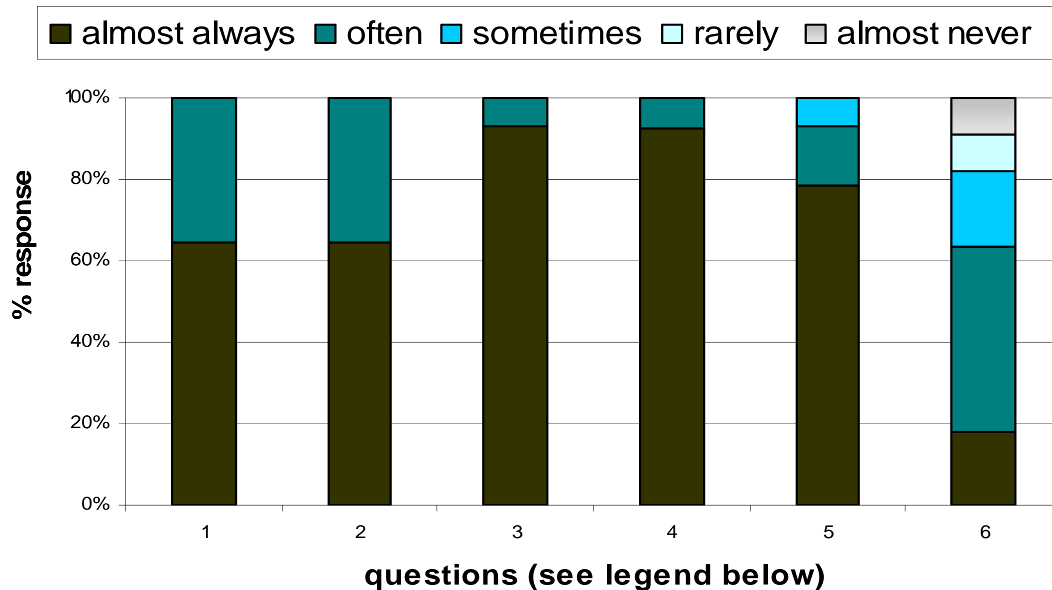
There is a system-wide policy regarding infection control (PD2005_247) outlining the broad principles of infection control within which all NSW health organisations can develop detailed operational guidelines appropriate to their own health care settings.

At the **statewide administrative** level the response indicated that there is a policy for infection control. The following indicators are monitored across the service:

- Healthcare acquired infections
- Needle stick injuries
- Sterilisation data
- Vaccination storage audits and incidents.

The **cluster/service** level was asked a number of questions relating to infection control. The responses are shown in Figure 9. All activities, with the exception of the observational studies of hand washing, are required practice, in line with NSW Health infection control policy.

Figure 9 Cluster/service level response on activities associated with infection control



Questions relating to infection control – cluster / service level

1 Hand washing occurs between patients
2 Hand washing occurs before and after touching blood or other contaminants even if gloves used
3 Gloves are worn during procedures/patient contact where activities are likely to generate splashes or sprays, performing invasive procedures / venipuncture or finger stick
4 Gloves are changed between each patient
5 Fluid resistant gowns are worn during procedures/patient contact
6 Observational studies of hand washing within clinical areas occur every month

The results indicate a moderately high level of compliance with the infection control policy. Justice Health was involved in the Clean Hands Save Lives Campaign where increasing the availability of alcohol-based hand rub near each patient location was one of the main focuses of the campaign. Because DCS does not allowing any form of alcohol-based products in a jail, Justice Health concentrated its efforts on the review of hand washing processes. The results show that all cluster/services responded almost always or often to hand washing between patients and after touching contaminants. Observational studies are not performed routinely and this is an area for improvement.

Six of the cluster/services responded “not applicable” to each of the six questions on infection control activities. Telephone verification with respondents during the assessment period resulted in a “not applicable” response being created for these questions. Services which included: pharmacy; connections project and the medical appointment unit have no direct patient contact, or their role is administrative in nature.

Recommendation:

Justice Health must continue to adapt current NSW health policies on infection control that meet the specific needs and challenges of Justice Health. Observation studies of compliance with hand washing protocols should be performed with outcomes reviewed by the quality committee.

7.6.6 Correct Patient/Site/Procedure

Relevant Policy Framework

NSW Health policy (PD2007_079) aims to prevent incorrect patient, incorrect procedure and incorrect site incidents. It does so by describing the steps that must be taken to ensure that an intended invasive or diagnostic procedure is performed on the correct patient, at the correct site, and, if applicable, the correct implants/prostheses and equipment.

Justice Health policy (1.096 Correct Patient, Correct Site & Correct Procedure

The **statewide administrative** level response indicated that there is a policy framework for correct patient/site/procedure. Activities associated with verifying the policy include:

- Undertaking observational studies and audits and
- Reviewing documentation and incidents.

At the **cluster/service** level a series of questions was asked about activities related to patient identification and correct site/procedure systems (Table 6).

Table 6 Cluster/service level - questions relating to correct patient/site/procedure

1	Valid, documented consent, for significant procedures or those involving significant risk
2	Left and right is written out in full, in documented consent
3	Operative sites are marked, while the patient is awake (where appropriate)
4	The patient participates in operative site marking (where appropriate)
5	Participating clinicians independently verify patient, procedure and site
6	"Time out" occurs prior to commencing procedure & patient identity/site/procedure are confirmed

The results obtained in response to these questions were unable to demonstrate any clear indication of the degree of implementation of the policy due to the large number of "not applicable" responses. Thirteen of the twenty cluster/services responded N/A to all questions related to the correct patient/site/procedure policy. Some of these included:

- Police cells
- Pharmacy
- Connections project
- Community mental health service
- Medical appointments unit
- Mental health
- Metropolitan Remand and Reception Centre
- Long Bay Health Centres.

It was determined that these questions, in this context, were irrelevant to the services above. The issue of patient identification, however is relevant to all Justice Health services, medication management, is an example. Future QSA surveys will address the general issue of patient identification.

8 Qualitative analysis of nominated highest risks to patient safety

As part of the self-assessment, the stream and cluster/service levels were asked to nominate what they considered were the three main risks to patient safety. This question was not asked at the statewide administrative level. A content analysis was undertaken by the QSA project team to identify patterns and common themes.

The risks identified by the six **streams** can be grouped into three common themes. These are:

- Access to patients for assessment and treatment commencement; monitoring of condition
- Medication management
- Adequacy / quality of service provision due to:
  - Access to services from external providers e.g. ultrasound / AHS clinics
  - Skill mix / experience of staff to manage patient numbers as well as plan and implement improvement.

At the **cluster/service** level four main themes were identified which related to:

- Lack of access to patients, leading to delay and missed treatments
- Medication errors
- Patient factors e.g. self harm, substance abuse, non-compliance with treatment
- Continuity of services.

Expectation of CEC:

Justice Health should review the identified risks to patient safety. It should focus improvement activities on those risks that pose the greatest harm to patients, either because of the frequency of occurrence or the level of harm caused.

Two themes relating to risk to patient safety and quality of care were identified in both the stream and cluster/service level responses. These related to access to patients and to the continuity of services. These issues are described in more detail below with specific CEC recommendations.

Risks identified by both the stream and cluster/service levels

Access to patients

There is consensus across Justice Health that the issue of timely patient access to services presents a major risk. The provision of routine and regular access to patients is constrained by the hours during which the DCS permits them to attend Justice Health clinics. There are also frequent situations where access may be prevented altogether, as a result of DCS staff

shortages, training days and correctional centre lockdowns. Analysis of incidents (e.g. RCAs) has shown lack of time with patient's leads to medication errors.

Recommendation:

That Justice Health must work with the Department of Corrective Services and Department of Juvenile Justice to ensure that procedures are in place to allow Justice Health staff timely and reliable access to patients for the provision of effective healthcare interventions.

Continuity of services

The stream and cluster/service levels both identified a key vulnerability around patient movement. This risk is manifested by lack of continuity of care and loss of follow-up of patients.

Tracking of patients through the system when prisoner movement is controlled by the DCS compounds the risk. The unpredictable nature of these movements and the delay in communicating with Justice Health staff can lead to patients not being completely assessed and managed within appropriate timeframes. Justice Health is considering the development of an electronic medical record. The CEC strongly supports this undertaking.

Recommendation:

Justice Health must develop and implement improved systems for the transfer of clinical information when there is a transfer of care between correctional facilities.

9 Next Steps

The QSA will be undertaken yearly. The 2008/09 QSA survey of Justice Health will take place in the second half of 2009. The 2008/09 survey will be more targeted, focusing on areas where improvement is indicated, based on these baseline survey findings. The questions posed within the activity statements will vary from year to year, as system are improved and standards are embedded. The 2008 survey will be developed following analysis and review of the 2007 data and discussion with NSW Health Quality and Safety Branch, Justice Health Governance Unit and the QSA advisory committee.

Verification

Following the QSA self-assessment, verification activities will be undertaken. The purpose of is to determine accuracy of responses and add further depth to the information provided in the activity statements. The information collected will be used to inform subsequent assessments. Verification activities can be divided into two groups:

First – activities that verify all responses through correlation of assessment responses and analysis of evidence provided in the activity statements.

Second – an onsite review of the levels assessed in Justice Health. The onsite visits will occur to a sample across the state. It is planned that the verification activities will occur over a 2 - 3 day timeframe with the focus limited to specific key issues identified in the QSA. Improvement plans developed in response to the recommendations will also be reviewed. The stream or cluster / stream chosen for the visit will receive adequate notice regarding the timing of the visit and requirements of the reviewers.

Recommendation:

The CEC needs to develop a targeted assessment for the 2008/09 QSA based on the issues identified from this report.

10 Bibliography

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Appendix 1

Relevant Justice Health Policies

QSA Domain	Policy No.	Policy Name
Governance	2.010 3.020 2.020 2.140 3.132	Code of Conduct Conduct and Discipline Corruption Prevention and Fraud Control Protected Disclosure Performance Management
Risk Management	2.155 5.070 2.135	Risk Management Framework Infection Control Policy development and Review
Incident Management	1.120 2.030	Death in Custody Incident Reporting and Management and Incident Reporting and Management Handbook
Complaints Management	2.015 2.016	Complaints Handling Management of a Complaint about a Clinician
Review Activities	1.096 2.137 5.123	Correct Patient, Correct Site & Correct Procedure Practice Improvement Projects Safe Introduction of New Interventional Procedures into Clinical Practice

Glossary of Terms

ACHS	Australian Council on Healthcare Standards
AHS	Area Health Service
ARMC	Audit and Risk Management Committee
CE	Chief Executive
CEC	Clinical Excellence Commission
CGU	Clinical Governance Unit
CMO	Career Medical Officer
CPI	Clinical Practice Improvement
DCS	Department of Corrective Services
DG	Director General
DJJ	Department of Juvenile Justice
ED	Emergency Department
GU	Governance Unit
IIMS	Incident Information Management System
IT	Information Technology
KPI	Key Performance Indicator
KPMG	KPMG Risk Advisory Services
MADAAC	Medical and Dental Appointments Advisory Committee
MH-OAT	Mental Health Outcome & Assessment Tools
MAGIC	Mothers and Gestation in Custody
MRSA	Multi Resistant Staphylococcus Aureus
NM	Nurse Manager
NSW DOH	New South Wales Department of Health
NSW QSB	New South Wales Quality and Safety Branch
NUM	Nursing Unit Manager
PAS	Patient Administration System
PHO	Public Health Organisation
PIPs	Practice Improvement Projects
PSCQP	Patient Safety and Clinical Quality Program
QC	Quality Council
QSA	Quality Systems Assessment
RCA	Root Cause Analysis
RIB	Reportable Incident Brief
SAC	Severity Assessment Code (1- 4)
VMO	Visiting Medical Officer

Acknowledgements

Report Editors

Ms Bernie Harrison
Ms Bernadette King
Mr Mike Peterson

QSA Report and Data Analysis Project Team

Ms Bernie Harrison
Ms Bernadette King
Mr Richard Gilbert
Dr Paul Tridgell

Members of the QSA Development Team (March 2006 – June 2007)

A/Prof Kathy Baker	Member, CEC Board
Prof Bruce Barraclough	Chairman, CEC Board
Dr George Bearham	Deputy CEO, CEC (to December 2006)
Dr Maree Bellamy	Independent Consultant (to June 2006)
Mr Matthew Daly	Director, Clinical Operations, SESIAHS
Ms Liz Forsyth	KPMG
Ms Bernie Harrison	Director Organisational Development & Education / Quality Systems Assessment, CEC
Ms Kate Hawkins	KPMG
Prof Cliff Hughes	CEO Clinical Excellence Commission
Dr Peter Kennedy	Deputy CEO, CEC (from December 2006)
Ms Louise Kershaw	KPMG
Dr Charles Pain	Director Clinical Governance SWAHS
Ms Sue-Anne Redmond	Director Clinical Governance, GWAHS
Ms Barbara Rodham	A/Director, Quality and Safety Branch, NSW Health (from March 2007)
Dr Michael Smith	Director, Quality and Safety Branch, NSW Health (to March 2007)
Dr Paul Tridgell	Australian Council for Safety and Quality in Health

Members of the QSA Advisory Committee (July 2008 – present)

Mr Kelvin Genn	Director, Quality and Safety Branch NSW DOH
Prof Philip Harris	CEC Board Member
Ms Bernie Harrison	Director Organisational Development & Education / Quality Systems Assessment, CEC
Prof Cliff Hughes	CEO Clinical Excellence Commission
Dr Peter Kennedy	Deputy CEO, CEC (from December 2006)
Dr Bill Lancashire	Member, CEC Clinical Council
Mr Joe McGirr	Director Clinical Operations, GSAHS
A/Prof Debra Thoms	Chief Nursing & Midwifery Officer NSW
Dr Paul Tridgell	Consultant

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QSA
QUALITY SYSTEMS ASSESSMENT

If you would like further information about the QSA, please contact:

Ms Bernie Harrison
Director, Organisation Development and Education
Quality Systems Assessment
Bernie.harrison@cec.health.nsw.gov.au
(02) 9382 7614

Ms Bernadette King
Program Leader, Quality Systems Assessment (QSA)
qsa@cec.health.nsw.gov.au
(02) 9382 7829

Or visit the CEC website
www.cec.health.nsw.gov.au

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