PERFORMANCE AUDIT 9 DECEMBER 2020

Managing the health, safety and wellbeing of nurses and junior doctors in high demand hospital environments

NEW SOUTH WALES AUDITOR-GENERAL'S REPORT

audit office
OF NEW SOUTH WALES

THE ROLE OF THE AUDITOR-GENERAL

The roles and responsibilities of the Auditor-General, and hence the Audit Office, are set out in the *Public Finance and Audit Act 1983* and the *Local Government Act 1993.*

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Financial audits are designed to add credibility to financial statements, enhancing their value to end-users. Also, the existence of such audits provides a constant stimulus to entities to ensure sound financial management.

Following a financial audit the Audit Office issues a variety of reports to entities and reports periodically to parliament. In combination these reports give opinions on the truth and fairness of financial statements, and comment on entity compliance with certain laws, regulations and government directives. They may comment on financial prudence, probity and waste, and recommend operational improvements.

We also conduct performance audits. These examine whether an entity is carrying out its activities effectively and doing so economically and efficiently and in compliance with relevant laws. Audits may cover all or parts of an entity's operations, or consider particular issues across a number of entities.

As well as financial and performance audits, the Auditor-General carries out special reviews and compliance engagements.

Performance audits are reported separately, with all other audits included in one of the regular volumes of the Auditor-General's Reports to Parliament – Financial Audits.

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In accordance with section *38E of the Public Finance and Audit Act 1983,* I present a report titled **'Managing the health, safety and wellbeing of nurses and junior doctors in high demand hospital environments'.**

Margaret Crawford
Auditor-General
9 December 2020

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Section one

Managing the health, safety and wellbeing of nurses and junior doctors in high demand hospital environments

Executive summary

Over the past decade, there have been increases in the numbers of health and safety incidents affecting nurses and junior doctors in NSW hospitals. These increases have been associated with higher numbers of patients with acute mental health conditions, age-related cognitive impairments, and patients presenting in emergency departments under the influence of drugs and alcohol.

This audit commenced in August 2019, with a focus on the health, safety and wellbeing of nurses and junior doctors in high demand hospital wards. Our audit focused on emergency departments, mental health wards and aged care wards during 'business as usual' periods of hospital operations.

In the early months of 2020, the novel coronavirus (COVID-19) brough new health and safety risks to hospital staff. These risks included the potential for infection amongst health workers, increased staff workloads, and impacts on staff wellbeing.

In May 2020, we expanded the focus of the audit to assess the effectiveness of NSW Health's management of the health and safety risks to staff during the COVID-19 health emergency. We assessed the impacts on emergency departments and intensive care units, as these were the wards where staff were most likely to come into contact with COVID-19.

The Audit Office acknowledges the ongoing health and safety challenges that the pandemic has brought to NSW Health staff – in particular to hospital clinicians and the managers who support them.

This audit assessed the effectiveness of NSW Health's:

- systems, forums and workplace cultures to support reporting and generate data about risk
- initiatives to support safe workplaces and effectively respond to health and safety incidents
- actions to continuously improve staff health, safety and wellbeing in hospital environments.

The first three chapters of this report describe the effectiveness of NSW Health's 'business as usual' health and safety risk management. The fourth and fifth chapters describe the effectiveness of NSW Health's health and safety risk management during the COVID-19 pandemic.

Conclusion

NSW Health's management of health and safety risks in NSW hospitals

NSW Health is effectively monitoring and managing most incidents and risks to the physical health and safety of nurses and junior doctors in NSW hospitals. However, systems and resources are not fully effective across all Local Health Districts for monitoring or managing psychological and wellbeing risks - particularly in relation to nurses.

NSW Health's incident management system is effective for recording health and safety incidents in hospital wards where incidents occur infrequently, and staff have time to log incident details during shift hours. However, in high demand wards where incidents and risks are common, staff report that they are unable to log all incidents due to the frequency of events, and the time it takes to record incidents in the system.

NSW Health is taking reasonable steps to manage and respond to physical health and safety incidents in NSW hospitals, but psychological and wellbeing risks and incidents are not routinely recorded or escalated to managers. Stress debriefing is not consistently available to staff after difficult or traumatic workplace incidents.

The Ministry of Health could improve its information sharing and data reporting on state-wide health and safety risks in NSW hospitals, and communicate risk trends to the wider NSW health system. This would assist managers to identify common health and safety issues, and target their responses. The Ministry has not set up systems or strategies to identify or support the expansion of successful health and safety initiatives across the NSW health system.

NSW Health's management of health and safety risks associated with COVID-19

To date, NSW Health has effectively managed most COVID-19 related health and safety risks to hospital staff. The overall effectiveness of NSW Health's preparations and responses to COVID-19 could have been improved in the early phases of the health emergency - from January to early April 2020 - by ensuring that hospital staff in all Local Health Districts had access to pandemic training, that all emergency response policies had been updated and circulated, that state-wide communication systems were able to be rapidly upscaled to deliver consistent messages to hospital staff across the health system, and that PPE supply lines could provide sufficient stock to meet requirements during all pandemic response phases.

Local Health District executives and hospital managers effectively guided and supported nurses and junior doctors to manage and minimise most COVID-19 health and safety risks in hospital environments. However, communication with frontline staff could have been improved in the early stages of the pandemic. The Ministry did not set up a centralised communication channel to communicate consistent messages and advice to hospital clinicians until April 2020. This finding is consistent with a finding from the 2009 review into NSW Health's response to the H1N1 influenza outbreak. Clinical staff advised that the lack of a centralised communication channel, substantially increased their workloads as they checked numerous sources for the latest and most authoritative advice.

Prior to COVID-19, pandemic response training was limited across the NSW Health system. Nurse managers of emergency departments and intensive care units reported that there was limited training or familiarisation with the NSW Pandemic Plan. Key policies describing infection control principles for emergency departments and intensive care units were outdated and had not been revised within required timelines.

NSW Health's planning and preparation for the supply and management of personal protective equipment (PPE) has been partially effective, with PPE available to hospital staff at all times. However, at various intervals, some PPE could not be sourced from established suppliers. Face masks, goggles and protective gowns were substituted with products that differed in shape, size and fitting, from the usual PPE stock. Staff reported that in the early stages of the pandemic, substituted masks were not locally fit tested by hospital staff in some emergency departments.

1. Audit recommendations

By December 2021, NSW Health should:

1. Evaluate the effectiveness of the new incident management system to enable full reporting of health and safety incidents and risks in all hospital wards, including those where incidents and risks are common, and monitor for consistency of reporting over time
2. Expand the categories of hospital incident data reported to Ministry executives in the Work Health and Safety Dashboard reports, including by linking injury data to incident types by hospital ward category, and monitor in conjunction with Local Health Districts for emerging trends and improvement over time
3. Ensure that nurses and junior doctors have regular opportunities to report on risks to their psychological health and wellbeing, and that system managers have access to aggregate data to guide responses to mitigate these risks
4. Develop and implement an evidence-based guiding framework and strategy to support hospital staff in the aftermath of traumatic or unexpected workplace incidents, and monitor implementation
5. At regular intervals, publicly report aggregate Root Cause Analysis data detailing the hospital system factors that contribute to clinical incidents
6. Develop and implement a systemwide platform for sharing research and information about hospital health and safety initiatives across the health system
7. Conduct a post-pandemic 'lessons learned' review focusing on the effectiveness of key strategies deployed in the management of the COVID-19 pandemic and make policy and operational recommendations for future pandemic responses. In particular, ensure:
    - regular scenario-based pandemic training for hospital staff
    - updated policies and protocols for hospital infection controls
    - capability to upscale authoritative communication with frontline health workers at the earliest notification of a health emergency and for the duration of the emergency
    - systems and safeguards to ensure the supply and availability of clinically appropriate personal protective equipment (PPE) during all phases of a pandemic.

1. Health and safety in NSW hospitals – risks and responsibilities

1.1 Hospital health and safety risks

The health and safety risks to nurses and junior doctors in NSW hospitals are generally categorised into physical incidents and risks, and psychological incidents and risks.

Of the physical injury types, body strains are the most common injuries for which nurses and junior doctors make worker's compensation claims through iCare. These injuries can be caused by excessive weight-bearing activities, repetitive actions, or from making sudden movements to support patients. Other types of common physical injuries include slips, trips and falls or body contact with equipment or moving objects. Physical injuries can sometimes be caused by the unintentional or impulsive actions of patients suffering from delirium or cognitive impairment. In rare instances, hospital staff have been assaulted and injured by intentional acts of patients or visitors.

Hospital staff can be exposed to psychological health and safety risks caused by exposure to trauma or prolonged periods of fatigue and stress, especially in high demand hospital environments. Hospital staff are also at risk of psychological injury as a result of verbal aggression by hospital patients, visitors or other hospital staff.

Ministry of Health data reveal that in 2018 there were 4,370 physical incidents involving hospital health staff across the 15 NSW Local Health Districts and the Sydney Children's Hospitals Network. This is an increase on 2017 when 3,859 incidents were recorded. As a proportion, the rates of physical incidents increased in 2018 to 3.4 per cent of hospital headcount as compared with three per cent of headcount for each of the previous three years. Incident data is not available for the second half of 2019 or for 2020, due to the re-deployment of Ministry staff to other data roles associated with COVID-19. The Ministry of Health's definition of physical incident is: 'where a person uses physical force or a weapon/implement that makes contact with the body of another person without their consent'.

According to the most current health and safety incident data, the main locations for hospital incidents are mental health wards (39.5 per cent), followed by emergency departments (nine per cent) and aged care wards (4.5 per cent).

Data also indicate that hospital health and safety incidents disproportionately impact on nurses. Nurses constitute around 40 per cent of the total hospital workforce and were impacted by 85.5 per cent of hospital health and safety incidents during the first half of 2019. Junior doctors make up seven per cent of the hospital workforce and combined with all other doctors and specialists, were involved in 1.5 per cent of incidents. The remainder of incidents involved security personnel and non-medical hospital staff.

Approximately 50,000 nurses and 8000 junior doctors are employed in public hospitals across New South Wales. Nurses and junior doctors join a range of other hospital staff that include senior doctors and specialists, diagnostic staff, allied health staff, clerical staff, domestic staff and other personal care staff.

1.2 Roles and responsibilities of system managers

NSW Health Agencies have obligations to take all reasonable steps to protect their workers (employed, agency and contractor) from health and safety risks and support them in the aftermath of workplace incidents. *NSW Health's Work Health and Safety: Better Practice Procedures* requires managers to 'identify any foreseeable hazards' and 'eliminate' or 'minimise the risk'.

Responsibility for monitoring and implementing risk reduction measures is shared across different tiers of the health system.

The Ministry of Health (Ministry) is the overall system manager with responsibility to guide the wider health system to understand and respond to risks. The Ministry establishes state-wide policy, develops systems for reporting risks, coordinates expert advice about workforce risk management, and evaluates health and safety practices and initiatives.

The Ministry is supported by Health Pillar organisations (Health Pillars) that are required to gather and monitor trend data about health and safety incidents, assess system-wide risks, and inform, train and assist the health workforce to manage these risks. Health Pillars are independent, board-governed statutory authorities. Those with specific health and safety responsibilities include the:

- Agency for Clinical Innovation
- Bureau of Health Information
- Clinical Excellence Commission
- Health Education and Training Institute NSW (HETI).

At the Local Health District level, the 15 Districts and the Sydney Children's Hospitals Network are responsible for monitoring health and safety incidents across their District, and providing support and resources to staff in the aftermath of incidents. Districts are responsible for supporting staff to recover in the workplace.

Local Health Districts develop preventative and reactive risk management strategies and initiatives for staff in their hospital services. They coordinate and provide resources to support staff wellbeing, such as exercise or meditation programs, and they develop initiatives aimed at preventing health and safety injuries.

Local Health Districts have obligations to ensure that hospitals are safe physical environments and they must take steps to mitigate all workplace risks, including the provision of appropriate safety equipment. Districts develop risk mitigation plans and dedicate funding and resources to address these risks.

While there is some high-level consistency in initiatives across Districts, local managers have discretion to tailor resources and programs to meet the needs of their services.

1.3 Systems for recording and reporting incidents and risks

NSW Health's systems for monitoring and reporting the health, safety and wellbeing of nurses and junior doctors in NSW hospitals include:

- hospital incident data from the Incident Information Management System (IIMS and IMS+) with records of incidents by type, ward, victim and instigator
- iCare compensation claims data about workplace injuries
- *Root Cause Analysis* investigations into hospital critical incidents where a health and safety factor resulted in a clinician error that contributed to patient deterioration or death
- staff surveys including the *People Matter Employee Survey*; the *JMO Your Training and Wellbeing Matters Survey*; and Pulse Surveys
- SafeWork NSW assessments and notifiable incidents data
- 2-yearly audits on the effectiveness of hospital health and safety management systems and reports of non-conformance.

The Ministry generates six-monthly reports about health and safety incidents and risks in NSW hospitals from data received from Local Health Districts and Specialty Health Networks. Health and Safety Dashboard reports provide Ministry executives with high-level summary data about incidents and hazards under various categories of hospital risk. The stated aim of the Dashboard reports is to inform responsible officers of 'business operations and its risks and hazards' as per the requirements of the *NSW Work Health and Safety Act 2011*.

Risk data is generated as a way of 'ensuring the provision of appropriate resources / processes to address or mitigate those risks, refining measures and controls through improvement cycles and responding to exceptions or anomalies'. Ministry executives review data about notifiable incidents to SafeWork NSW and data about physical incidents in hospital wards across the NSW hospital system.

Local Health Districts participate in monthly or quarterly health and safety meetings as a minimum. Some Districts have daily health and safety briefings. Local Health District executives receive detailed reports about health and safety incidents in their services.

2. Audit findings: Effectiveness of health and safety systems and support

2.1 Collecting accurate data and monitoring risk

NSW's hospital incident management system captures most hospital incidents but does not have the required capability for rapid recording of multiple risks in wards where incidents are common

NSW hospital staff are required to record all health and safety incidents and workplace hazards in an information management system known as IIMS or IMS+. NSW Health's incident management policy requires that staff record a minimum, mandatory dataset for each incident. The policy requires 'prompt' reporting, meaning that incidents should be recorded 'as soon as is practicable', and 'preferably by the end of the working day' within shift hours. Incident records must be made by the person involved in the risk – the 'notifier'.

In most wards, staff are able to record incidents as they occur. Incident reporting reflects the number and type of workplace hazards and provides NSW Health managers with accurate data about risk levels in each ward. However, in some high demand areas such as mental health wards and emergency departments, incidents occur in high numbers and incident reporting can be extensive. In these wards, staff are required to manage clinical workloads along with all incident reporting requirements.

NSW Health's incident management system is not designed for rapid reporting. A number of screens must be navigated, and a range of classification details must be completed to progress through each stage of the system and ultimately finalise a record.

In 2019, NSW Health made adaptations to the existing incident reporting system (IIMS) to improve a range of reporting functions. A new modified system (IMS+) was introduced late in 2019, with full implementation expected across all Local Health Districts by the end of 2020. The modified system contains some health and safety improvements, including a new feedback function that notifies staff when an incident is resolved, but it has not been modified to improve rapid reporting. The Clinical Excellence Commission advises that it takes approximately ten minutes to complete a single record in the new system, and additional modifications are required if functionality is to be improved for rapid reporting.

The limitations of IIMS and the modified IMS+ for rapid reporting mean that health and safety incident reporting is more onerous where the risks are most common.

The Ministry's health and safety incident reports describe high-level risks, but not all risks to hospital staff

Local Health Districts are responsible for managing all hospital health and safety incidents and risks and reporting these risks to the Ministry of Health. Ministry executives review health and safety data reports via quarterly meetings. Ministry reports contain high-level incident data about the numbers of physical incidents that occurred in the past six-month reporting period. Reporting identifies the hospital wards where the highest per centage of incidents occurred, and the segments of the workforce affected by the physical incidents.

The Ministry's health and safety reports provide an overview of health and safety incidents across the health system, though more detail would assist managers to better understand the risks. For example, health and safety incident reports do not contain enough detail to describe the degree or the severity of workplace incidents. Reports contain totals of physical incidents by Local Health District, but they do not identify the proportions of physical incidents that resulted in staff injuries, or the severity of the injuries.

Data reports do not identify the intent of the person responsible for the incident. While they contain data about the different instigators of hospitals incidents - for example, inpatients, outpatients, visitors or staff – they do not provide detail that differentiates incidents that were caused by accidental contact between patients and staff, from incidents that were acts of aggression. These limitations prevent system managers from identifying different types of risks to staff and limit the ability of system managers to target systemic responses to current or emerging risk types.

The Ministry advises that it is unlikely that hospital staff will be able to record the 'intent' of incident instigators. The Ministry advises that 'there are different legal definitions of intent, and this is a difficult concept for hospital staff to determine'.

The Ministry does collect data about police call-outs to hospitals, but this information is not currently included in Dashboard reports. According to Ministry data, in 2018, police were called to 115 hospital incidents - approximately 2.6 per cent of hospital incidents. This is an increase on 2017 when police were called to about two per cent of hospital incidents in the calendar year.

Some of the changes to the IMS+ system aim to improve data consistency. IMS+ has a function that gives each incident an automatic severity rating or 'harm score' based on the details of the event. However, it is not possible to assess whether additional health and safety data will be reported to Ministry executives in their quarterly meetings, as health and safety reports have not been generated since mid-2019. According to the Ministry, health and safety reporting has been postponed because data personnel are not available to generate reports. These staff have been deployed to COVID-19 duties throughout 2020.

The Ministry advises that health and safety incident data could be improved through encouraging greater consistency and constancy in recording practices in hospitals across the health system. According to the Ministry, work is in progress with unions, managers and staff to improve data reporting.

Local Health District managers would benefit from detailed aggregate data about the work health and safety risk factors that contribute to clinical mistakes in hospitals

Clinical Excellence Commission data show that some clinical mistakes made by nurses and junior doctors in NSW hospitals are influenced by factors related to staff health and safety. These can include fatigue and poor training, along with system risk factors such as poor workforce culture, poor governance or the lack of an appropriately skilled workforce.

When there is evidence that organisational deficits or individual errors have contributed to the harm or death of a patient in NSW hospitals, an investigation usually follows. The investigation assesses all contributing factors to the incident and, if necessary, recommends system improvements or changes to hospital practices.

The Clinical Excellence Commission assesses risk factors, classifies them into a range of categories, and escalates issues of concern to the Local Health District and to the NSW Clinical Risk Action Group - which is the peak quality and safety group within NSW Health. These classifications include a range of staff health and safety risks. Investigations are known as Root Cause Analyses.

The Clinical Excellence Commission publishes a limited range of aggregate Root Cause Analysis data about health and safety factors that contribute to hospital clinical incidents. However, more detailed aggregate data is available to assist Local Health Districts and hospital managers to understand state-wide health and safety risks. The Clinical Excellence Commission advises that there are no real impediments that prevent the sharing of more detailed aggregate data, as long as the information does not identify events or any confidential information.

Local Health District executives advise that Root Cause Analysis trend data may provide useful insights into the risks to their workforce as well as risks to patients. Knowledge of systemic risk factors could assist managers to take steps to remediate potential risks. In addition, the distribution of Root Cause Analysis trend data to a wider audience of clinical staff, unions and researchers may have the added benefit of improving the overall awareness of systemwide risks and assist in the implementation of proactive and preventive activity.

Under its Performance Agreement with the Ministry of Health, the Clinical Excellence Commission has an obligation to identify, develop and disseminate state-wide information about clinical quality and safety in health care. The distribution of clinical incident trend data is likely to fulfil part of this obligation.

We requested data from the Clinical Excellence Commission about the health and safety factors that contribute to clinical incidents in NSW hospitals. In a five-year period spanning January 2015 to October 2019, the data reveal that health and safety factors played a role in 2,405 clinical incidents in NSW hospitals. Exhibit 1 describes the health and safety deficits that led to adverse outcomes in patient care.

Exhibit 1: Selected Root Cause Analysis data describing health and safety system factors that contributed to adverse outcomes for NSW hospital patients from 1 January 2015 to 31 October 2019, Clinical Excellence Commission

Root Cause Analysis Finding	Explanation	Frequency Count
Environment	High patient numbers with high acuity	397
	Poor workplace culture affecting practices and routines	320
	Clinical governance deficit	63
Supervision	Support from senior clinicians inadequate	401
	Poor escalation to more experienced colleagues	313
	Delegation lacking – failure to properly assign roles	86
Teamwork	Teamwork not evident	458
	No identified lead clinician	199
	Roles unclear / inappropriate	169
Workforce	Training / education inadequate	416
	Rostering / staff ratio inadequate	326
	Lack of access / availability of senior staff	238
	Skill mix and skill levels not adequate	211
	Orientation / induction suboptimal	103

Source: Clinical Excellence Commission.

The Ministry has surveys and forums to understand the health and safety risks to junior doctors, but more forums are needed to understand the risks to nurses

In 2017 and 2018 NSW Health took steps to understand the risks to junior doctors through the *JMO Your Training and Wellbeing Matters Survey*. This survey asks junior doctors to reflect upon their levels of workplace stress, access to training and supervision, and experiences of workplace bullying. While the survey was not conducted in 2019 or 2020, according to the Ministry of Health, it will be re-introduced in 2021. The survey offers junior doctors an opportunity to provide confidential feedback on their health and safety experiences, concerns and challenges. Just under one quarter of all junior doctors responded to the survey in 2018.

In 2017, Local Health Districts were required to establish 'JMO Complaints Officer' positions to receive and monitor complaints from junior doctors. These designated officers provided an opportunity for junior doctors to report on a range of workplace concerns, including matters affecting their health, safety and wellbeing.

According to the Ministry of Health, Local Health Districts were to fund these positions from existing budgets as workload requirements were not expected to be very large. In 2020, only three of the 15 Local Health Districts retain these positions.

NSW Health does not have sufficiently detailed surveys or forums to generate information about the health, safety and wellbeing of nurses. The primary source of information about nurse wellbeing is the NSW Public Service Commission's *People Matter Employee Survey*. While this survey contains nurse views on their satisfaction with senior managers and responses to questions about workplace bullying, it lacks any information about levels of workplace fatigue, burnout, levels of workplace violence, or views about the safety of equipment and hospital infrastructure.

The *People Matter Employee Survey* is not sufficiently detailed to inform managers about the full nature and extent of hospital health and safety risks for nurses. NSW Health has not developed supplementary surveys or forums for nurses to confidentially report these workplace risks. Local Health Districts and Ministry executives advise that the primary forum for nurses to report psychological and wellbeing risks is to immediate managers. This is suitable in many cases, but may not always be suitable, for example, in instances where the same managers are the subject of complaints about workplace conditions, culture or other sensitive matters.

There are discrepancies between sources of data about levels of bullying in the workplace and information to explain the discrepancies

In 2019, the *People Matter Employee Survey* indicated that more than 20 per cent of health staff experienced bullying in the past 12 months. Hospital-generated bullying complaints data do not reflect these rates. From January to June 2019, Ministry data shows 54 new staff bullying complaints were initiated across the entire health workforce while 115 existing bullying complaints were under investigation. The data do not distinguish the segments of the health workforce to which the existing bullying complaints refer.

IN the period from January to November 2019, 18 nurse complaints of bullying were finalised, and nine workplace bullying complaints were finalised for junior and senior doctors combined.

Some of the discrepancies in the data could be explained by the limitations of self-reported information. For example, some staff who anonymously self-report an experience of bullying may not fully appreciate the specific definition of bullying in public sector codes of conduct, or may be airing personal grievances rather than bullying matters. That said, the Ministry does not have sufficient information to explain the significant discrepancy between the low numbers of formal bullying complaints and the high levels of bullying reported in its survey data.

Compliance audits assist in monitoring facility and infrastructure risks

Every two years NSW Health undertakes mandatory independent work health and safety audits of hospitals. Audits determine the effectiveness of management systems and identify strengths and opportunities for improvements. Audits assess compliance with the NSW Work Health & Safety Act and Regulation, the Safe Work Australia Codes of Practice, and NSW Health's work health and safety policies and procedures.

Results of audits and recommendations are reported to the Ministry along with Hospital Boards or a committee of the Board, such as the Audit and Risk Committee. Hospital audit reports monitor improvements in non-compliance, including action to rectify infrastructure safety, testing and maintenance, and completions in mandatory training.

Reporting to the Ministry executive occurs when there is non-compliance with health and safety audit recommendations or when non-compliances reach a level where:

- Legal or regulatory action may be taken against the Facility/Service
- Workers and others may be seriously injured
- There will be a major disruption to the Facility/Service if corrective action is not taken
- The matter may be a state-wide issue
- There may be media interest.

A summary audit report to Ministry executives in 2019, indicates that 11 Local Health Districts met work health and safety standards. However, 'significant non-conformance issues' were identified in four Local Health Districts where mandatory tasks were not completed, or standards were not achieved. One Local Health District failed to meet required organisational violence and security risk assessment standards. Other Local Health Districts were not compliant with requirements to conduct and monitor staff health and safety training needs analyses or were remediating previous actions before commencing new health and safety audit cycles.

When non-compliance issues are identified, Local Health Districts must demonstrate actions to meet mandatory requirements or standards, and these actions are monitored, and reported to Ministry executives.

2.2 Risk management strategies across the health system

Health and safety research and initiatives are not always shared across the system

Local Health Districts are responsible for health and safety in their services and develop a range of staff safety initiatives and programs. These initiatives supplement the mandatory health and safety programs and procedures required by State legislation and regulation. Health and safety programs and initiatives are mostly funded from Local Health District budgets. Districts target their approaches to address local risks and requirements. For example, some Districts have developed audio-visual messaging to improve patient and visitor behaviours in emergency departments. Others have developed projects to assist staff to manage the long-term impacts of violence on their health and wellbeing.

Some Districts have implemented emergency department concierge services. They provide dedicated assistance, support and information updates to people who are waiting in emergency rooms. This function can assist in the prevention of aggressive escalations of visitor or patient behaviour.

In 2018, the Ministry provided funding for junior doctor health and safety initiatives through the *JMO Be Well Project* initiative. Local Health Districts were able to apply for funding via an application and approval process. Eight Districts were successful. Some developed and delivered mental health first aid courses, others focused on partnerships with local agencies to support Aboriginal junior doctors in the workforce. One District developed staff workshops focused on positive psychology techniques and interventions designed to change workplace culture.

NSW Health has not established an effective system or forum for sharing health and safety initiatives across the State. Local Health District executives advised us that while they sometimes share information and ideas with other Districts through their human resource meetings, in general, sharing is limited and not systematised or routine.

There is potential for greater sharing of health and safety initiatives and ideas across the system. Some funded initiatives may have broader or even state-wide applications. The sharing of ideas and research is likely to have positive cost implications for the health system.

Exhibit 2 shows some of the District-based initiatives that aim to reduce the incidence of violence and harassment in hospital workplaces.

Exhibit 2: Local Health District health and safety initiatives

'Speaking safety' initiative

One Local Health District is implementing a two-part staff training module: 'Speaking Safely'. The first is about developing staff capability for escalating conversations about health and safety concerns, including bullying behaviour. The second part is an online option for staff to anonymously report health and safety concerns. The District has been publicising this option to provide a bridge for staff who do not feel comfortable to report directly.

'Call Chat' initiative

A Local Health District has been training managers for a number of years to deal with issues like bullying and harassment. The training focusses on interpersonal relationships. The initiative involves upskilling managers in their interpersonal capabilities. The training is focussed on creating openness amongst staff to discuss local issues as well as creating open forums where staff can share ideas on reducing bullying and harassment. This District has an email address where people can report bullying and harassment confidentially.

'I am safe, you are safe, we are safe' initiative

One District has an initiative that is about recognising and rewarding safe behaviour throughout the organisation. It encourages staff to make safe choices in all circumstances. The initiative focuses on managers as role models who demonstrate care for the safety of staff and of patients and in doing so, model behaviours for all staff. The concept is publicised with an emphasis on collective safety amongst the wider hospital community.

Source: Audit interviews with Local Health District executive teams 2019–2020.

Local Health Districts offer varying levels of staff support and resources in the aftermath of health and safety incidents

All Local Health Districts conduct hospital hazard inspections and convene health and safety forums to discuss and identify trends and issues related to workforce safety. Safety Coordinators also identify the health, safety and wellbeing support needs of staff in their District. Some larger Districts have extensive support and resources for staff after workplace incidents, while others have fewer resources to support nurses and junior doctors to recover after workplace incidents.

In one Local Health District, post-incident activity and support for staff begins with immediate identification of involved staff and staff witnesses. Debriefs are conducted at shift changes where psychological first aid and individual trauma counselling is offered to all affected personnel. The District has an extensive protocol to report on the progress and wellbeing of affected staff in the aftermath of health and safety incidents.

Other Local Health Districts describe economies of scale that limit their ability to employ additional staff or procure external support services. Clinical staff in some regional hospitals do not have the same level of access to resources that are routinely available in larger metropolitan hospitals. In these Districts, post-incident support for staff is generally provided by nurse unit managers.

Executives from all Local Health Districts told us that they are immediately notified after any serious hospital health and safety incident. Notifications occur no later than 24 hours after the incident. In the event of a work-related injury or illness, an approved process is initiated through the NSW Injury Management and Return to Work policy. Responses may include treatment of the injury, rehabilitation to assist a return to work, or retraining for a new skill or job. These processes are consistent across the State.

At the time of writing this report, the System Purchasing Branch of the NSW Ministry of Health, in partnership with the Clinical Excellence Commission, had purchased three licenses from the Schwartz Centre for Compassionate Care to implement a type of structured group forum where clinical and non-clinical staff meet regularly to discuss the emotional and social aspects of working in healthcare. These are known as Schwartz Rounds and the Ministry advises that they are to be implemented within three Local Health Districts in 2020–21.

According to the Ministry of Health, by the end of 2020, legislation will be enacted to strengthen incident management across the NSW Health system. Part of this with include Preliminary Risk Assessments aimed at supporting the safety of people in health environments; addressing staff psychological wellbeing following a serious clinical incident; and specifying how support has been provided after an incident.

The Ministry has not dedicated sufficient resources to address state-wide health and safety risks

The Ministry has not dedicated sufficient resources to assess systemwide health and safety data and develop initiatives to address state-wide risks, in particular risks to nursing staff. In 2019, the Ministry dedicated a budget of $150,000 for state-wide health and safety research and projects. Projects are focused on workplace risks with high numbers of compensation claims or risk areas where compensation claims are increasing over time.

Ministry funding has been sufficient to develop three projects to a preliminary scope stage, but projects have not been expanded due to the limited resources. Funding is not sufficient to publish and share materials with the health workforce. The scoped projects include research into nurse ageing and body stress, staff psychological injury and vicarious trauma, and a resilience toolkit with advice for creating an age-friendly workplace.

More funding has been available for junior doctor health and safety initiatives. According to the Ministry of Health, the *JMO Wellbeing and Support Plan* and *JMO Be Well* projects were funded at approximately $4.0 million over four years.

3. Audit findings: Staff experiences of health and safety risks and support

3.1 Interviews with Local Health District Executives and nurses and junior doctors in NSW hospitals

To understand the health and safety risks to nurses and junior doctors, staff from the audit office conducted a series of interviews with hospital staff and Local Health District executives during 2019 and 2020. The different interviewee groups were asked a series of consistent questions about workplace risks and the systems used to record these risks. They were asked about the nature of workplace incidents and the supports available following health and safety incidents. See Appendix two for more information about the interview methodology. In summary, we spoke to:

- Executives from all 15 Local Health Districts and the Sydney Children's Hospital Network
- 83 nurses from 13 hospitals across four Local Health Districts. Interviewees were from high demand wards in NSW hospitals including emergency departments, aged care wards, mental health wards and intensive care units
- 35 junior doctors from ten hospitals across four Local Health Districts. Interviewees were from high demand wards in NSW hospitals including emergency departments, aged care wards, mental health wards and intensive care units.

The interview responses of NSW Health executives and frontline staff are reported throughout this chapter. While the numbers of nurses and junior doctors who were interviewed by audit staff represent a small proportion of the workforce, their responses point to a number of health and safety issues where there is limited aggregate data available from NSW Health or from other information sources. They are described in this chapter as areas for NSW Health to further investigate.

Stress debriefing is not always available to staff after workplace incidents

Nurses and junior doctors in all Local Health Districts told audit staff that in high stress, high demand hospital wards, they are sometimes exposed to experiences that are overwhelming, threatening or distressing.

Approximately one-third of the nurses we interviewed told us that they always have access to a form of follow-up, debriefing and support after a workplace incident. Support is usually provided by clinical managers and is sometimes supplemented by resources from the Local Health District. The forms of support include access to a post incident support person, team-based psychological first aid sessions or trauma recovery debriefing. A further third of interviewed nurses advised us that stress debriefing is sometimes available, or available on occasions where the incident is very serious. Fourteen per cent of interviewed nurses told us that they had never received follow-up or support after a workplace incident.

Almost 40 per cent of the junior doctors we interviewed told us that follow-up or support was rare or had never been offered after they were involved in a clinical incident. Our interviews suggest that support options and debriefing practices are not routine or systematised across the NSW health system.

Counselling options are available for all public hospital employees through the Employee Assistance Program (EAP). However, hospital staff told us that while EAP is useful for some therapeutic requirements, it is not a substitute for traumatic incident debriefing. They advised that stress debriefing fulfils a different function from counselling and should occur soon after the incident. Since EAP appointments need to be booked in advance, sessions are not always available at the times when they are needed. The Ministry advised that in some hospitals, the EAP service is located onsite, and in these hospitals, rapid debriefing can occur.

At the beginning and end of shifts, hospital staff participate in some form of handover, which can include safety huddles or in the case of an incident, a 'hot debrief'. In these handover sessions, workplace safety issues are generally discussed. Nurses told audit staff that these processes are predominantly focused on patient safety and care, and do not always focus on staff wellbeing.

Similarly, in the aftermath of serious clinical incidents, staff are required to participate in formal clinical debriefs. The intent of these debriefs is to improve clinical performance and accountability.

While stress debriefing can, and does occur in some shift handovers, practices are not routine across NSW hospitals. Nurses advised us that debriefs are not always conducted by staff with appropriate training or expertise. According to the majority of interviewed nurses, the task of providing support and debriefing is usually provided by nurse managers. On occasion, these nurse managers may also be impacted by the incident. They reported that external and expert team debriefing is rare.

Hospital health and safety debriefing and support services resources are provided by Local Health Districts. According to Local Health District executives, resources are directed to the areas where the needs are greatest. Service agreements between the Ministry and Local Health Districts could be used as a means to strengthen the staff wellbeing focus after hospital incidents.

Nurses and junior doctors do not always have access to essential safety equipment

Nurses and junior doctors use manual handling equipment such as hoists, slings and slide sheets to lift and move patients. This equipment reduces the risk of soft tissue injuries in frontline staff. Hospital iCare injury data show that soft tissue 'body stress' injuries were the most common injury type amongst nurses and junior doctors in the past five years.

For nurses, compensation claims for body stress are almost double the rate of the next most common injury type - slips, trips and falls. In the period from July 2019 to end of June 2020, nurses made 633 claims for body stress injuries.

Similarly, body stress injuries are the most common injury type amongst hospital doctors and other medical staff. Compensation claims data do not separate junior doctors from other medical staff, so it is not possible to determine injury levels of junior doctors. Nevertheless, overall injury data of medical staff show that there are more than twice as many body stress injuries as those of next highest injury type. In the period from July 2019 to end of June 2020, medical staff including junior doctors made 544 claims for body stress injuries.

Half of the nurses we interviewed reported that they did not always use manual handling equipment when appropriate. The main reasons that prevent nurses from using appropriate equipment include instances when urgent action is required. Nurses report that in some instances, equipment is poorly located or hard to find, and sometimes they lack training in how to use new equipment. In some hospitals, staff advised that equipment was broken or there was insufficient equipment for all hospital wards.

Thirty of the 35 junior doctors that we interviewed told us that in most instances they were able to follow safe handling practices with sharps (needles). In the instances when safety was compromised, it was usually because wards lacked the required equipment. They told us that some sharps bins are poorly located, missing or full, and sometimes there is a reduced ability to follow procedure due to the clinical acuity of the situation.

Hospital nurse managers report working hours that are not recorded, claimed, remunerated or reported to system managers

NSW Health monitors the working hours of its nurses and junior doctors through a rostering system that gives managers visibility of staff rosters and overtime hours. The system is designed so that staff working hours comply with health and safety regulations. The system sends alerts to managers when staff hours are not compliant with health and safety guidelines.

All of the nurses who were interviewed for this audit explained that they do not log excess hours in the HealthRoster system. They advised that these hours are not recorded because it is not customary for nurses to claim overtime for administrative tasks, so they do not record, claim or seek remuneration for excess hours. As there are no records of their hours, there is no information for managers to understand the levels of overtime.

Almost 90 per cent of nurses we interviewed for this audit told us that they have worked unpaid overtime hours in excess of their allocated shift hours. Of this group, almost one-third told us that they work overtime on a daily basis. It was nurse unit managers who were most likely to report working overtime hours.

When asked why they do not claim overtime, all nurses we spoke to advised that they are not permitted to claim overtime to complete outstanding administrative tasks. Any overtime requires pre-approval from more senior managers, and these approvals are only made for overtime that is for clinical overflow tasks. In general, nurses and nurse unit managers do not claim overtime to complete tasks such as incident reporting or long handovers to the next shift. In most instances, unpaid overtime periods are relatively short, and in some wards, there are arrangements where nurses can leave early when they have worked additional hours.

However, nurse unit managers in some hospitals told us that they have significant administrative workloads that are not able to be completed during shifts. They explained that the administrative burden is particularly high in the week when they complete staff monthly rosters. Just over half of the nurse unit managers we interviewed, told us that they have difficulty meeting workload expectations during shift hours.

NSW Health does not currently employ alternative mechanisms such as surveys or other mechanisms, to understand the workloads of nursing staff. The Ministry advises that while it is not currently using alternate mechanisms to understand the unclaimed overtime of staff, it may be possible to assess overtime hours if personnel remain at work to complete tasks. Computer time stamping or staff swipe card time stamping are possible ways to assess staff working hours. However, the Ministry advises that it is difficult to objectively test overtime if nurse unit managers complete administrative tasks at home or outside the workplace.

The Ministry also advises that staff workloads and levels of fatigue are monitored via Reasonable Workload Committees and that union groups monitor the working conditions of hospital staff to ensure compliance with award provisions. These entities operate as a feedback loop between staff, Local Health Districts and the Ministry.

Culture and complicated claims processes prevent some junior doctors from recording or claiming overtime

To claim overtime, doctors must be able to show that they meet certain criteria according to NSW Health policy. If they meet these criteria, they must complete a claim process which includes documenting records of the last patient they saw during the overtime period, and selecting the reasons for the overtime from a range of permitted tasks. These can include medical emergency, transfer of a patient, and mandatory training.

The *JMO Your Training and Wellbeing Matters* survey describes the reasons junior doctors decide not to claim for un-rostered overtime. Data from the 2018 state-wide survey reveal that 79 per cent of survey respondents do not always claim overtime. The reasons include: they did not believe the amount was worth claiming (40 per cent), concern about the perception that they can't manage the role (35 per cent), lack of clarity about what can be claimed (31 per cent), process for claiming too difficult (31 per cent), perceived impact on career opportunities (27 per cent) and supervisor not supportive (16 per cent). According to the state-wide survey, 21 per cent of junior doctors do not have any barrier to claiming overtime that is un-rostered.

More than a third of junior doctors who were interviewed for this audit, report that they are working unpaid overtime on a daily basis to meet heavy workloads along with the pressure of expectations of senior staff, colleagues and themselves. Some of the additional hours are due to training or catching up on learning requirements. Junior doctors advised the audit team that there are different expectations in different hospital environments and levels of overtime can be influenced by local workplace culture and the influence of individual senior managers.

Numerous health and safety policies make the system difficult to navigate

The NSW Health website lists a compendium of health and safety policies, regulations and laws that mandate and guide the practices of hospital staff. There are 17 policies listed on the health and safety section of the website and these form a subset of a more complex framework of policies that describe workplace management and workplace conduct. In total, there are more than 30 policies that apply to workplace health and safety practices in NSW hospitals.

Hospital clinicians report that health and safety policies are not arranged in ways that are easily navigated. Many policies interact with each other and contain references to other policies. Over ten per cent of clinical staff report that they have had difficulty understanding their obligations; that induction training was not sufficient, and that they are underinformed, in particular in relation to health and safety incident management and reporting.

NSW Health's *Incident Management Policy* was not located on the Ministry's health and safety landing page when we checked this site in September 2020. This policy describes the incident reporting obligations of hospital staff. It sets out the types of workplace health and safety incidents that should be recorded, and the processes for recording incidents in the incident management database. This policy was updated in 2020.

In September 2020, a link to the updated policy in the overarching *Work Health and Safety: Better Practice Procedures* document navigates to a rescinded policy. Some junior doctors advised us that they were unaware of their incident reporting obligations. Some were of the view that incident reporting was the responsibility of nurses.

Health and safety risks can be numerous in some wards and staff are encouraged to report physical risks, but there is less emphasis and support for psychological risk reporting

Nurses and junior doctors told audit staff that NSW Health has created a workplace culture that encourages them to report physical injuries and risks such as trip hazards, chemical hazards, physical violence or security risks. They advised that signage about physical safety is extensive in hospitals, and that they report physical risks when time permits.

However, over a quarter of the nurses we interviewed for this audit told us that the incident reporting system has limited functionality for recording health and safety incidents, and this is a disincentive to reporting. Nurses and junior doctors advised us that they do not routinely record 'more minor' health and safety incidents when time is limited. For example, nearly one-third of the nurses we interviewed reported that they would not record verbal abuse by patients, and 45 per cent told us that they may record the incident, but it would depend on the severity of the verbal abuse.

Most nurses who were interviewed for this audit told us that they record physical incidents in the incident management system. However, more than ten per cent told us that they do not always record physical aggression by patients who are cognitively impaired. When asked about the most common forms of physical aggression, nurses told us that punching was most common, followed by hitting or slapping. They told us that they report incidents if they are injured, but in general, for this cohort, reporting is not routine if there is no injury. Nurses told us that these health and safety risks are particularly common in aged care wards. In mental health wards, nurses told us that verbal aggression is so common that it is not possible to record all incidents during shift hours.

Almost a third of nurses who were interviewed for this audit told us that they had experienced workplace bullying. Of those who reported bullying, 70 per cent said that they did not report it because they feared repercussions. Nurses can make complaints to higher level managers in human resource departments, although they advise that the formality of this process can be a disincentive.

NSW Health does not have systems or surveys for hospital staff to confidentially report wellbeing risks. Wellbeing risks can include workload levels, the impacts of workplace trauma, burnout from workplace stressors, the impacts of prolonged exposure to patient aggression, or workplace bullying

While nurses and junior doctors complete the *People Matter Employee Survey* annually, this survey does not capture levels of fatigue and burnout, access to meal breaks and other breaks, levels of unclaimed overtime, or the impacts of workplace violence.

In 2018–19, psychological injuries and mental stress made up more than 12 per cent of all compensable workplace injuries for NSW nurses and 18 per cent of compensable injuries for all medical staff including junior doctors. From 2014 to 2019, the numbers of nurse compensable injuries for mental stress or psychological injury increased by 70 per cent.

4. Health and safety responsibilities and requirements during a pandemic

4.1 NSW policy and governance arrangements during a pandemic

A series of governance arrangements are set in motion when an infectious disease health emergency is declared in NSW. These arrangements are described in the *Health Influenza Pandemic Plan* (Pandemic Plan) 2016. During a health emergency, NSW Health becomes the lead combat agency and joins the State Emergency Operations Controller to form a peak decision-making body to coordinate policy responses and pandemic management across the State.

The Pandemic Plan describes NSW Health's legislated duty of care to ensure appropriate hospital infection control measures, including the provision of Personal Protective Equipment (PPE). It sets out four stages in the preparation and the management of a pandemic. The actions at each stage assist in the mitigation of health and safety risks to hospital staff:

- stage one: ongoing 'prevention' and surveillance activity to prevent and control outbreaks
- stage two: 'preparedness' activity, when pandemic pathogens have been identified by national or international health agencies
- stage three: 'response phase' which is activated once a virus has been identified with pandemic potential
- stage four: 'recovery' phase as health agencies transition back to normal duties as the pandemic has passed.

Within the NSW Health system, the Ministry and its Health Pillar organisations and HealthShare NSW are responsible for key pandemic activities including emergency management responses and governance arrangements to:

- procure and distribute PPE and ensure quality control over PPE sources including access to the State Medical Stockpile, the National Medical Stockpile, and alternative supplies
- develop and distribute educational and training modules
- determine key clinical standards and procedures to reduce the risk of infection and monitor compliance with standards
- communicate with health staff state-wide, and with external stakeholders (including communities of practice) and partner agencies
- monitor the impact of the pandemic on health system performance and prepare for potential workforce contingency plans
- conduct root cause analysis and investigation of hospital-related staff infections.

According to the Pandemic Plan, when pandemic pathogens are identified by national or international health agencies, NSW Health system managers are required to immediately communicate with 'clinical groups in health facilities including emergency departments, infectious diseases, infection control and critical care groups'. During this preparedness phase, system managers should ensure appropriate 'development of the workforce, particularly through training in infection control and through participation in exercises and testing responses to a range of pandemic scenarios.

The Pandemic Plan devolves responsibility for hospital business continuity to the Chief Executives of Local Health Districts. However, Chief Executives must rely on advice from the Ministry if significant changes are to be made to models of infection control and patient clinical care. The Pandemic Plan is a high-level governance framework and does not contain detailed clinical guidance to assist the NSW hospital health workforce in local arrangements.

Hospitals are responsible for location specific emergency management plans, policies and procedures; establishing pandemic management arrangements for their wards; coordinating Ministry and Local Health District messages to wards to ensure they are effective and compliant; managing distribution of PPE across the hospital and adequate supply for each ward, monitoring overtime; tracking pandemic related costs; and ensuring effective internal control over PPE supplies.

The NSW Public Health Emergency Response Preparedness Minimum Standards policy directive describes the responsibilities of NSW Health system managers for hospital staff training in preparation for health emergencies. All new starters at public health units who have potential responsibilities in emergency response situations must complete three mandatory online training modules, In addition, Local Health Districts must conduct annual training in at least one emergency exercise, actual response or relevant training session such as Incident Control System training. Training must include re-familiarisation with PPE if this is relevant to the risks identified in their response role.

Nationally, advice about infection control is provided through the national Infection Control Expert Group (ICEG). This group includes physicians and clinical experts who advise the Australian Health Protection Principal Committee (AHPPC) on the best available infection control practices for Australia. Updated advice from the ICEG is communicated to State Government agencies who then provide guidance to the hospital heath workforce.

4.2 Our audit focus on health and safety during COVID-19

Our audit assessed NSW Health's management of the health and safety of nurses and junior doctors during the COVID-19 pandemic. We considered the actions of health managers to:

- assist frontline health workers to access PPE and infection control resources for COVID-19 procedures and responses
- provide relevant safety guidance and training to assist nurses and junior doctors to manage health and safety risks as they emerged in 2020.

We used the following methods to reach our audit findings:

- interviews and meetings with Ministry of Health executives
- reviews of NSW Health data and reports
- interviews with the hospital manager / coordinator responsible for ordering and distributing PPE to the emergency departments and intensive care wards in all 15 NSW Local Health Districts
- interviews with nurse managers from emergency departments of hospitals that were most likely to receive COVID-19 patients in all 15 Local Health Districts
- interviews with nurse managers from intensive care wards of hospitals that were most likely to receive COVID-19 patients in all 15 Local Health Districts
- case studies of three Local Health District responses to COVID-19.

There have been three additional inquiries into the management of COVID-19 where NSW Health is a respondent:

- the Special Commission of Inquiry into the Ruby Princess
- the Independent review into the Newmarch House COVID-19 outbreak
- the Public Accountability Committee's inquiry into the NSW Government's management of the COVID-19 pandemic.

4.3 COVID-19 pandemic timeline

The first evidence of the COVID-19 virus emerged in December 2019 when health clinicians in Wuhan, China identified clusters of pneumonia cases. In January 2020, the international media started to report on what appeared to be a growing health risk in mainland China.

Throughout January 2020, the World Health Organisation issued alerts about a novel coronavirus and encouraged health entities to take precautions. On 30 January the World Health Organisation declared the coronavirus to be a global health emergency of international concern.

On 11 March 2020, COVID-19 was declared a pandemic. It had spread to 114 countries including Australia.

On 25 January 2020, NSW had the first confirmed case of COVID-19. This was an overseas traveller who recovered in hotel quarantine. A month later, on 25 February 2020, NSW had the first COVID-19 community infection, indicating person-to-person transmission in NSW. A patient at the Ryde Hospital tested positive for COVID-19, and subsequent testing identified a first cluster of cases in Northern Sydney. Some of these cases were healthcare workers at the Ryde Hospital.

As at 18 November 2020, there have been 4,509 COVID-19 infections in NSW and 53 deaths. 3.336 million tests have been conducted across NSW.

According to the most current Ministry data about COVID-19 infections amongst healthcare workers (as at 29 June 2020) a total of 208 healthcare workers have been infected with the COVID-19 virus in NSW, with 88 infections through suspected workplace exposure. Other healthcare worker infections are suspected to have been acquired overseas or through non-work-related activity. To date, no NSW healthcare worker has died as a result of contracting COVID-19.

According to the World Health Organisation, coronaviruses are similar to influenza diseases. Both cause respiratory illness, and both require the same infection control measures. There are some distinguishing features between the diseases. The COVID-19 virus has a higher reproductive number than influenza – meaning a person infected with COVID-19 will pass on the infection to more people than a person infected with influenza. For COVID-19, this is understood to be between two to 2.5 subsequent infections for each case. The mortality rate for COVID-19 also appears to be higher than for influenza.

5. Audit findings: Effectiveness of health and safety responses and support for hospital staff during COVID-19

Local Health Districts were effective in leading health and safety infection control activity

According the *NSW Health Influenza Pandemic Plan* (Pandemic Plan), the Chief Executives of Local Health Districts have ultimate responsibility for public health unit preparations during health emergencies. If necessary, they can 'draw on the support of the State Pandemic Management Team and local emergency management resources'.

During the preparations and early response phases to the COVID-19 pandemic, Local Health Districts were at the forefront of most NSW hospital activity. They took the lead role in developing hospital infection control protocols and guidance about the appropriate uses of Personal Protective Equipment (PPE). Each Local Health District established its own responses to the health emergency, based on the best clinical advice available to them. The localised approach meant that there were some minor differences in infection control practices across the NSW health system.

Throughout February and March 2020, there was limited centralised policy or guidance from the Ministry and its Pillar Health agencies about COVID-19 infection control practices. It was not possible to mandate practices at a time when information about the virus was evolving. Clinical responses were changing as more became known about COVID-19, especially about its patterns of transmission and its impacts on people with the disease.

During February and March 2020, Local Health District executives communicated with hospital staff via a range of methods. Some sent daily e-memos with the latest updates. Some scheduled more regular meetings with hospital clinicians. Some Districts set up extensive staff training sessions and information briefings to keep all personnel updated with the latest advice. Physical distancing made it difficult to bring staff together in large groups, so a range of communications measures were implemented.

Clinical staff also utilised their clinical training and expertise to prepare their wards and train frontline staff in infection control procedures. Some sourced information from national and international colleagues to add to localised knowledge of the virus.

When the first evidence of COVID-19 community transmission was identified in the Northern Sydney Local Health District, hospital staff followed infection control protocols that were based on local guidance and information. With the support from the District executive team and infectious diseases experts, hospital clinicians set up their own infection control protocols and PPE protections. Within a week the District had produced a matrix to guide staff in the uses of PPE during COVID-19 procedures, and had circulated the guidance to all hospital clinicians.

At the end of March 2020, a version of the Northern Sydney PPE matrix was published on the Clinical Excellence Commission's website and it has now become NSW Health's standard guideline for PPE during COVID-19 procedures. Once this guideline was published centrally, infection control practices were standardised across NSW hospitals.

This form of District-led policy making is not 'business as usual' practice for NSW Health. Policy making processes were somewhat reversed during the early response phases to COVID-19. This flexible policy approach supports the governance arrangements described in the Pandemic Plan, which assigns responsibility for 'supporting and maintaining quality care across health services and implementing infection control measures as appropriate' to Local Health Districts.

In non-health emergency situations, clinical policy and protocols are usually initiated and developed by the Ministry and the Clinical Excellence Commission and are subsequently shared across the health system after a quality control process. The localised approach adopted in the months from February to March 2020, allowed for rapid and flexible responses to changing information – to protect the health and safety of the hospital workforce and the wider community.

Hospital staff across NSW would have been better prepared for COVID-19 if pandemic training had been delivered across all Local Health Districts in the past decade

Local Health Districts are responsible for training hospital staff in preparation for public health emergencies. NSW's policy describing *Public Health Emergency Response Preparedness Minimum Standards* requires that clinical staff participate in at least one annual emergency training exercise if they hold a position where they are likely to be called upon in an emergency. Staff must participate in an actual response exercise or a relevant training session. The training must also include re-familiarisation with PPE.

Available evidence about emergency response training in NSW indicates that at least two Local Health Districts have delivered pandemic focussed training in the past decade. Our interviews with managers of emergency departments and intensive care units indicates that most other Districts have focused their emergency training on mass patient trauma incidents such as plane crashes, train crashes and terrorist attacks. While the potential for these types of mass trauma events is real, and warrants training and preparation, significant global outbreaks of diseases have also had potential to threaten NSW communities. In previous decades, global health communities have been at risk of diseases such as the Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS).

In the two Districts where pandemic training was provided in NSW, staff participated in community influenza vaccination exercises. These were focused on upskilling staff to follow emergency command structures, manage high volume patient flows, and organise sanitisation logistics during a hospital-based training exercise.

Our interviews with nurse managers in emergency departments and intensive care units indicate that in the majority of other Local Health Districts, key personnel were unaware of the NSW Pandemic Plan. Interviewed staff also reported insufficient scenario-based training in pandemic responses over the last ten years.

The Ministry, the Clinical Excellence Commission and the Health Education and Training Institute (HETI) are responsible for online training and 'state-wide strategies and resources to maintain high levels of compliance with infection control and patient safety recommendations'. The HETI website contains online training modules in infection control and PPE donning and doffing procedures. Other infection control information and research is available on the websites of the Clinical Excellence Commission and the Agency for Clinical Innovation.

Online training modules are effective for upskilling staff in a range of skills, but are not a substitute for real-time, rapid incident response training. Face-to-face training provides opportunities for first responders to test procedures in hospital environments. Incident response training provides opportunities for staff to assess their levels of compliance with protocols and their competence with equipment in scenario situations. It is the responsibility of Local Health Districts to provide this form of training to the health staff in their District.

Two NSW Health policies that govern clinical arrangements during pandemics are outdated

The Ministry had not updated two policies that had the potential to assist emergency departments and intensive care units in aspects of their ward preparation for the COVID-19 pandemic. Both policies were on the NSW Health website, but neither were shared with hospital staff in the planning phases for the pandemic. Both policies are out of date and have not been revised within required timeframes.

The 2010 *Influenza Pandemic - Providing Critical Care* policy was due for review in May 2015 and was not updated at the time of the COVID-19 health emergency. Similarly, the 2007 policy *Hospital Response to Pandemic Influenza Part 1: Emergency Department Response* was due for review in June 2012 and has not been updated.

These policies were designed to assist clinical staff to make necessary ward arrangements for infection control. They set out the steps for rapid identification of contingent workforces, isolation procedures, and management of patient flows to separate those with suspected infection from other patient cohorts. They were a potential addendum to the NSW Pandemic Plan which describes the command and control responsibilities of health agencies in health emergencies.

Our interviews with nurse managers from emergency departments and intensive care units indicate that in the absence of pandemic policy, they sought clinical guidance from external sources and Local Health District experts. Interviewees told us that a lack of policy guidance about ward arrangements and infection control practices in a pandemic increased their workloads and hours of overtime in the early response phases to COVID-19. With the support of Local Health Districts, clinical staff made rapid adjustments in order to respond to changing testing requirements and ward arrangements.

The Ministry was slow to establish a centralised communication channel to communicate with frontline staff

NSW Health's governance and communication arrangements during a pandemic are set out in the Pandemic Plan. The Plan requires that government agencies 'commence enhanced arrangements, establish communications measures' and confirm 'governance arrangements' when there is evidence of person to person transmission during an influenza outbreak. NSW Health received the first notifications of the novel coronavirus risks in January 2020.

During the preparation and early response phases to COVID-19, the Ministry and its central agencies were slow in establishing a single, authoritative channel through which to communicate consistent messages to frontline staff. Clinical staff required up-to-date information about COVID-19 testing criteria as requirements were changing rapidly, sometimes daily. While there was no expectation for fixed policy at this time, hospital staff required the latest instructions about treatment requirements, and updates on the numbers of COVID-19 infections in their region.

As information about COVID-19 was evolving, information was communicated across the health system via 'multiple channels and sources'. While the Ministry and its central agencies communicated extensively with Local Health Districts during March 2020, hospital staff reported to us that they weren't always sure where they could find the latest advice about testing protocols or infection controls.

Frontline staff told audit office staff that they were checking multiple sources and time-stamping advice to ensure they had the most up to date information on a daily basis. While some Local Health Districts managed clear communication links with frontline staff, nurse managers told us that communication was 'chaotic' during the early phases of pandemic preparation. Key personnel were not always available outside business hours and nurse managers advise that they spent hours at the end of shifts, seeking and printing the latest advice for weekend and night shift personnel.

By the end of March 2020, the Ministry and the Clinical Excellence Commission websites became better organised to communicate with frontline clinicians.

A recommendation to the Ministry of Health after H1N1 swine flu could be equally applied in the COVID-19 context. The NSW Government's report: *Key Recommendations on Pandemic (H1N1) 2009 Influenza* recommended the establishment of 'clear pathways of communication … so that all employees have confidence in where their information will come from and who they should approach if they need additional information.'

NSW Health acknowledges the challenges and the lessons from the early phases of the COVID-19 pandemic. For example, a strategy released in August 2020, sets out NSW Health's own recommendation for the future management of PPE including: 'Aligning a single source of truth for PPE education and evidence-based guidance to ensure clarity of information on appropriate use, supported by an influential network of Infection Prevention and Control (IPC) practitioners at the forefront.'

Ministry executives advise that communication with health staff has improved since the early phases of the pandemic. The Ministry now sends weekly COVID-19 updates to over 130,000 health staff via email. In addition, NSW Health now has two COVID-19 tabs on its website with current information, including COVID-19 testing advice. According to Ministry executives, these communication channels could be used or replicated if needed for future health emergencies. The Ministry also provides health information and updates via a phone application called Med App. This App is preferred by doctors and is less likely to be used by nurses. As at October 2020, there are 13,000 users of Med App. Push notifications can be made on Med App through SMS alerts.

Personal protective equipment (PPE) was not always available in required sizes and some hospital masks and gowns were substituted with products that differed from the usual items

Since the emergence of COVID-19 in Australia, all clinicians in NSW hospitals have had access to some form of PPE for their clinical requirements. If staff did not have appropriate equipment for each COVID-19 related procedure, they were guided by the formal advice issued to the NSW Health workforce on 11 March 2020 stating that: 'The safety of NSW Health staff is a priority at all times, especially during COVID-19. Where safe working practices confirm specific PPE (e.g. face shields/masks or other equipment) are required for the protection of staff due to COVID-19, in all circumstances:

- staff are to wear prescribed PPE as instructed
- staff are not to undertake or be required to undertake tasks requiring PPE if the PPE is not available for use. Any such tasks are not to proceed until required PPE is available
- any staff member who is concerned about their safety must raise their concerns immediately to their manager.'

At periods during March and April 2020, some PPE items were not available in the required sizes or the regular brands to which staff were accustomed. HealthShare NSW was not able to source PPE from usual suppliers. HealthShare NSW sourced PPE including N95 masks from non-traditional suppliers. Some PPE items differed in shape and size from the usual hospital equipment. While senior executives from HealthShare NSW advise that all products were approved by the Therapeutic Goods Administration (TGA), in some hospitals, nurse managers advise that staff were not able to 'fit test' substituted masks. Fit testing determines the type and the size of the respirator mask that achieves an adequate seal on an individual's face.

In March and April 2020, 'duck bill' (N95) masks were not available in some hospitals. According to stock managers and clinical managers in Local Health Districts, duck bills are the preferred mask for staff with smaller faces, particularly female staff members. The duck bill mask is a standard PPE product, and as such, is fit tested during mandatory PPE training. During the early response phases to COVID-19, most Local Health Districts were provided with substitute N95 masks. Fit testing of the substituted N95 masks was not able to be conducted in all NSW hospitals during the early phases of COVID-19. During the first wave of COVID-19 in March and April 2020, hospital staff told audit staff that there was no time and a lack of equipment to appropriately fit test substituted N95 masks.

Nurse managers in emergency departments advise that in some instances, staff made adaptations to PPE to improve protections, such as doubling masks, adding elastics or bringing their own equipment. These adaptations were not consistent with guidelines. Nurse managers advise that in some cases, adaptations to PPE or ill-fitting masks created pressure sores and contact dermatitis.

Just over half of the stock managers of Local Health Districts advised that PPE stock was procured from outside the HealthShare NSW system. Stock managers in some Districts advise that facial shields and goggles sourced from non-traditional suppliers by HealthShare NSW were of a lesser quality than standard equipment. Stock managers and nurse managers reported that the changes in PPE products caused confusion and stress amongst staff.

Local Health Districts were proactive in assisting hospital staff to mitigate risks of COVID-19 infections. Some Local Health Districts assigned 'tiger teams' to assist staff with their PPE practices. Tiger teams provide clinical expertise and advice to staff, answer questions about infection control and provide training on PPE practice in hospital ward environments. They assist and support PPE donning and doffing practices to ensure the appropriate sequencing of applying and removing PPE for effective infection control. They provide mask fit checking guidance to assist staff in correct PPE practices.

Districts ran extensive refresher PPE training sessions for clinical staff. Some hospitals ran regular PPE demonstrations so that staff could observe correct PPE procedures at set times during the day. These activities assisted staff to implement appropriate infection control in the period before the Clinical Excellence Commission's web-based materials and videos became available in late March and early April 2020. These online resources now provide comprehensive guidance to hospital staff in PPE practices.

HealthShare NSW placed limits or caps on some high-demand PPE items that were too low to meet requirements in some Local Health Districts and had to be adjusted to meet actual demand

The NSW Pandemic Plan describes the responsibilities of the Ministry and its central agencies to manage and maintain the State Medical Stockpile of essential PPE supplies and antiviral medications. During a pandemic, HealthShare NSW has responsibility for warehousing, monitoring and distributing health supplies to the health workforce.

Due to a reported global shortage of PPE and limits to the NSW stockpile, HealthShare NSW placed limits on the provision of approximately 100 high-demand items to NSW hospitals. HealthShare NSW advise that the PPE order capping ceilings were implemented 'to ensure local stockpiling does not occur'. A centralised ordering process was established with Local Health Districts so that PPE product ordering occurred through single hospital locations (214 across the State), rather than at the ward level. Escalation processes were established to allow Districts to request one-off increases to supply, and a process was set up to permanently increase the order cap limit for any PPE item by facility.

According to HealthShare NSW, 'as incoming central supply has improved, order caps have subsequently increased in line with strong engagement and governance with the Local Health Districts to ensure the appropriate levels of supply are provided'. The original capped levels were determined by assessing PPE usage in wards during the flu season of 2019. As the flu season case numbers of 2019 were relatively low, some Local Health District managers advised that the levels of PPE during 2019 were not comparable to the level of PPE required for the COVID-19 pandemic.

After advocacy from hospital stock managers and clinicians, HealthShare NSW increased capped PPE levels in many Local Health Districts.

Executive members of the State Health Emergency Operations Centre (SHEOC) advise that its PPE supply strategy needs to be carefully developed as there are vast differences in PPE usage rates during 'business as usual' periods and pandemic periods. If NSW Health kept the level of PPE required in planning for a worst-case scenario, this would equate to an extensive surplus of PPE that could not be utilised during business as usual periods. The SHEOC Executive advise that it is not feasible or economical to store this level of PPE. They advise that given the costs of PPE, and the fact that the products have a shelf life, a diversified supply line is a more reliable method for ensuring PPE during surge and non-surge periods.

Early data modelling showed ICU patient numbers at levels not manageable with levels of ventilators and equipment

Early projections of patient numbers requiring acute care for COVID-19, were at levels that would not have been manageable with the equipment and resources of NSW hospitals.
Throughout March through to May 2020, government data modelling indicated significant surges of community infections and surges in intensive care patients.

Early estimates were based on overseas trends, and if actual cases had matched projections, NSW hospitals would not have had sufficient ventilators to meet demand. The knowledge of this shortfall caused high levels of anxiety among nursing and medical staff.

While the data was based on the best available information, it had negative implications for the health and safety of the nurse and junior doctor workforce. Managers of intensive care wards and emergency departments reported stress amongst the workforce. Staff concerns were primarily about being faced with 'the unmanageable', along with heightened fears about contracting the virus with the knowledge that there was insufficient equipment to treat acute patients.

As it transpired, overall numbers of COVID-19 infections were lower than projected during the early months of the pandemic. The lower infection rates in the general population have meant fewer instances of patients requiring intensive care in NSW hospitals. In addition, HealthShare NSW has been able to increase the numbers of ventilators in NSW hospitals to prepare for future surges in patients requiring acute respiratory care.

SHEOC Executive advise that NSW Health undertook an accelerated procurement strategy in early 2020 to increase its stock of ventilators, and that ventilator capacity has always far-exceeded actual requirements.

NSW Health has developed a strategy to improve the management of PPE for the NSW health workforce

In August 2020, NSW Health released a strategy that sets out its future management and planning approaches to the provision of PPE for the NSW Health workforce. NSW Health's *Personal Protective Equipment (PPE) Strategy* describes the learnings and challenges during the COVID-19 pandemic in sourcing and distributing PPE. It sets out the systems and methods for distributing PPE to staff and patients and focuses on how staff are kept informed on the appropriate use of PPE at all times. A supporting communications strategy has been developed to support its implementation.

The strategy contains enhanced transparency measures to regularly inform staff about PPE stock levels and to provide data about PPE usage rates by item types in wards in NSW hospitals.

The NSW Health PPE strategy describes a changed approach to ordering, storing and allocating PPE. This includes diversifying the supply lines for PPE products to increase supply options in circumstances where supply lines become disrupted. It includes a centralised system for coordinating the supply of hospital PPE through Local Heath District coordination points and centralised distribution points in large hospitals.

Our interviews with hospital PPE stock managers and nurse managers indicate that staff find the new ordering system to be an improvement upon the previous stock ordering method.

According to the *Personal Protective Equipment (PPE) Strategy*, NSW health is upgrading its models for monitoring and benchmarking PPE usage across the health system. Systems are being improved for forecasting demand volumes during business as usual periods and during health emergency surges.

Section two

Appendices

Appendix one – Response from agency

Ms Margaret Crawford
Auditor-General for NSW
Audit Office of NSW
GPO Box 12
Sydney NSW 2001

Our ref H20/131166

Dear Ms Crawford Margaret

NSW Health response to Performance Audit Report – Managing the Health, Safety and Well-being of Nurses and Junior Doctors in High-Demand Hospital Environments

Thank you for your letter of 20 November 2020 seeking NSW Health's formal response to your performance audit report on *Managing the Health, Safety and Wellbeing of Nurses and Junior Doctors in High-Demand Hospital Environments.*

The health, safety and wellbeing of our frontline staff has never been of more importance than during the current COVID-19 pandemic. The outcomes achieved by NSW Health during this challenging time are a testament to the dedication of our staff and the systems and frameworks which provide assurance on their safety.

In reading the audit report, it is important to note that its content reflects a moment in time in the early phase of the COVID-19 pandemic. As the pandemic setting has evolved, significant work has been undertaken to strengthen staff knowledge and confidence in policies and practices associated with operating in a COVID-safe fashion.

Following a review of the audit report I can advise that all recommendations are accepted by NSW Health and will be incorporated into planned activity. In responding, I would like to highlight the following points:

1. The findings and recommendations of the audit report regarding workforce support and incident reporting need to be considered through an understanding of NSW Health's governance model. Local Health Districts and Specialty Networks assess and mitigate incidents as most appropriate to their local setting, rather than being directed by the Ministry of Health.

   Within this context, there is an expectation that workplace issues such as those highlighted would be subject to local surfacing and resolution, assisted by the extensive requirements of relevant employment awards, legislation and policy which have been purposely designed to mitigate these issues.

2. A key feature of NSW Health's successful response to the COVID-19 pandemic has been the centralised oversight of performance, strategy and policy development by the Ministry of Health and governed through weekly state-wide pandemic meetings with all NSW Health Chief Executives. Through this mechanism, all frontline services have been informed of developments as the pandemic has evolved.

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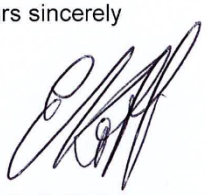
This approach has been further strengthened through the role of the NSW Chief Health Officer in directing the 16 public health units within Local Health Districts and Specialty Networks and also in the rapid establishment by the Ministry of Health of centralised procurement functions through HealthShare NSW and clinical advice and guidance with regard to the use of personal protective equipment by the Clinical Excellence Commission.

Collectively, these processes form a network of resources for the Health System and ensure the provision of consistent advice to all frontline staff.

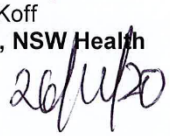
In addition to the above points, please find attached to this letter a summary of NSW Health's responses to the individual recommendations made in this report. I thank you and the lead auditors for your ongoing engagement with NSW Health and its representatives during this audit program.

Yours sincerely



Elizabeth Koff
Secretary, NSW Health

Encl.



Recommendation	NSW Health Response	
By December 2021, NSW Health should:		
1. Evaluate the effectiveness of the new incident management system to enable full reporting of health and safety incidents and risks in all hospital wards, including those where incidents and risks are common and monitor for consistency of reporting over time.	Accept	The Clinical Excellence Commission has led the implementation of a new incident management system, IMS+, across the Health System. IMS+ has been developed specifically for NSW Health and enables staff to report clinical, work health and safety and corporate incidents in a timely and effective manner. The system has also been developed to enable analysis of data on a state-wide level, to guide the identification, assessment and mitigation of risks. In 2021, the effectiveness of IMS+ will be assessed as part of a planned program evaluation process, giving consideration to the findings of this report.
2. Expand the categories of hospital incident data reported to Ministry executives in the Work Health and Safety Dashboard reports - including by linking injury data to incident types by hospital ward category and monitor in conjunction with Local Health Districts for emerging trends and improvement over time.	Accept	The Ministry of Health will review the current dashboard reporting structure to include information on ward category and other data which may assist in identifying system-wide trends for investigation. Consideration will also be given to how data from the new IMS+ system can be used to enhance reporting. The Ministry will continue to work with the Local Health Districts to identify emerging trends and to support Districts in preventing and responding to incidents at a local level.
3. Ensure that nurses and junior doctors have regular opportunities to report on their psychological health and wellbeing, and that system managers have access to aggregate information to guide responses to mitigate these risks.	Accept	For junior doctors, The Ministry of Health will conduct the third and final *Your Training and Wellbeing Matters* survey in 2021. Post 2021, the Medical Board of Australia's annual survey of trainee doctors will be used to collect relevant data, with a focus on health and wellbeing. Aggregated data will be reported by facility and made available to relevant staff in each Local Health District and Specialty Network. The Ministry will also investigate options for engaging with nursing staff over the same time period.

Recommendation	NSW Health Response	
4. Develop and implement an evidence based guiding framework and strategy to support hospital staff in the aftermath of traumatic or unexpected workplace incidents and monitor implementation.	Accept	In collaboration with key Health System leads, the findings of this audit will be reviewed and incorporated into activity. Of note, NSW is enacting new legislation with respect to the management of serious incidents from 14 December 2020. At this time a new NSW Health Incident Management policy directive will be introduced. Among other enhancements, the new policy will set revised requirements for the assessment and escalation of risk and will also give a focus to supporting staff psychological wellbeing following a serious clinical incident.
5. At regular intervals, publicly report aggregate Root Cause Analysis data detailing the hospital system factors that contribute to clinical incidents.	Accept	The Clinical Excellence Commission will continue to publicly report aggregate root cause analysis data relating to serious clinical incidents, in order to outline key systems factors that contribute to clinical incidents. The effectiveness of this practice will be assessed with respect to the findings of this report and to identify where enhancements can be made.
6. Develop and implement a systemwide platform for sharing research and information about hospital health and safety initiatives across the health system.	Accept	The Ministry of Health will consider opportunities to facilitate information sharing to guide development and implementation of a system-wide platform, in consultation with key stakeholders within NSW Health, including the Clinical Excellence Commission, HealthShare NSW and Local Health Districts and Specialty Networks.
7. Conduct a post-pandemic 'lessons learned' review focusing on the effectiveness of key strategies deployed in the management of the COVID-19 pandemic and making policy and operational recommendations for future pandemic response. In particular, ensure: a) regular scenario based pandemic training for hospital staff b) updated policies and protocols on hospital infection controls c) capability to upscale authoritative communication with frontline health workers at the earliest notification of a health emergency and for the duration of the emergency d) systems and safeguards to ensure the availability of clinically appropriate personal protective equipment (PPE) during all phases of a pandemic.	Accept	The Ministry of Health will lead a review on NSW Health's response to the COVID-19 pandemic, to inform planning for future pandemic response. It is proposed that this work will be completed when appropriate to do so, post-pandemic. The points highlighted by this recommendation will be included in the terms of reference for review, among other items of priority for the Health System.

Appendix two – Audit methodology

NSW Health is the auditee, with a focus on the Ministry of Health and its pillar organisations including the Clinical Excellence Commission and HealthShare NSW; all 15 Local Health Districts and the Children's Hospital Speciality Health Network.

The following are not auditees: SafeWork NSW; the State Insurance Regulatory Authority and iCare (the NSW Government agency managing insurance for injured health staff); and St Vincent's Health Network.

This audit does not assess the management of injured hospital staff being supported outside of the workplace.

Methodology:

The following methods were used to source evidence for the performance audit:

Methods to assess health and safety during business as usual in hospital environments

- Assessment of Ministry of Health documents describing work health and safety data collections, NSW Health survey information, COVID-19 circulars, communication with the workforce, NSW Health web-based materials, NSW Health policies, regulations and laws governing the health and safety of nurses and junior doctors.
- Meetings with the Ministry of Health, the Clinical Excellence Commission, SHEOC members, the NSW AMA, and the NSW Nurses and Midwives Association.
- Interviews with 15 Local Health District Executive teams and the Sydney Children's Hospital Specialty Health Network.
- Interviews with nurses and junior doctors from four selected Local Health Districts about health and safety during business as usual periods. Interviews were conducted with:
  - Nurses: 83 nurses from 13 hospitals including 14 nurse unit managers
  - Junior Doctors: 35 junior doctors from ten hospitals. (Four junior doctors were in their first year).

Methods to assess health and safety during COVID-19

- Assessment of Ministry of Health documents describing work health and safety data collections, COVID-19 circulars, Communications with the workforce, NSW Health web-based materials, NSW Health policies, regulations and laws governing pandemic preparations.
- Meetings with the Ministry of Health, the Clinical Excellence Commission, SHEOC members, HETI, HealthShare NSW.
- Interviews with 15 nurse managers from emergency departments focussed on COVID-19 at a selected hospital in each of the 15 Local Health Districts. Hospitals were selected by Local Health District executives on the basis that they were most likely to test and treat COVID-19 patients.
- Interviews with 15 nurse managers from intensive care units focussed on COVID-19 at a selected hospital in each of the 15 Local Health Districts. Hospitals were selected by Local Health District executives on the basis that they were most likely to test and treat COVID-19 patients.
- Interviews with 15 PPE stock managers focussed on COVID-19 across all of the 15 Local Health Districts.
- In-depth COVID-19 briefing sessions with three Local Health District executive teams

Appendix three – About the audit

Audit objective

This audit assessed the effectiveness of NSW Health in managing the health, safety and wellbeing of nurses and junior doctors in high demand hospital environments.

Audit criteria

We addressed the audit objective by assessing whether NSW Health has:

1. established effective systems, forums and workplace cultures to
   - support the reporting of work health and safety concerns, and
   - generate data and information that reflects the full nature and extent of risk
2. taken all reasonable steps to create safe workplaces and respond to health and safety risks as they emerged
3. taken effective action to continuously improve work health, safety and staff wellbeing in hospital environments.

Audit scope and focus

In assessing the criteria, we examined NSW Health's actions to support the health, safety and wellbeing of nurses and junior doctors during business as usual periods and during the period of preparations and responses to the COVID-19 health emergency - from January to August 2020.

Audit exclusions

The audit did not examine:

- SafeWork NSW
- State Insurance Regulatory Authority and iCare (the NSW Government agency managing insurance for injured health staff)
- The St Vincent's Health Network
- Justice Health and Forensic Mental Health Network
- Public Mental Health Hospitals and Private Hospitals
- Non-clinical health staff
- Fully qualified doctors and medical specialists.

Audit approach

Our procedures included:

1. Interviewing:
   - executives from the Ministry of Health, the Clinical Excellence Commission, the SHEOC, HETI, HealthShare NSW
   - executive teams from all Local Health Districts and the Sydney Children's Hospital Specialty Health Network
   - nurses and junior doctors from a selected range of Local Health District hospitals and from the Sydney Children's Hospital Specialty Health Network
   - PPE stock managers in all Local Health Districts

2. Examining:
    a) a range of NSW Health's work, health and safety documents - including policies, protocols and procedures
    b) NSW Health web-based materials
    c) regulations and laws governing the health and safety of nurses and junior doctors
    d) COVID-19 circulars and email communication with the workforce

3. Analysing data:
    a) health and safety data from NSW Health's Incident Information Management System
    b) staff compensation data for injuries sustained in hospital workplaces
    c) Root Cause Analysis data about the factors leading up to clinical incidents in hospitals.

The audit approach was complemented by quality assurance processes within the Audit Office to ensure compliance with professional standards.

Audit methodology

Our performance audit methodology is designed to satisfy Australian Audit Standard ASAE 3500 Performance Engagements and other professional standards. The standards require the audit team to comply with relevant ethical requirements and plan and perform the audit to obtain reasonable assurance and draw a conclusion on the audit objective. Our processes have also been designed to comply with requirements specified in the *Public Finance and Audit Act 1983* and the *Local Government Act 1993*.

Acknowledgements

We gratefully acknowledge the co-operation and assistance provided by the Ministry of Health and its Pillar Agencies, all Local Health Districts and the Sydney Children's Hospital Specialty Health Network and SHEOC executives. We gratefully acknowledge the co-operation and assistance of the nurses and junior doctors who participated in our audit interviews

Audit cost

The estimated cost of this audit including overheads is $557,300.

Appendix four – Performance auditing

What are performance audits?

Performance audits determine whether State or Local Government entities carry out their activities effectively, and do so economically and efficiently and in compliance with all relevant laws.

The activities examined by a performance audit may include a government program, all or part of an audited entity, or more than one entity. They can also consider particular issues which affect the whole public sector and/or the whole Local Government sector. They cannot question the merits of government policy objectives.

The Auditor-General's mandate to undertake performance audits is set out in section 38B of the *Public Finance and Audit Act 1983* for State Government entities, and in section 421D of the *Local Government Act 1993* for Local Government entities.

Why do we conduct performance audits?

Performance audits provide independent assurance to the NSW Parliament and the public.

Through their recommendations, performance audits seek to improve the value for money the community receives from government services.

Performance audits are selected at the discretion of the Auditor-General who seeks input from parliamentarians, State and Local Government entities, other interested stakeholders and Audit Office research.

How are performance audits selected?

When selecting and scoping topics, we aim to choose topics that reflect the interests of Parliament in holding the government to account. Performance audits are selected at the discretion of the Auditor-General based on our own research, suggestions from the public, and consultation with parliamentarians, agency heads and key government stakeholders. Our three-year performance audit program is published on the website and is reviewed annually to ensure it continues to address significant issues of interest to Parliament, aligns with government priorities, and reflects contemporary thinking on public sector management. Our program is sufficiently flexible to allow us to respond readily to any emerging issues.

What happens during the phases of a performance audit?

Performance audits have three key phases: planning, fieldwork and report writing.

During the planning phase, the audit team develops an understanding of the audit topic and responsible entities and defines the objective and scope of the audit.

The planning phase also identifies the audit criteria. These are standards of performance against which the audited entity, program or activities are assessed. Criteria may be based on relevant legislation, internal policies and procedures, industry standards, best practice, government targets, benchmarks or published guidelines.

At the completion of fieldwork, the audit team meets with management representatives to discuss all significant matters arising out of the audit. Following this, a draft performance audit report is prepared.

The audit team then meets with management representatives to check that facts presented in the draft report are accurate and to seek input in developing practical recommendations on areas of improvement.

A final report is then provided to the head of the audited entity who is invited to formally respond to the report. The report presented to the NSW Parliament includes any response from the head of the audited entity. The relevant minister and the Treasurer are also provided with a copy of the final report. In performance audits that involve multiple entities, there may be responses from more than one audited entity or from a nominated coordinating entity.

Who checks to see if recommendations have been implemented?

After the report is presented to the NSW Parliament, it is usual for the entity's audit committee to monitor progress with the implementation of recommendations.

In addition, it is the practice of Parliament's Public Accounts Committee to conduct reviews or hold inquiries into matters raised in performance audit reports. The reviews and inquiries are usually held 12 months after the report received by the NSW Parliament. These reports are available on the NSW Parliament website.

Who audits the auditors?

Our performance audits are subject to internal and external quality reviews against relevant Australian and international standards.

The Public Accounts Committee appoints an independent reviewer to report on compliance with auditing practices and standards every four years. The reviewer's report is presented to the NSW Parliament and available on its website.

Periodic peer reviews by other Audit Offices test our activities against relevant standards and better practice.

Each audit is subject to internal review prior to its release.

Who pays for performance audits?

No fee is charged for performance audits. Our performance audit services are funded by the NSW Parliament.

Further information and copies of reports

For further information, including copies of performance audit reports and a list of audits currently in-progress, please see our website www.audit.nsw.gov.au or contact us on 9275 7100.

Professional people with purpose

OUR VISION

Our insights inform and challenge government to improve outcomes for citizens.

OUR PURPOSE

To help parliament hold government accountable for its use of public resources.

OUR VALUES

Pride in purpose

Curious and open-minded

Valuing people

Contagious integrity

Courage (even when it's uncomfortable)

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