Building a Better Health Service
CARE COMPASSION TRUST LEARNING

Healthcare Audit

End of year Report 2017

Quality Assurance and Verification Division

February 2018

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1. Introduction

Healthcare Audit (HCA) is an objective, internal assurance activity designed to add value and improve the safety and quality of health and social care services. As part of the Quality Assurance and Verification Division (QAVD) it plays a key role in the assurance framework of the Health Service Executive (HSE). It supports senior management at local and national level by providing a systematic, disciplined approach to evaluating and improving the effectiveness of their governance, accountability, control and risk management processes.

The primary aim of HCA is to seek sufficient evidence to provide a level of assurance to local and national senior management on the quality and safety of health and social care services. HCA makes recommendations to inform quality improvement and supports the HSE in achieving the goals set out in the Corporate Plan (2015-2017) by:

- Providing valuable and evidence based information to inform decision making on quality improvement at local and national level,
- Testing the effectiveness of internal controls that are identified to manage risk,
- Providing evidence for managers in relation to signing the Statement of Internal Control, and
- Identifying good practice for sharing, learning and implementation across the system.

2. Rapid Appraisal 2017

In 2017 a new Assistant National Director was appointed to HCA and one of the first tasks they undertook was to engage with stakeholders to conduct a rapid appraisal of the work carried out by the function.

The aim of the appraisal was to inform the future approach and methods of HCA and how best to identify and prioritise the audit programme. This resulted in nine actions that stakeholders believed were required to bring HCA from where it is to where it could be to deliver higher quality audit data and intelligence to have optimum assurance and to contribute to sustainable improvement in service user outcomes.

The recommendations arising from the rapid appraisal will underpin the development of HCA and how audits are prioritised from 2018 into the future. The findings of the appraisal identified the need to develop a three year HCA Strategy and increase the number and organisation wide coverage of audits. While HCA will continue to respond and engage with requests for audits from within the HSE, future audit programmes will be primarily based on, for example:

- Emerging safety concerns,
- Issues that affect and are of concern to patients and service users,
- Risk and gaps in the controls assurance process, and
- Themes from analysis of serious incidents and complaints.

Arising from the rapid appraisal of HCA in 2017, more robust processes for monitoring and reporting on the implementation of recommendations are being developed with a view to strengthening governance and accountability in the HSE and this will be a priority for 2018.

The rapid appraisal also identified the need to continue improving the capability, capacity and profile of the HCA team to deliver more sophisticated audits that provide enhanced information and intelligence on the safety and quality of health and social care services. This included the

need to build capacity for local areas to conduct local audits with the HCA team conducting validation audits of these.

3. Staffing

During this year, four additional Healthcare Auditors were recruited. This brings the size of the team to 17.

4. Healthcare Audits Completed and in Progress

The HCA team undertook a planned programme of audits across the organisation. The following sets out an overview of the work carried out.

Tables 1 and 2 below outline the national audits completed by the HCA team in 2017 and those in progress at year end. Individual audits across ***33*** sites on seven national policies or processes were completed. Individual audit reports were issued to the services concerned. A further ***5*** audits covering ***45*** sites were commenced in 2017 and these are due to be completed in quarter one and early in quarter two in 2018. It should be noted that the average number of audit sites per national audit for audits completed in 2017 was 4.71. The average number of audits sites for national audits in progress in December 2017 was 9. This represents a significant increase in audit activity which has been made possible by the increase in HCA staffing which occurred in 2017.

Executive summaries on each national audit, combining the main findings and recommendations, were issued to the relevant National Director of the service or area subject to audit. These were also published to the HSE website.

Table 1: Audits completed in 2017

Ref Code	Audit Theme	Number of Audit Sites	Requested By	Completed
QAV003/2016	Audit of National **Open Disclosure** Policy in selected acute hospitals	4	Quality Improve. Division	30/1/17
QAV006/2016	Audit of the implementation of informed consent and supported decision making practices as Part 1 of the **National Consent Policy** (2014)	4	Quality Improve. Division	30/1/17
QAV 007/2016	Audit of compliance with Section 7 of the National Ambulance Service (NAS) Policy on the **Management of Controlled Drugs** (including morphine sulphate and midazolam) (2010)	6	National Ambulance Service (NAS)	10/5/17
QAV008/2016	Audit of compliance with the **Irish Paediatric Early Warning System** – National Clinical Guideline No.12	4	Acute Hospitals	24/5/17
QAV010/2016	Audit of the **justification process in diagnostic radiology** in selected locations	6	QAVD	21/7/17
QAV001/2017	Audit of compliance with National Ambulance Service (NAS) procedure on appropriate **hospital access for suspected stroke patients**.	3	National Ambulance Service (NAS)	28/9/17
QAV003/2017	Audit of the integrated risk management process based on the HSE **Integrated Incident Management Policy**	6	QAVD	19/12/17

Table 2: Audits in progress in December 2017

Ref. Code	Audit Title	Number of Audit Sites	Requested By	Expected Completion
QAV002/2017	Audit of compliance with Section 7.2.3 of the Safety Incident Management Policy 2014 in relation to the **decision not to proceed to investigation of serious reportable events (SREs)**	9	QAVD	January 2018
QAV004/2017	Audit of the Health Service Executive (HSE) National Counselling Service(NCS) Guidelines on **Risk Management and Child Protection** in the context of Counselling / Therapy (December 2012) with specific reference to the referral documentation sent by the NCS to TUSLA-The Child and Family Agency.	10	Mental Health	March 2018
QAV005/2017	Audit of Implementation of selected recommendations from the National Clinical Guidelines on the **National Early Warning Score** (2014)	9	Acute Hospitals	April 2018
QAV006/2017	Audit of compliance with implementation of **Clinical Handover (Communication)** in acute hospital services. children's hospital services and maternity services as set out in the National Clinical Guidelines (NCGs) No 5 and No 11	9	Acute Hospitals	April 2018
QAV007/2017	Audit of compliance against Standard 3 of the HSE Standards and Recommended Practices for **Healthcare Records** in Intellectual Disability Services and Maternity Services	8	QAVD	April 2018

5. Healthcare Audits Completed 2011 – 2017

Since January 2011, 76 audits on various national policies and other HSE processes have been completed, which involved visits to 322 sites. The table below presents a breakdown of national audits by the requesting HSE Division.

Table 2: Distribution of audits by national division in 2017 and 2011-2017

Requesting Division	2017				Jan 2011 – Dec 2017	
	National Audits Completed	Audit Sites Completed	National Audits in Progress	Audit Sites in Progress	National Audits Completed	Audit Sites Completed
Acute	1	4	2	18	28	138
Primary Care	0	0	0	0	2	2
Mental Health	0	0	1	10	5	16
Social Care	0	0	0	0	12	35
QAVD	2	12	2	17	18	61
QID	2	8	0	0	3	12
Child & Family Services	External to HSE				1	6
Clinical Programmes	0	0	0	0	1	9
NAS	2	9	0	0	4	20
ONMSD	0	0	0	0	1	11

Health & Wellbeing	0	0	0	0	1	12
Totals:	**7**	**33**	**5**	**45**	**76**	**322**

6. Healthcare Audit Recommendations 2017

Audit site reports containing local recommendations were issued to the senior most accountable person for implementation in the service concerned.

Summary reports for national audits were issued to the senior most accountable person in the relevant HSE division. These set out recommendations for implementation at national level and any good practice initiatives found during an audit so that they can be shared across the system as appropriate.

National recommendations inform the senior most accountable person in the service or area subject to audit of the necessary actions required to address identified deficits. The local recommendations made at site or service level are detailed in an appendix to the summary report.

Progress on the implementation of recommendations is periodically reported to HCA by the relevant national division. Any areas of concern can be subject to re-audit at the request of the National Director of QAVD.

39 recommendations were made in respect of the seven national audits completed in 2017. Recommendations can be considered under a number of themes, for example, "policies, procedures, protocols and guidelines (PPPGs)" refer to a recommendation to revise a policy whilst a recommendation on "communication" refers to improving information sharing, learning from incidents, collaboration across divisions and hospital groups, etc. The number and percentage of recommendations pertaining to each theme are outlined below.

Table 3: National recommendations by theme January – December 2017

Recommendation Theme	Number	Percentage
Communication	2	5%
Local Audit	1	2%
Documentation and Records Management	19	49%
Policies, Procedures, Protocols and Guidelines (PPPGs)	9	23%
Risk Management and Controls	5	13%
Training / Supervision	3	8%
Total	**39**	**100%**

Analysis of the top six categories of recommendations made over the last four years 2014 to 2017 (see Table 4 below), illustrates that there was significant growth this year for recommendations made in relation to documentation/records management and PPPGs.

There was however a notable decrease in the number of recommendations related to communication and training and supervision.

It is important to note that the change in percentage rates from year to year is a reflection of the type of national audits selected for the HCA programme in that year and this accounts for what may seem like a dramatic increase or decrease in one particular theme.

Table 4: Top Recommendations by Theme 2014 – 2017

Recommendation Theme	2014	2015	2016	2017
Communication	12%	12%	27%	5%
Documentation and Records Management	24%	27%	20%	49%
Governance / Accountability	18%	10%	5%	0%
PPPGs	14%	12%	10%	23%
Risk Management and Controls	5%	7%	12%	13%
Training / Supervision	15%	16%	17%	8%

7. Conclusion

During 2017 the HCA team completed ***7*** national audits across ***33*** sites. This significant amount of work contributed evidence based recommendations at local level to support services to develop quality improvement plans for individual health and social services. The national recommendations that emanated from these audits provided valuable information and intelligence to HSE National Directors to inform decision making and overall development of higher quality, responsive and consistent services nationwide.

It is important to note that audits are only of use to services if recommendations are specific, measurable, attainable, realistic and time-framed (SMART). Implementation of HCA recommendations continues to be a challenge across the HSE. The HSE is reviewing processes around the monitoring and implementation of healthcare audit recommendations with a view to strengthening governance and accountability and this will be a priority for 2018.

Implementation of the findings from the rapid appraisal in the coming year will present exciting opportunities for the HCA Team and we will continue to keep the safety and quality of services to patients and service users at the heart of our work. To this end, we have commenced placing patients and service user representatives at the centre of our work on developing HCA plans and procedures. We will continue to improve our HCA methods and in turn increase the usefulness of HCA data for quality assurance and better patient and service user outcomes.

I would like to thank all the divisions and services for their support and co-operation in the conduct of the audits.

I would like to finish by acknowledging the performance, dedication and commitment of the HCA team who as a developing assurance service continues to make a positive difference to the quality and safety of patient and service user care in the HSE. HCA as an assurance service will continue to be an essential component of the assurance framework under the auspices of the National Director of the QAV Division. Ms. Cora McCaughan

Assistant National Director, Healthcare Audit, Quality Assurance and Verification Division.

Appendix 1

Summary of Objective, Scope and Recommendations of National Audits in 2017

Open Disclosure

QAV 003/2016 - Audit of the National Open Disclosure Policy in selected acute hospitals

Audit Aim/Objective: To establish if there was evidence at hospital level of:

1. Leadership commitment to open disclosure with effective governance processes in place,
2. Training programmes for staff with responsibility for managing the open disclosure process,
3. An acknowledgement, apology or expression of regret and an explanation of the circumstances of the incident to the patient,
4. Information and support to patients, their families and the staff involved in the incident, and
5. Quality improvement and learning outcomes from adverse incidents examined.

Number of Individual Sites Audits: 4 (All acute hospital sites)

Details of Sites: Sligo University Hospital, Mercy University Hospital Cork, Connolly Hospital and the Rotunda Hospital

Key Audit Findings: The audit team was able to provide reasonable assurance that the open disclosure policy was operating effectively across all four sites included in the audit. Evidence suggested that implementation of the national policy was governed appropriately, that open disclosure was practiced in a timely manner and that it was well co-ordinated between senior management and medical staff. Documentation of open disclosure in the healthcare record was evident but it was inconsistent with regard to the level of detail and the approach taken. There was no evidence of the evaluation of the effectiveness of the open disclosure training programme.

Audit Recommendations:

The National Director of Acute Hospitals must ensure that:

1. A standardised approach is followed with regard to documenting open disclosure in the healthcare record.
2. An evaluation of the effectiveness of the open disclosure training programme is undertaken in acute hospitals.

Informed Consent and Supported Decision Making

QAV 006/2016 - Audit of the implementation of informed consent and supported decision making practices as per Part 1 of the National Consent Policy (2013)

Audit Aim/Objective: To establish the level of implementation of Part 1 of the National Consent Policy in selected sites through the following:

1. Establish the level of managerial and clinical support for the policy to include communication and staff education on the consent policy,
2. Establish from selected sites the number of incidents and complaints received in relation to informed consent practices in the previous 12 months,
3. Review healthcare records in selected sites for evidence of documented practices of informed consent, and
4. Ascertain service user experience in the communication of informed consent practices.

Number of Individual Sites Audits: 4 sites (1acute hospital site, 1 rehabilitation hospital site, 1 primary care centre site, and 1 long stay service for older people site)

Details of Sites: Portarlington Primary Care Centre, St. Johns Community Hospital Wexford, Mayo University Hospital and the National Rehabilitation Hospital

Key Audit Findings: Based of the available evidence the audit team could provide limited assurance on the implementation of the National Consent Policy (Part 1) in all four sites included in the audit. There was no evidence of a co-ordinated approach to communication and circulation of the policy. The responsibility for training on the policy was devolved to each health and social care discipline but it was found to be ad-hoc and lacked a planned approach. However, the team could provide reasonable assurance that written consent for all operative or invasive procedures and social care interventions were documented in the healthcare records. Finally, as there were no formal complaints made in the sites concerned the audit team were not in a position to make any findings on this issue.

Audit Recommendations:

1. The senior most accountable person at national level in the acute, primary and social care divisions must develop a framework for implementation of the National Consent Policy in order to ensure a co-ordinated approach to the communication and training for all health and social care staff

Management of Controlled Drugs in the National Ambulance Service

QAV 007/2016 - Audit of compliance with Section 7 of the National Ambulance Service (NAS) Policy on the Management of Controlled Drugs (including morphine sulphate and midazolam) 2011

Audit Aims/Objectives: To provide assurance that ambulance stations were compliant with the NAS Policy on Controlled Drugs 2011. More specifically, the objective of the audit was to assess the level of compliance at a sample of locations with the requirements of section 7 of the NAS policy

Number of Individual Sites Audits: 6 (i.e. 6 ambulance stations from 3 HSE regions)

Details of Sites: Merlin Park Galway, Roscommon, Cork City, Waterford, Tallaght and Tullamore

Key Audit Findings: Based on available evidence the audit team could not provide reasonable assurance that the six ambulance stations included in the audit were fully compliant with all aspects of section 7 of the NAS policy. The audit team identified inconsistencies in countersigning and witnessing of stock movements within the various Controlled Drug Station Record Books and the manner in which disposals were recorded

Audit Recommendations:

1. The NAS Policy for the Management of Controlled Drugs must be amended as follows:
    - All numbering and section headings must be corrected,
    - Reference must be made to the relevant clinical directives (ref 02/2011 and 07/2015) issued since publication of the 2011 policy regarding the amendment to section 7.5 on the disposal of unused or damaged ampoules, the introduction of Fentanyl, and the cessation of the use of oral morphine and oral midazolam,
    - Reference should be made to the changes with regard to the storage and documentation arrangements for Buccolam,
    - A table should be included outlining the schedule of each controlled substance covered by the policy, together with the necessary storage, security and documentation requirements according to the Misuse of Drugs Act 1997, 1884 and 1988, and
    - Consider and address where necessary, those practices highlighted in the audit report which were at variance with practices found at other stations included in the audit.
2. Management must seek confirmation from all stations of the key safe code(s) currently in use and clarify (by way of a policy revision, if necessary) the requirements around changing the codes on station safe keys.
3. Management must consider whether, in light of the findings in this audit report, the policy is appropriately worded regarding the use of (and register of) Controlled Drugs Requisition Books (paragraphs (7.2.6 and 7.2.7 on page 5 of the policy), to ensure that NAS issued books are used for their sole intended purpose and full traceability.
4. Management must clarify (by way of a policy revision, if necessary) the requirements around the disposal of unused or damages ampoules as follows:
    - What details are required to be recorded regarding the disposals of partly used or damaged ampoules,
    - Where details are to be recorded, i.e., on the patient care records and within the various Controlled Drugs Station Record Books, and
    - Whether the revised requirements necessitate the production, distribution and use of a new Controlled Drug Station Record Book, which should take place without delay, and that the design of the new books should also remove reference to controlled substances no the subject of the policy.

Once amended, the policy should be revised and communicated formally to all NAS ambulance stations and personnel.

Irish Paediatric Early Warning System

QAV008/2016 - Audit of compliance with the Irish Paediatric Early Warning System–National Clinical Guideline (NCG) No.12

Audit Aim/Objectives: To establish if there was evidence of:

1. An appropriately documented paediatric early warning system (PEWS) chart to include scoring of the six core physiological parameters and additional parameters (recommendations 3 & 4 NCG),
2. Adherence to the escalation guideline for PEWS (recommendation 6 & 8 NCG),
3. PEWS training undertaken at site level (recommendation 16 NCG), and
4. PEWS audits undertaken at site level (recommendation 18 NCG).

Number of Individual Site Audits: 4 (3 acute hospital sites and 1 paediatric hospital site)

Details of Sites: Cork University Hospital, Temple Street Children's University Hospital, Midland Regional Hospital Portlaoise and Portiuncula University Hospital

Key Audit Findings: The audit team could provide limited assurance that PEWS was appropriately documented to include scoring of the six core physiological parameters and additional parameters in line with the NCG and or local policy in three of the four hospitals included in the audit. In the case of the fourth hospital no assurance could be given on this. On adherence to the escalation guideline limited assurance was given to all four hospital sites

Two hospitals had evidence of a PEWS training programme in line with the NCG. A further hospital could be given limited assurance on this and no assurance could be given to the remaining hospital.

Once hospital had evidence of a robust culture of local auditing and limited assurance on this could be given to two further hospitals. In the case of the remaining hospital no assurance could be given as there was no evidence of local auditing on PEWS.

Audit Recommendations

The National Director for Acute Hospitals must ensure that all acute hospitals are aware of their responsibilities and accountability for the effective implementation of PEWS as a nationally agreed tool and standard. More specifically, the National Director must:

1. Ensure that an evaluation of the effectiveness of PEWS training is undertaken in all relevant acute hospitals.
2. Liaise with the PEWS Steering Group to ensure a review of the education on and the positioning of the 'frequency of observations' and 'reassess within' variables on the PEWS chart, given the low percentage of compliance with completing these variables where they were clinically required.
3. Communicate/circulate to all hospitals the following recommendations which were common to all four audit sites and the need for all hospitals to ensure their compliance with same.

- PEWS charts must be documented in line with the national guidelines as follows:
    - All relevant staff must document all core parameter scores on the PEWS chart and ensure that the overall score is correct to deliver an effective clinical response,
    - Nursing staff must complete the 'frequency of observations' and 'reassess within' sections as clinically appropriate on the PEWS chart,
    - Nursing staff must complete a full set of observations in the required timeframe (minimum observation frequency specified for PEWS scores) as per each hospitals paediatric observation chart escalation, and
    - The correct PEWS chart for the appropriate age is used at all times.
- All relevant staff must adhere to the local PEWS escalation guide; in particular all staff must document within a child's record the rationale for the decision not to escalate scores of ≥ 3.
- All relevant staff must document within a child's healthcare record any responses to PEWS scores of ≥ 3, so that minimum alert and minimum response are clearly demonstrated.
- Medical staff must date, time and sign all entries in the healthcare records (as per the HSE Standards and Recommended Practices for Healthcare Records Management 2011)
- Medical and nursing staff must include a reference to PEWS scores (when relevant) in the documented management plans.
- Medical staff must document medical escalation suspensions and parameter amendments in the medical management plans as per the standards detailed within the NCG and relevant PEWS User Manuals.

An audit programme must be developed and adhered to in line with the NCG to include patient outcome such as PEWS alert calls audits

Justification Process in Diagnostic Radiology
QAV010/2016 – Audit of the justification process in diagnostic radiology in selected locations **Audit Aim/Objectives: The objectives for this audit were to:** 1. Confirm that selected locations have governance structures, policies, procedures, protocols and guidelines in place that support the justification process, 2. Confirm that selected locations are following the justification principle as outlined in section 5 of the MERU manual, 3. Identify any audits completed and training and education provided on the justification process, and 4. Identify areas of good practice. **Number of Individual Site Audits:** 6 (6 acute hospital sites including 2 private hospitals) **Details of Sites:** Mater Misericordiae University Hospital (Pilot Site), Hermitage Medical Centre, Cork University Hospital, University Hospital Kerry, Galway Clinic, Mayo University Hospital and Our Lady's Hospital Navan

Key Audit Findings: Based on the available evidence the audit team could provide reasonable assurance that all six hospitals had governance structures and PPPGs in place to support the justification process and were engaged in local auditing and training. Reasonable assurance could also be provided that five hospitals had appropriate documentation in place to support the justification principle as set out in section 5 of the MERU manual. Limited assurance was provided to the one remaining site on this issue.

Recommendations:

The most senior accountable person for Medical Exposure Radiation Unit (MERU) must:

1. Amend section 5 of the Radiation Protection Manual to include further guidance for all facilities using medical ionising radiation regarding a local justification protocol. Based on the findings for this audit, the protocol must include the following:
   - Guidance to the practitioner in charge regarding the formal delegation of authority to justify procedures and that this practice must be formally documented in the local procedure, and
   - Guidance regarding the requirements in relation to comforters and carers and that this must be reflected in the local comforters and carers policy.

Once amended, section 5 of the Radiation Protection Manual should be reissued and communicated formally to all facilities using medical ionising radiation

National Ambulance Service Hospital Access for Suspected Stroke Patients

QAV001/2017 - Audit of compliance with National Ambulance Service (NAS) procedure on appropriate hospital access for suspected stroke patients

Audit Aim/Objectives: The overall aim of this audit was to provide assurance that NAS comprising South, West and North Leinster areas were compliant with the procedure for Appropriate Hospital Access for Suspected Stoke Patients. More specifically, this audit was to establish whether the procedure for initiating appropriate hospital access for a suspected stroke patient was adhered to and documented in relation to:

1. Assessment and documentation of FAST[1],
2. Documentation of the four hour timeframe between symptom onset and hospital destination for patients, and
3. Documentation of the appropriate hospital and that the destination was pre alerted regarding patients with a positive FAST.

Number of Individual Site Audits: 3 (Desktop audit of patient care records in 3 HSE regions)

Details of Sites: NAS North Leinster, NAS West and NAS South

Key Audit Findings: Based on the available evidence the audit team could not provide reasonable assurance that the NAS were compliant with NAS procedure (NASCG 010). The primary areas of

[1] FAST is an acronym for the test taken for suspected victims of stroke and stands for facial drooping, arm weakness, speech difficulties and the time to call emergency services.

non-compliance were as follows:

1. A lack of consistency was found in the documentation examined in respect of the times recorded by ambulance personnel,
2. Achievement of the four hour timeframe could not be established in one third of the patient care records reviewed, and
3. The pre alert time was not documented in 87% of patient care records that had a FAST positive test recorded.

Audit Recommendations: The senior most accountable person in the NAS must establish the causal factors for non-compliance with the NASCH 010 and put in place measures to ensure the following is adhered to:

1. Clarification of the time of the FAST assessment to be recorded and its documentation on the patient care record.
2. Documentation of the key times to determine the four hour timeframe on the patient care record.
3. Documentation of the pre alert time on the patient care records.
4. Documentation of the current standard abbreviations for all hospitals on the patient care record.

Integrated Risk Management Process

QAV003/2017 - Audit of the integrated risk management process based on the HSE Integrated Incident Management Policy

Audit Aims/Objectives: The aim of this audit was to provide assurance that the Integrated Risk Management Policy was being implemented and more specifically to:

1. Establish, on a sample basis, whether risks had been appropriately identified, assessed and treated, recorded and monitored at divisional, acute hospital group and community healthcare organisational levels as per the policy.
2. Determine for selected facilities whether, based on available evidence, that risk had been considered appropriately by management, and whether effective communication and notification of risk had taken place as per the policy

Number of Individual Site Audits: 6 (2 hospital group sites, 2 community healthcare organisation sites, and 2 national division sites)

Details of Sites: University of Limerick Hospital Group, Royal College of Surgeons in Ireland Hospital Group, Community Healthcare Organisation Area 5, Community Healthcare Organisation Area 1, Mental Health Division and Acute Hospital Division

Key Audit Findings: Based on available evidence the audit team could provide reasonable assurance that one hospital group and two national divisions had appropriately identified, assessed, treated, recorded and monitored risks under the Integrated Risk Management Policy. Reasonable assurance can also be given to one further hospital group but it was noted that the

manner in which some information was recorded on the risk assessment forms and register was not in line with the policy. Limited assurance was given to the two community healthcare organisations.

Reasonable assurance could be given to the consideration, communication and notification of risks in alignment with the policy in the hospital groups and national divisions subject to audit. Limited assurance was given to the two community healthcare organisations.

Audit Recommendations:

1. A stand-alone risk register for community healthcare organisation (CHO) A should be established, containing only those risks that are appropriate to a CHO area level risk register, rather than a local health office area level risk register.
2. The deficiencies in the divisional risk registers, and the consequent deficiencies in the corporate risk register as highlighted in table 1 of the audit summary report and throughout the report, should be addressed by management in CHO B as a matter of urgency.
3. All actions undertaken to mitigate risks should be recorded on the risk register by CHO B.
4. Action plans should be developed by CHO B as per the Integrated Risk Management Policy for each 'red' risk, and recorded with the relevant risk on the register.
5. Hospital group A must identify 'risk owners' on the risk assessment forms, and 'due dates' for any actions designed to mitigate the risks.