Report of the ACHS National Safety and Quality Health Service (NSQHS) Standards Survey

The Geelong Clinic

St Albans Park, Victoria

Organisation Code: 22 09 97

Survey Date: 7-9 November 2016

ACHS Accreditation Status: **ACCREDITED**

Disclaimer:
The information contained in this report is based on the evidence provided by the participating organisation at the time of the accreditation survey and information that the organisation supplied through the reporting and editing process. Accreditation issued by ACHS/ACHSI does not guarantee the safety, quality or acceptability of an organisation or its services or programs, or that legislative and funding requirements are being met, or will be met.

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About the Australian Council on Healthcare Standards

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

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

The principles upon which all ACHS programs are developed and the characteristics displayed by an improving organisation are:

- a customer focus
- strong leadership
- a culture of improving
- evidence of outcomes
- striving for best practice.

These principles can be applied to every aspect of service within an organisation.

What is Accreditation?

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

How to Use this Survey Report

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

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

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

1 Survey Team Summary Report
2 Actions Rating Summary Report
3 Recommendations from Current Survey

1 Survey Team Summary Report

Consists of the following:

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

Ratings

Each action within a Standard is rated by the organisation and the survey team with one of the following ratings. The survey team also provides an overall rating for the Standard. If one core action is Not Met the overall rating for that Standard is Not Met.
The report will identify individual actions that have recommendations and/or comments.

The rating levels are:

NM – Not Met
The actions required have not been achieved

SM – Satisfactorily Met
The actions required have been achieved

MM - Met with Merit
In addition to achieving the actions required, measures of good quality and a higher level of achievement are evident. This would mean a culture of safety, evaluation and improvement is evident throughout the hospital in relation to the action or standard under review.

Action Recommendations

Recommendations are highlighted areas for improvement due to a need to improve performance under an action. Surveyors are required to make a recommendation where an action is rated as Not Met to provide guidance and to provide an organisation with the maximum opportunity to improve. Recommendations in the survey report need to be reviewed and prioritised for prompt action and will be reviewed by the survey team at the next on site survey.

Risk ratings and risk comments will be included where applicable. Risk ratings are applied to recommendations where the action rating is Not Met to show the level of risk associated with the particular action. A risk comment will be given if the risk is rated greater than low.
Risk ratings could be:

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular action.
Recommendations are structured as follows:
The action numbering relates to the Standard, Item and Action.

4 Recommendations from Previous Survey

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

The action numbering relates to the month and year of survey and the action number. For example, recommendation number NSQHSS0613. 1.1.1 is a recommendation from a NSQHS Standards Survey conducted in June 2013 with an action number of 1.1.1.

5 Standards Rating Summary Report

This section summarises the ratings for each Standard allocated by the survey team.

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

Survey Report

Survey Overview

The Geelong Clinic was surveyed over a four-day period by two surveyors conducting a review of the National Safety & Quality Health Service Standards (NSQHSS), National Standards for Mental Health Services (NSMHS) and the Trauma Recovery Program (TRP) Standards.

The Geelong Clinic is owned by Healthscope. As a 45 bed private psychiatric hospital, it offers speciality psychiatric services in inpatient, outpatient and outreach modalities. There are specific programs focused on Eating Disorders, Veterans Post Traumatic Stress Disorders, addictive behaviours (including substance withdrawal and rehabilitation) and general high prevalence disorders. Specialised treatments include electroconvulsive therapy and Transcranial Magnetic Stimulation. Through affiliations with Deakin University research and a commitment to enquiry and continuing best practice is fostered. The Clinic provides clinical experience for health professional students. A rotation program provides an opportunity for psychiatric registrars employed through the Barwon public mental health service to gain experience in the private sector.

Close linkages with Geelong Private Hospital, another Healthscope facility exist through having a shared general manager, a shared infection control consultant and access to out-of-hours medical support from that facility. Staff from Geelong Clinic participate in Healthscope "Cluster" meetings. These provide important opportunities for staff to meet with clinicians with similar interests and reflect on current best practice initiatives. Other benefits derived from being a member of the Healthscope group include the access to shared learnings from clinical incidents which may have occurred in other facilities and the opportunities to benchmark data with like facilities.

Both recommendations from the previous survey have been addressed. Suggestions have been made with a view to strengthening the governance of infection control by ensuring that the title, terms of reference and minutes of the current Geelong Private Hospital Committee be revised to reflect the role of this committee in monitoring infection control matters and promoting Standard 3 at The Geelong Clinic. It was noted that a new infection control co-ordinator will need to be shortly appointed and that there is an intention to increase the onsite presence of HICMR - the private organisation which provides infection control advice and support to the organisation.

As a hospital whose role is focused on the provision of mental health services, audit material sighted demonstrated a consistent record of very low or nil occurrences for patient falls, pressure injuries and infections. Surveyors confirmed that appropriate assessment and screening processes are in place.

Surveyors had the opportunity to meet with several consumers. Their feedback was universally positive, appreciative of staff and the organisation's initiatives to provide supportive care in a safe environment. The consolidation and contribution of consumer consultants has been recognised in this survey with a rating of MM for action 2.1.1.

An array of initiatives related to patient safety and risk minimisation have led surveyors to rate MM for actions 1.1.2, 1.2.2 and 1.8.2.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

The organisation provides governance for safety and quality through a variety of clearly identified policies and processes. Strategic Direction is provided by the Healthscope Corporate Safety and Quality Plan 2016/2017. The Geelong Clinic Safety and Quality Work Health and Safety and Infection Control Plan 2016/2017 is congruent with the corporate document. It contains goals for the coming year and evaluation of gaols from the previous plan.

Reporting to the Healthscope Board occurs via the monthly General Manager report which includes detailed sections on quality and compliance with specific commentary on quality Key Performance indicators, patient satisfaction results, accreditation preparation and infection control. The Geelong Clinic Department of Heads/Quality meeting is the forum for review of quality and risk data. Key Performance Indicators are expressed in terms of the ten National Standards. The Medical Advisory Committee minutes showed evidence of information being provided re incidents, sentinel events (0) and new clinical policies.

During survey examples were provided of consideration being given to addressing safety and quality of care issues in business decision making (e.g. implementation of the electronic leave register and the upgrading of some patient rooms with enhanced body protection certification and improvements to the Time Out procedure to be conducted before Transcranial Magnetic Stimulation (TMS) and consolidation of bedside clinical handover).

Staff responsibilities regarding safety and quality are reinforced in the orientation program with sections devoted to incidents, hazards, emergencies and Work Health and Safety. The registered nurse job description was noted to contain a section headed “Key Responsibility No 5 = Quality and Risk Management” placing emphasis on participation in meetings, developing quality plans and identifying areas of improvement and taking ownership of projects.

Agency staff are not used. Psychiatric registers are provided from the Barwon Public Hospital training program. Geelong Clinic has a history of proactive recruitment to VMO positions from this cohort. Records of registrars having completed required mandatory training (prior to commencing their Geelong Clinic secondment) through the Barwon system were sighted.

The Healthscope corporate policy outlines requirements for mandatory training. The document indicates what is required at orientation, relates subjects to relevant National Standards, nominates required frequency and status of e- learning options. Competency based training is provided for Basic Life Support, Medication administration and aggression management. Compliance was reported to be 92%. Oversight of the risk register is provided by the Director of Nursing. Evidence of processes for risks being reviewed and updated was sighted through minutes of the Department Heads meetings. The risk register is defined by subcategory, trend analysis, controls, inherent and residual risk. Strategies to reduce risk include environment and ligature audits and monthly checks of the duress system. Since the last survey, there have been major changes to the way patient leave is managed. The hospital is now permanently locked and entry and exit only occurs after authorisation has been validated. The Hospital has invested in an impressive Imatis electronic leave system. Patients are risk assessed prior to leave, and are provided with a written card which must be produced at reception prior to the doors being opened.

Data feed into the electronic system provides a 'tracking'' mechanism with alerts provided to both senior management and patients, if the leave period has expired. On return, patients and their belongings are checked for any items which cause harm to themselves or others. Patients interviewed during this survey commented favourably on the effectiveness of the system and procedures and verbalised appreciation of the fact that staff were taking such an effort to ensure their safety. This project is one of several which has supported surveyors to rate actions 1.1.2, 1.2.2 and 1.8.2 with MM.

Duress alarms are provided throughout the hospital. There is a process for regular testing. Clinical staff are provided with phones for additional security.

Clinical practice

Geelong Clinic offers a diverse range of mental health interventions in formats encompassing inpatient, outpatient, outreach and day patient modalities. Treatments can be targeted for those with addictive behavioural challenges, eating disorders and mood disorders. For the past 13 years, the hospital has been offering a Trauma Response Programme, focused on supporting Veterans of the Australian Armed Services who are experiencing post-traumatic stress disorders. Electro convulsive therapy and transcranial magnetic stimulation are also offered in a dedicated area which is well equipped.

Healthscope Corporate Policies specifically targeted for mental health services are available. The organisation has policies/procedures providing direction for the provision of Electro Convulsive Therapy and Transcranial Magnetic Stimulation. Documents outline the requirements for admission and clinical assessment of patients. Compliance with guidelines is monitored via incidents reported through RiskMan, supervisory observation in the clinical environments and the results of audits of risk assessments which are conducted either quarterly or annually.

All services are subjected to multidisciplinary case review arrangements. It was noted that patients in the Eating Disorders Program attend the case reviews. A strength of all programs is the commitment to ensuring patient goals and aspirations are reflected in the treatment plans and that these are regularly reviewed both in case reviews and when appropriate during clinical handover.

Medical records are subjected to an annual audit against pre-determined criterion. It is suggested that for future surveys greater clarity be provided around how data from clinical record auditing occurs be provided. This could be achieved by providing a collated summary of all activities associated with clinical record audits. It is also suggested that the nominated performance targets for some aspects of the clinical file should be reviewed. Currently for example there is a requirement for 100% of all files to obtain financial consent but only 75% of files to contain evidence of medical, nursing and allied health documentation. Audit results sighted during survey did note that much higher rates of compliance with these specifics were evident.

Track and Trigger observation charts are used. There is a flowchart outlining steps to be taken in the event of a deteriorating patient. There is capacity to direct admit to the Geelong Private Hospital (a Healthscope acute care facility) when this is clinically indicated. Staff also have access to the out-of-hours medical officer at Geelong Private.

Signs are placed on patient areas inviting carers/family to escalate care if it is perceived appropriate.

Performance and skills management

There are well established Healthscope corporate policies which underpin the credentialling and granting of scope of practice of the clinical workforce. Since the last survey e-credentialling has been introduced, resulting in greater system efficiencies. Only three psychiatrists are approved to administer ECT. Monitoring occurs to ensure that these practitioners deliver at least 25 treatments per year (some of these treatments may be provided in other facilities). Psychiatric registrars do not provide ECT at Geelong clinic. Evidence was sighted of VMO and allied health files being audited on 14/10/16 with an outcome of compliance against all audit criteria.

Any new procedure would need to be approved by the MAC as well as being aligned to the strategic plan and approved by Healthscope Corporate. It was noted that in Victoria (unlike many other states), there is no requirement for criminal record checks to be conducted on current or prospective staff.

Healthscope Corporate policies underpin arrangements to ensure that all employees participate in an annual performance review. These are conducted annually by the department manager with a focus on identification of strengths and agreement on goals and planned achievements for the forth coming year. Records of compliance with completion of appraisals was provided.

Incident and complaints management

Incidents are recorded electronically in RiskMan. There is a formalised system for review involving department head and executive staff. Incidents are discussed at the monthly departmental heads meetings and information is also provided at the Medical Advisory Committee. Hard copies of committee meetings are placed in the staff room. Incidents are reported through the KPI process to Healthscope Corporate. Strategies to minimise risk to patients are initiated through the Healthscope Cluster meetings which are specifically tasked to progress all of components of the National Standards.

There are very few complaints made. Serious complaints are responded to in writing and when appropriate, executive staff will offer to meet with a complainant. A flowchart has been developed to assist any consumer wishing to make a complaint.

Any serious complaint or incident will be discussed at the weekly executive meeting, or more expeditiously if necessary. Feedback to the workforce on complaints and incidents is provided at the Department of Heads monthly meeting. The organisation also has a strong commitment to disseminating lessons learned from serious incidents in other Healthscope Hospitals. Serious matters are also referred to the Medical Advisory Committee. Any complaint or incident associated with a senior medical practitioner would be referred to the Healthscope Chief Medical Officer.

There is a Healthscope policy on open disclosure and an open disclosure e learning package available for all clinical staff is provided. Open disclosure incidents are recorded on RiskMan.

Patient rights and engagement

The Healthscope Charter of Rights is consistent with the National Charter of Patient Rights. The brochure has recently been enlarged and revised to contain the consumer “tick of approval". It is provided to consumers at the time of admission. Responses in the patient satisfaction survey suggest that 90.5% of patients are satisfied with the information provided about patient rights. A consumer consultant and access to interpreters is available for those experiencing difficulty in understanding their healthcare rights.

Staff have described patients as being at the centre of their care. Care is taken to clarify patient expectations at the time of their admission and ensure congruity with diagnosis and priorities identified by the admitting psychiatrist. Patients have the opportunity to sign their care plan. During survey, it was explained that the 2015 result showing that only 69.61% of patients having an individual care plan (ACHS Mental Health Inpatient 6 general comparison report), was explainable by a newly introduced care plan. Carers also have the opportunity to sign off on care plans if this is agreed by the consumer.

Patients are provided with the document "10 Tips for Safer Healthcare". Results of the January-March 2016 Patient impression survey question "How well do you know your rights" received an 87% satisfaction response.

Several consent forms were noted. These include the financial consent on admission, the patient agreement, also signed on admission and the consent for ECT form. This later document is detailed to indicate the number of treatments being agreed to and the duration of the course of treatment. A "plain English" brochure explaining ECT is available.

Consumers have the opportunity to have advance care directives placed on their clinical record. Pamphlets are available and the subject is mentioned in the patient compendium. In the event a consumer requires advice or assistance, the consumer would be referred to the Barwon Advanced Care Co-ordinator.

Patient clinical records are retained in the staff stations. These areas are locked with restricted access. Care plans are held in the patient bedroom. The results of the Patient Satisfaction surveys are used to inform and improve health services. Examples of issues addressed included noise, room temperatures and the development of the eating disorders program. Consumer feedback from the community meetings which are held three times a week also provide valuable feedback.

Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.1.1	SM	SM
1.1.2	SM	MM
1.2.1	SM	SM
1.2.2	SM	MM
1.3.1	SM	SM
1.3.2	SM	SM
1.3.3	SM	SM
1.4.1	SM	SM
1.4.2	SM	SM
1.4.3	SM	SM
1.4.4	SM	SM
1.5.1	SM	SM
1.5.2	SM	SM
1.6.1	SM	SM
1.6.2	SM	SM

Action 1.1.2 Core

Organisation's Self-Rating: SM **Surveyor Rating:** MM

Surveyor Comment:

A variety of initiatives progressed since the last survey reflect how the impact on patient safety and quality of care has been considered in the context of business decision making. These include: the implementation of the IMATIS electronic leave register, the refurbishment of patient bathrooms with special emphasis being given to elimination of ligature points where possible, nurse procedural changes requiring hourly rounding, systematic checking of patient belongings and the development of purpose built Eating Disorders Space with dining and lounge facilities. All improvements are sustainable, have impact on the entire organisation and have been evaluated.

Surveyor's Recommendation:

No recommendation

Action 1.2.2 Core

Organisation's Self-Rating: SM **Surveyor Rating:** MM

Surveyor Comment:

Since last survey, the organisation has implemented a series of strategies which individually and collectively contribute to enhancing the safety of patients under the care of Geelong Clinic. These initiatives include: a systematic checking of patient bags and belongings for items of risk and any medications (on admission and every time a patient returns from leave), the commencement of hourly rounding by nursing staff 24 hours a day, and the implementation of a formalised process for granting and monitoring of patient leave described in detail in the criterion summary. Other associated initiatives include use of paper bags (rather than plastic) as rubbish bin liners, a formal ligature audit, environment reviews and building "lock-down" so that only authorised individuals can enter and leave the building. All these initiatives are applicable across the entire organisation. They are sustainable, have been introduced across the entire facility, have been evaluated with improvement built into day-to-day operations.

Surveyor's Recommendation:

No recommendation

Clinical practice

Ratings

Action	Organisation	Surveyor
1.7.1	SM	SM
1.7.2	SM	SM
1.8.1	SM	SM
1.8.2	SM	MM
1.8.3	SM	SM
1.9.1	SM	SM
1.9.2	SM	SM

Action 1.8.2 Core

Organisation's Self-Rating: SM **Surveyor Rating:** MM

Surveyor Comment:

Since the last survey, a series of initiatives have been taken, all of which contribute to reducing the risk for "at-risk" patients. These include: 24 hour "lock down" of the hospital, so thus enabling checks of everyone entering and leaving the building, developing a formalised patient leave system with inbuilt checks and authorisation (discussed in detail in the criterion one summary), the introduction of hourly nurse rounding 24 hours a day and the introduction of environmental and ligature audits.

Audits demonstrating staff compliance with revised procedures demonstrate general application across the organisation. The initiatives are clearly sustainable.

Surveyor's Recommendation:

No recommendation

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM
1.10.3	SM	SM
1.10.4	SM	SM
1.10.5	SM	SM
1.11.1	SM	SM
1.11.2	SM	SM
1.12.1	SM	SM
1.13.1	SM	SM
1.13.2	SM	SM

Incident and complaints management

Ratings

Action	Organisation	Surveyor
1.14.1	SM	SM
1.14.2	SM	SM
1.14.3	SM	SM
1.14.4	SM	SM
1.14.5	SM	SM
1.15.1	SM	SM
1.15.2	SM	SM
1.15.3	SM	SM
1.15.4	SM	SM
1.16.1	SM	SM
1.16.2	SM	SM

Patient rights and engagement

Ratings

Action	Organisation	Surveyor
1.17.1	SM	SM
1.17.2	SM	SM
1.17.3	SM	SM
1.18.1	SM	SM
1.18.2	SM	SM
1.18.3	SM	SM
1.18.4	SM	SM
1.19.1	SM	SM
1.19.2	SM	SM
1.20.1	SM	SM

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

The treatment is led by the consultant in partnership with the consumer. Each unit has a multidisciplinary meeting each week attended by one of three consumer consultants. The limitation to this is the number of hours available for the consumer consultants to work. The general ward consumer consultant is a member of the HealthScope Mental Health Cluster meetings and led the planning for Mental Health Month this year. This consumer consultant is also a member of the State Advisory Consumer Committee which meets quarterly. There is also a consumer consultant position for the Eating Disorders Program (vacant at time of survey but about to be filled). The third consultant position is aligned with the Trauma Response Programme.

At least once a week the patient meets with their treating consultant. The staff training for patient-centred care is available as a mandatory eLearning module and on 1 November 2016, 92% staff had completed the training. The consumer consultants working in each of the units are involved in the teams' planning sessions and provide regular feedback with both impromptu and written reports to the Nursing Unit Managers and the Director of Nursing. In one unit the consumer consultant leads one of the regular inpatient sessions to discuss current issues. In one of the other units the consumer consultant co-facilitates group sessions with one of the clinicians.

The consolidation and contribution of consumer consultants is recognised with a rating of MM for action 2.1.1.

Consumer partnership in designing care

An example of consumer partnership at the Geelong Clinic is the soon to be implemented PREP program with the Eating Disorders program. PREP was developed in collaboration with the then consumer consultant, Clinical Director and clinical team. PREP is described as a program that can put into practice the teachings from LEAP (Learn to Eat at Peace - the current Eating Disorders treatment modality). Patients will be shopping and cooking in vivo. The idea of considering this new program was in part feedback from the patients and the consumer consultant who believed that having a program that was able to put into practice the learnings from LEAP would be a great inclusion for the service. It took at least six months of planning and investigating viabilities, which has resulted in the service commencing this new program in February 2017. During a consumer forum one of the current inpatients of the Eating Disorder Program was looking forward to the program commencing, but was disappointed it was not available prior to them finishing the LEAP program.

There is a patient compendium in each of the bedroom rooms with information for patients and carers readily available as a resource. The information is discussed during Intake and the Assessment process and handouts are given. The compendium is designed as a backup resource as a reminder for patients and carers. The literature developed by services is in process including a review by the consumer's consultants. When this occurs the brochure has a stamp stating that it's "Consumer Approved". Most of the brochures with the patient compendium have been reviewed by the consumer consultants.

Consumer partnership in service measurement and evaluation

One of the consumer consultants is on the membership of the Geelong Clinic "Safety and Quality, Work Health Safety and Infection Control Committee". At the meeting the results of incidents reported in RiskMan, Clinical Indicators, audit results, HealthScope KPI reports are discussed and action plans developed when the results are lower than expected target. When patients' literature is reviewed the consumer consultants are included in the review process and feel listened to when suggestions for improvement are made. During the consumer forum the patients all reported that the staff were very professional and they felt listened to. If there was an issue the patient wanted to discuss and the staff were not available at the time of enquiry, the patients all reported that the staff would always get back to them when they could. Feedback is encouraged from consumers and carers and the rating of satisfaction with the service have been greater than 90% on regular occasions.

Consumer partnership in service planning

Ratings

Action	Organisation	Surveyor
2.1.1	SM	MM
2.1.2	SM	SM
2.2.1	SM	SM
2.2.2	SM	SM
2.3.1	SM	SM
2.4.1	SM	SM
2.4.2	SM	SM

Action 2.1.1 Developmental

Organisation's Self-Rating: SM **Surveyor Rating:** MM

Surveyor Comment:

The organisation has three consumer consultant positions working approximately 12 hours per week. One of the consultants is a member of the Mental Health Cluster meetings and co-coordinated the local Mental Health Month activities this year. The Geelong Clinic is flexible with the hours the consultants work and one of them is currently a volunteer as he trials the role. Being a previous graduate of the program (TRP-PTSD) he participates in the program when he is able. The consumer consultant participating in the Cluster meetings also attends the National Consumer Advisory Committee - and is very active in promoting consumer engagement in all aspects of the clinical operations. All consultants attend ward meetings at least weekly with the patients currently in each of the units.

Having a consultant working at Cluster level benefits the organisation with feedback both ways on current consumer practices and feedback. With the input into the State Advisory Consumer Committee it is an opportunity to promote the services current consumer initiatives for sharing across the members.

When asked about the role the consumer consultant felt that they were able to contribute their experience with providing feedback on consultation papers requiring consumer feedback. This consumer consultant facilitates a discussion group on the unit that has regular high attendance. The group is an opportunity for participants to have discussions amongst their peers which is able to be escalated for senior staff to address any issues as required. The consumer consultant and the staff spoke highly of each other's roles which is evidence of this practice being effective and occurring as part of day-to-day operations.

Surveyor's Recommendation:

No recommendation

Consumer partnership in designing care

Ratings

Action	Organisation	Surveyor
2.5.1	SM	SM
2.6.1	SM	SM
2.6.2	SM	SM

Consumer partnership in service measurement and evaluation

Ratings

Action	Organisation	Surveyor
2.7.1	SM	SM
2.8.1	SM	SM
2.8.2	SM	SM
2.9.1	SM	SM
2.9.2	SM	SM

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

The Geelong Clinic is represented on the Infection Control Committee which is based at the Geelong Private Hospital, another Healthscope Facility. The infection control consultant from that hospital spends about a day a fortnight at Geelong Clinic. It was noted that the current temporary occupant of this position will shortly retire so a replacement will be required. Since the last survey, the organisation has contracted with HICMR to provide infectious diseases support and expertise to Geelong Clinic. There was no representative from HICMR at the hospital for this survey and it was reported that presence occurs only once a year although there are plans to increase the frequency of contact. Advice from an infectious diseases physician would also be available from Geelong Private Hospital if required. At the Geelong Clinic site, infection matters are considered as part of the Heads of Department meeting with reference to the Medical Advisory Committee if necessary. It is suggested that the current title, terms of reference and minutes content of the Geelong Private Hospital infection control committee might be reviewed to provide greater prominence to the role of this committee in providing oversight for Geelong Clinic. In particular there should be capacity to clearly demonstrate which audit results and resultant actions belong to each facility.

Infection prevention and control strategies

Ongoing surveillance is provided by the clinical nurse consultant to whom abnormal pathology results are reported directly. It was noted that there have been no serious infections since the last survey. The standardised Key Performance Indicators which are reported to Healthscope Corporate include several infection control items. The trended data sighted show that for Geelong Clinic, most of these have no reported incidents (i.e. Hospital bacteraemia, multi-resistant organisms and clostridium difficile).

Since the last survey considerable attention has been given to improving staff compliance with hand hygiene. Alcohol foam dispensers have been installed in public corridors. Whilst it was reported that audit results demonstrated an improvement of compliance from 32% to 82 %, surveyor observations supported management comment that further work will be required before staff have internalised the importance of hand washing and are consistently demonstrating compliance. The Director of Nursing is one of two hand hygiene auditors. It is suggested additional auditors who have a regular presence in each of the clinical areas should be appointed so that role modelling and compliance observation can be strengthened. It is also suggested that there are further opportunities to emphasise the importance of hand washing for visitors and patients - for example a foam dispensing booth with appropriate signage at the front door of the hospital would clearly indicate expectations. Discussion of the importance of hand washing at the thrice weekly community meetings and creating an expectation of patient hand washing prior to partaking of meals in the dining room may also raise the profile.

Some Hospital Acquired Infection reports were noted during survey. It is suggested the format of these reports be reviewed so that when there is a ‘nil’ result or occurrence that this be clearly indicated. Currently a report with a ‘nil’ result appears to be a blank document which could be viewed as an incomplete template.

Whilst staff are offered the opportunity to receive influenza vaccinations, the uptake is reported to be only about 40%. In the event of a serious community outbreak of influenza (which would presumably also impact on staff), this low impact may negatively impact on organisational capacity to provide business continuity. A Pandemic Influenza Plan for 2016 was noted. Data demonstrating base line information regarding staff vaccination status for Pertussis, Hep B and Varicella was noted however the information was undated. It is suggested the accompanying pie charts would be more easily read if more contrasting colours were utilised.

To enhance staff compliance with aseptic technique training, the learning program has been taken “off line” and is now delivered in a paper based format. A risk assessment associated with aseptic technique was sighted. Currently the organisational strategy is for clinical nursing staff only to be trained in aseptic technique. Accordingly, action 3.10.1 has been assessed at SM at the transitional level. Training of relevant staff was noted to have increased from 26.3% in January / March 2016 to 59.6% in April/June. The number of times aseptic technique needs to be practised in this organisation is very small.

Staff adherence to policies is monitored by observation and monitoring of key performance data which is reported to the both the Heads of Department locally and the Healthscope Corporate body. During survey, results of audits conducted by HICMR were noted. These included audits of clinical units, procedural suite (ECT / Transcranial stimulation) and cleaning services amongst others.

Staff have access to the detailed Healthscope Corporate and HICMR infection control policies, available both electronically and in hard copy. Geelong Clinic is represented on the Healthscope Infection Control "Cluster" committee.

It was noted that catering services are subjected to three separate audit processes - that conducted by HICMR, City Council and an external audit conducted by “100% Food Industry”. The inspection conducted in 2015 under the Victorian Food Act noted "record keeping to be of a high standard and premises were very clean and well organised". Surveyors from this survey are in agreement with these findings.

Managing patients with infections or colonisations

Policies related to standard and transmission precautions are provided by both HICMR and Healthscope Corporate.

Following an outbreak of gastroenteritis, a new “when to report infectious outbreak” flowchart has been developed. In addition, an "outbreak "kit" has been assembled containing an initial supply of PPE, patient information signage etc. Patient education material, eg posters showing cough technique were displayed around the hospital. Staff have access to Personal Protective Equipment. One of the annual mandatory eLearning programs required of staff is focused on standard precautions.

In the event of a patient demonstrating signs of a serious infection, transfer to a more suitable hospital would occur.

Antimicrobial stewardship

Point prevalence audits are conducted in March and September. Results are reported back to the Medical Advisory Committee. Both the Director of Nursing and General Manager are members of this committee. Records of antimicrobial usage at Geelong Clinic were sighted for the second and third quarters of 2016. It was noted that only about 5 patients per month have antibiotics. It is suggested a “traffic light system” or similar would be a useful mechanism to enhance nursing staff knowledge of antibiotics. Staff have access through the Healthscope intranet to the Therapeutic Guidelines.

Cleaning, disinfection and sterilisation

Evidence was sighted of schedules for all areas of the hospital and for audit results. Surveyors noted all areas of the hospital appeared to be maintained to very high standards and this was reflected in positive data noted from the patient satisfaction survey which has questions about cleanliness.

Senior staff interviewed demonstrated contemporaneous knowledge of AS 4187: 2014 and it was noted that a gap analysis has already been conducted. Whilst the impact of this standard for Geelong Clinic should be relatively small the organisation appeared to be well advanced in being able to demonstrate the Commission's requirements into the coming years. A change in practice since last survey ensures that no medical devices are re-sterilised. Previously a small number of devices were sent off campus for sterilising.

Laundry and linen supplies are managed by an external contractor. There are systems to ensure reliability and quality of this service.

For the purposes of this review, action 3.17.1 (traceability systems) has been assessed as N/A as no sterile reusable medical instruments and devices are utilised.

Communicating with patients and carers

Information about organisational initiatives is available on the Healthscope website. In addition, the patient compendium, available at every bedside, has information about infection control and the importance of hand hygiene. Throughout the facility, there are posters and pamphlets about the 5 moments of hand hygiene and appropriate cough etiquette. It was noted that the "Patient Compendium' was reviewed by consumers and has received the consumer endorsement tick.

Governance and systems for infection prevention, control and surveillance

Ratings

Action	Organisation	Surveyor
3.1.1	SM	SM
3.1.2	SM	SM
3.1.3	SM	SM
3.1.4	SM	SM
3.2.1	SM	SM
3.2.2	SM	SM
3.3.1	SM	SM
3.3.2	SM	SM
3.4.1	SM	SM
3.4.2	SM	SM
3.4.3	SM	SM

Infection prevention and control strategies

Ratings

Action	Organisation	Surveyor
3.5.1	SM	SM
3.5.2	SM	SM
3.5.3	SM	SM
3.6.1	SM	SM
3.7.1	SM	SM
3.8.1	SM	SM
3.9.1	SM	SM
3.10.1	SM	SM
3.10.2	SM	SM
3.10.3	SM	SM

Managing patients with infections or colonisations

Ratings

Action	Organisation	Surveyor
3.11.1	SM	SM
3.11.2	SM	SM
3.11.3	SM	SM

3.11.4	SM	SM
3.11.5	SM	SM
3.12.1	SM	SM
3.13.1	SM	SM
3.13.2	SM	SM

Antimicrobial stewardship

Ratings

Action	Organisation	Surveyor
3.14.1	SM	SM
3.14.2	SM	SM
3.14.3	SM	SM
3.14.4	SM	SM

Cleaning, disinfection and sterilisation

Ratings

Action	Organisation	Surveyor
3.15.1	SM	SM
3.15.2	SM	SM
3.15.3	SM	SM
3.16.1	SM	SM
3.17.1	SM	N/A
3.18.1	SM	SM

Action 3.17.1 Core

Organisation's Self-Rating: SM **Surveyor Rating:** N/A

Surveyor NA Comment:

Sterile reusable devices are not used in this hospital.

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

There is a strong governance framework within the Geelong Clinic for medication management. There is a number of HealthScope policies covering all aspects of medication management in use at the Clinic. The Clinic has a contract with an independent pharmacy - EPIC which is responsible for some medication audits and provides 24 hours a day phone support to the service. EPIC visit the clinic twice a week and audit patient's medication and collect unused/ returned medication. They provide resource material including information on new medications and circulate Medication Alerts as they become aware of them. Information sheets on the different medications are available for patients and carers.

Medication incidents are reported on RiskMan, risk assessed and investigated. Nurses involved in medication errors are expected to complete a "Reflective Practice" form. When completed the nurse will then discuss the issue with the unit NUM. This practice has been an opportunity for the nurse to identify potential solutions to reduce or eliminate future occurrence of the error. The self-assessment audit of the National Inpatient Medication Chart for 2016 gave the service a result of 71%. Some of the questions were non-applicable which gave a false negative result. Staff are able to access hard copy MIMs information within each of the units and able to access the intranet and internet for additional resources as required.

Documentation of patient information

The service uses a hard copy medical record with the current medication chart and medication management plans are kept in the medication room. During the intake process staff record medication history. When they are admitted a Medication Management Plan is commenced. This document records the patient's medication history, current medications prescribed and any allergies. Audits are completed regularly on the unit to ensure completion and these results usually demonstrate 100% compliance. Audits are reported through the Cluster Medication Safety Committee and actioned accordingly.

Medication management processes

Earlier this year there was a flux of medication errors relating to administration. As a result of the RNs completion of the Reflective Practice tool medication times have been communicated to all patients, to promote the RNs completion of medication administration without being interrupted. Since this implementation there has been a noticeable decrease in these types of incidents. At the patients' forum, patients all said that they felt involved in their medication treatment and staff assisted them with any medication queries that they had.

Continuity of medication management

If there is a patient transfer to another hospital, a thorough clinical handover is completed which includes copies of the medication management plan. At point of discharge a copy of the plan is given to the patient and treating general practitioner. Collaborative history taking is completed with family members and they are included in the discharge planning. The referral agency is given a copy of the discharge summary which include any changes in medication.

Communicating with patients and carers

During the bedside handover any changes in medication are raised and the patient is included in the discussion. The consumer consultant in the general unit facilitates discussion around issues identified by the inpatients. If any of the patients had concerns about their medication the consumer consultant would then pass the information on the staff and request them to follow up. The pharmacist will provide inpatient information sessions to the units as required, at least fortnightly. Audit results of satisfaction of patient information provided at discharge regarding their medications for 2016 ranged from 91 to 100%.

Governance and systems for medication safety

Ratings

Action	Organisation	Surveyor
4.1.1	SM	SM
4.1.2	SM	SM
4.2.1	SM	SM
4.2.2	SM	SM
4.3.1	SM	SM
4.3.2	SM	SM
4.3.3	SM	SM
4.4.1	SM	SM
4.4.2	SM	SM
4.5.1	SM	SM
4.5.2	SM	SM

Documentation of patient information

Ratings

Action	Organisation	Surveyor
4.6.1	SM	SM
4.6.2	SM	SM
4.7.1	SM	SM
4.7.2	SM	SM
4.7.3	SM	SM
4.8.1	SM	SM

Medication management processes

Ratings

Action	Organisation	Surveyor
4.9.1	SM	SM
4.9.2	SM	SM
4.9.3	SM	SM
4.10.1	SM	SM
4.10.2	SM	SM
4.10.3	SM	SM
4.10.4	SM	SM

4.10.5	SM	SM
4.10.6	SM	SM
4.11.1	SM	SM
4.11.2	SM	SM

Continuity of medication management

Ratings

Action	Organisation	Surveyor
4.12.1	SM	SM
4.12.2	SM	SM
4.12.3	SM	SM
4.12.4	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
4.13.1	SM	SM
4.13.2	SM	SM
4.14.1	SM	SM
4.15.1	SM	SM
4.15.2	SM	SM

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

There is strong policy framework in place to support patient ID and procedure matching that meets legislative requirements. All patients are required to wear wristbands that give four identifiers; name, DOB, MRN and gender. ID is checked prior to patients being dispensed their medication. When patients return from leave, they wait in the waiting room for one of the nurses to take them back to their room where the nurse will discuss how the leave went and complete a mini admission assessment. As part of this assessment, a new ID band is given if the patient had removed it when going on leave.

1. The August 2016 audit of patient wearing their IDs was 100% and previous results checked were in the high 90s if not 100%.
2. During the consumer forum meeting all patients were asked if they were wearing their ID and they raised their wrists to confirm same = 100%.

Processes to transfer care

Transfer of care can occur within the Clinic if a patient is attending for TMS or ECT and externally to another hospital e.g. The Geelong Private Hospital. Patient ID is checked and medication management plans are provided at time of transfer. All members of the treating team are involved with providing a complete history that is included in the discharge/ transfer document.

Processes to match patients and their care

Time Out processes clearly state that prior to commencing ECT all staff must stop what they are doing to go through the reasons for the procedure with the patient and checking to ensure that the current procedure is being carried out with the correct patient. Any incidents are reported on RiskMan and investigated prior to discussion at the Quality and Risk, Work Health Safety, Infection Control Committee.

An incident reported on RiskMan earlier this year was as a result of treatment error involving TMS - the patient had a lower dose for total treatment regime. The error was only picked up after they were readmitted and the medication chart updated. Open Disclosure occurred and the patient was reassured as they were concerned that the treatment course didn't work as well as previous courses of treatment. They felt unwell in a shorter period of time. An outcome of the incident review is that two RNs complete time out before the TMS treatment begins. This revised practice has been implemented across all HealthScope services providing TMS.

Identification of individual patients

Ratings

Action	Organisation	Surveyor
5.1.1	SM	SM
5.1.2	SM	SM
5.2.1	SM	SM
5.2.2	SM	SM
5.3.1	SM	SM

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

Action	Organisation	Surveyor
5.5.1	SM	SM
5.5.2	SM	SM
5.5.3	SM	SM

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Healthscope corporate policy provides direction on clinical handover. It was noted that clinical handover processes have been reviewed for Healthscope acute care settings with an outcome being the production of a video. Work is about to start on reviewing the policy from a mental health setting perspective. Consumers are involved in these reviews.

Clinical handover processes

Since the last survey, considerable changes to the processes associated with patient leave have occurred. Implementation of the electronic leave register has been accompanied with formalised processes for leave approval, patient exiting from the building and most importantly, written information and verbal advice being given to any carers who will be escorting patients going on leave. Telephone numbers are provided should additional advice be required. A similarly structured process underpins requirements when patients return from leave.

A locally produced brochure explains expectations. Consumers have been involved in reviewing handover processes and the information brochure. ISOBAR is the approved tool. The prompt sheet used by nurses has been revised within the past year. Patient feedback results suggest that 97.3% of patients believe the current processes promote inclusion. Staff comfort with policy associated with handover is reported to have increased from 10 % in 2013 to 80% in 2016.

Surveyors were provided with the background leading to changes to practice which were instituted to improve clinical handover and therefore Time Out procedures following an incident involving "under dosing" of a patient receiving Transcranial Magnetic Stimulation. These changes which now require two staff to be involved in handover, will minimise the risk of patients not receiving the treatment ordered.

Patient feedback results mentioned above demonstrate high levels of satisfaction with handover processes. It was confirmed that patients are actively involved in Time Out procedures which occur before a patient is anaesthetised for ECT.

Patient and carer involvement in clinical handover

Patients are given information about clinical handover and the programmed bedside clinical handover at 2.30 every day. They are invited to ensure they are in their bedrooms at this time, should they wish to participate in the handover process. During survey, it was noted that a high proportion of the patient cohort of the ward visited, did chose to participate. Surveyors observed comfortable interactions between staff and patients, with the handover process including identity checks, reference to any physical observation and test results or plans and the opportunity provided to reflect on objectives and achievements from the day.

Governance and leadership for effective clinical handover

Ratings

Action	Organisation	Surveyor
6.1.1	SM	SM
6.1.2	SM	SM
6.1.3	SM	SM

Clinical handover processes

Ratings

Action	Organisation	Surveyor
6.2.1	SM	SM
6.3.1	SM	SM
6.3.2	SM	SM
6.3.3	SM	SM
6.3.4	SM	SM
6.4.1	SM	SM
6.4.2	SM	SM

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

Standard 7 is not applicable to this organisation.

Governance and systems for blood and blood product prescribing and clinical use

Ratings

Action	Organisation	Surveyor
7.1.1	N/A	N/A
7.1.2	N/A	N/A
7.1.3	N/A	N/A
7.2.1	N/A	N/A
7.2.2	N/A	N/A
7.3.1	N/A	N/A
7.3.2	N/A	N/A
7.3.3	N/A	N/A
7.4.1	N/A	N/A

Documenting patient information

Ratings

Action	Organisation	Surveyor
7.5.1	N/A	N/A
7.5.2	N/A	N/A
7.5.3	N/A	N/A
7.6.1	N/A	N/A
7.6.2	N/A	N/A
7.6.3	N/A	N/A

Managing blood and blood product safety

Ratings

Action	Organisation	Surveyor
7.7.1	N/A	N/A
7.7.2	N/A	N/A
7.8.1	N/A	N/A
7.8.2	N/A	N/A

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
7.9.1	N/A	N/A
7.9.2	N/A	N/A
7.10.1	N/A	N/A
7.11.1	N/A	N/A

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

Policies and procedures have been developed and are in use across all units within Geelong Clinic with the framework provided by HealthScope governance systems. The service has adapted the Waterlow assessment form and documentation audits confirm that the form is completed and accessible within the medical record. Use of the form assists with identifying people at risk of developing pressure injuries and the checklist includes checking skin integrity. The assessment form is completed on admission and reviewed as required. For patients identified at risk, a referral for OT assessment is made. There are two Occupational Therapists working in TGC and when they receive a referral for Pressure Injury assessment this is completed promptly and a management plan together with a prevention plan is developed with the patient.

Any incidents would be reported on RiskMan and discussed at the Quality and Risk, Work Health Safety and Infection Control Committee meeting. The Clinical Indicator Peer Report for the second half of 2015, TGC reported 0% rate pressure injuries which is similar result for the other organisations.

Preventing pressure injuries

The assessment form is completed on admission. Approximately one admitted person per month is assessed as 'low risk' of developing a pressure injury. The service reported an 80% completion of pressure injury assessments in 2014. In 2016 100% completion of the assessment form within 8 hours of admission was reported. An eLearning package has been developed and implemented for staff in the Preventing and Managing Pressure injuries.

Managing pressure injuries

Since 2013 when the service commenced using the assessment tool, there have been no incidences reported of pressure injuries during an admission. There have also been no patients admitted with a pressure injury. On the form are colour illustrations of the pressure injuries and different stages. Aids are available from a local contractor should a patient develop or be admitted to the service with a pressure injury.

Communicating with patients and carers

Brochures are readily available for patients and carers. A copy is kept in the patient's compendium which is to be found in each of the bedrooms. The brochure has been developed in consultation with the consumer consultants.

Governance and systems for the prevention and management of pressure injuries

Ratings

Action	Organisation	Surveyor
8.1.1	SM	SM
8.1.2	SM	SM
8.2.1	SM	SM
8.2.2	SM	SM
8.2.3	SM	SM
8.2.4	SM	SM
8.3.1	SM	SM
8.4.1	SM	SM

Preventing pressure injuries

Ratings

Action	Organisation	Surveyor
8.5.1	SM	SM
8.5.2	SM	SM
8.5.3	SM	SM
8.6.1	SM	SM
8.6.2	SM	SM
8.6.3	SM	SM
8.7.1	SM	SM
8.7.2	SM	SM
8.7.3	SM	SM
8.7.4	SM	SM

Managing pressure injuries

Ratings

Action	Organisation	Surveyor
8.8.1	SM	SM
8.8.2	SM	SM
8.8.3	SM	SM
8.8.4	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

STANDARD 9
RECOGNISING AND RESPONDING TO CLINICAL DETERIORATION IN ACUTE HEALTH CARE

Surveyor Summary

Establishing recognition and response systems

Corporate policies support approaches related to deteriorating patient, basic life support and advance care directives. There is a policy which clarifies criterion by which potential patients can be excluded from admission. This policy effectively minimises risk of patients with identified physiological / medical challenges from being admitted and thus reduces the volume of patients whose clinical conditions deteriorate whilst in hospital.

Recognising clinical deterioration and escalating care

An early warning observation chart is utilised and a flowchart provides direction for staff in the event of recognition of a patients deteriorating status. It was noted that Healthscope Corporate is currently reviewing the current observation chart with the view of adopting the NSW Clinical Excellence Commission latest version of the chart.

All patients have at least daily observations taken. Surveyors noted that during the bedside clinical handover dialogue between staff and patients occurred related to observations. The frequency of observations is determined individually for each patient; this is appropriate given the cohorts of patients with eating disorders and addiction challenges. Compliance audit results for 2015 and 2016 were sighted. These audits review issues such as graphics, frequency of observations, pulse rate, blood pressure, respirations, oxygen saturation. Results sighted showed 100% compliance.

Responding to clinical deterioration

Both the observation charts and the relevant flow chart provide criterion for calling for assistance and escalating care. Evidence was sighted of the organisation tracking and analysing Code Blue incidents over the past three years; on average there are three per year. These incidents have been classified into subcategories of re-feeding, anxiety, chest pain (No subsequent Abnormalities Detected) and other acute issues such as anaphalyxis, renal failure (identified on admission) and aspiration pneumonia. It was noted that in all cases, there was full recovery with patients returning to Geelong Clinic after assessment and review in an acute care hospital.

Whilst all nursing staff are trained in basic life support, additional training has been provided to ensure that those staff who participate in ECT delivery are proficient at use of the defibrillator. The organisation has a semi-automated defibrillator and staff training in its use is provided by the Director of Nursing. There are two emergency trolleys.

Routine procedure in the event of a Code Blue call is for the Ambulance Service of Victoria to be called, thus providing access to personnel with Advance Life Support skills.

Communicating with patients and carers

Signage in each patient bedroom alerts patients and families to the option of seeking staff support in an emergency situation by pressing the emergency call bell. It was noted that currently there is nothing in the patient compendium which reminds visitors / consumers of how an escalation of care would be progressed. It is suggested that there may be value in reviewing the Queensland Health “Ryan’s Rule” approach which provides clear guidelines and a hierarchy of response options, to enable patients and family to escalate care response in the event of any concerns. The organisation reported that there has been one incidence of family escalation of care in the past three years. This was reported through RiskMan.

It was noted that nursing staff conduct hourly rounding and this does provide an additional opportunity for patient / family to identify and escalate emerging concerns.

Intake paperwork contains the question “do you have an advance care directive”. Such a directive would form part of the clinical record.

Establishing recognition and response systems

Ratings

Action	Organisation	Surveyor
9.1.1	SM	SM
9.1.2	SM	SM
9.2.1	SM	SM
9.2.2	SM	SM
9.2.3	SM	SM
9.2.4	SM	SM

Recognising clinical deterioration and escalating care

Ratings

Action	Organisation	Surveyor
9.3.1	SM	SM
9.3.2	SM	SM
9.3.3	SM	SM
9.4.1	SM	SM
9.4.2	SM	SM
9.4.3	SM	SM

Responding to clinical deterioration

Ratings

Action	Organisation	Surveyor
9.5.1	SM	SM
9.5.2	SM	SM
9.6.1	SM	SM
9.6.2	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
9.7.1	SM	SM
9.8.1	SM	SM
9.8.2	SM	SM
9.9.1	SM	SM
9.9.2	SM	SM
9.9.3	SM	SM
9.9.4	SM	SM

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

Appropriate policies and procedures are in place at the Geelong Clinic to meet legislative requirements. Hard copy policy manuals are available in the unit with electronic versions available on the intranet. Risks are reported on RiskMan and incidences reviewed at local quality and risk, work health safety and infection control meetings. Falls are reported monthly as a Mental Health Cluster KPI and during 2016 the rates were between 0.08 to 0.23% which is lower than the 0.3% target for the organisation. None of the falls resulted in a fracture or closed head injury.

The ACHS Clinical Indicator peer group report results for second half of 2015 TGC report eight instances of patient falls which is 0.11% rate. This is lower than the aggregate rate for similar organisations.

Screening and assessing risks of falls and harm from falling

All patients are screened and assessed for falls risk during their admission process using the FRAT tool. The population of TGC is such that generally if there is any risk associated with the assessment it is generally a low risk. Whenever a risk is identified a referral for further assessment by allied health professional to develop a prevention management plan is completed. Aids for walking are able to be hired if required. Documentation audits are completed to ensure assessments are regularly carried out on admission and updated when required.

Preventing falls and harm from falling

There is a brochure titled "Keeping a step ahead of falls" which is readily available for patients and family members. A copy is to be found in the patient compendium in each of the bedrooms. The brochure was recently reviewed by the consumer consultants. One of the patients spoke during the consumer forum of being informed by a staff member to put shoes or slippers on his feet as he was walking around the unit with socks on. The nurse explained that wearing socks in the bathroom increases the risk of a fall and the patient was quite happy to comply.

Communicating with patients and carers

Posters are on display within the units and sighted on notice boards promoting the brochure. On admission all patients are expected to complete the front page of the care plan which invites them to nominate a rating on 8 issues that they might require assistance with. The patient then signs off on their care plan to address their goals during admission.

Governance and systems for the prevention of falls

Ratings

Action	Organisation	Surveyor
10.1.1	SM	SM
10.1.2	SM	SM
10.2.1	SM	SM
10.2.2	SM	SM
10.2.3	SM	SM
10.2.4	SM	SM
10.3.1	SM	SM
10.4.1	SM	SM

Screening and assessing risks of falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.5.1	SM	SM
10.5.2	SM	SM
10.5.3	SM	SM
10.6.1	SM	SM
10.6.2	SM	SM
10.6.3	SM	SM

Preventing falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.7.1	SM	SM
10.7.2	SM	SM
10.7.3	SM	SM
10.8.1	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

National Standards for Mental Health Services (Unmapped Criteria) to NSQHS Standards

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

STANDARD 1 Rights and Responsibilities

The rights and responsibilities of people affected by mental health problems and / or mental illness are upheld by the mental health service (MHS) and are documented, prominently displayed, applied and promoted throughout all phases of care.

Surveyor Summary
1.9 The MHS is upholding the rights of the consumer to be treated in the least restrictive environment. The Geelong Clinic only admits people voluntarily and there is no seclusion room. If at intake or during admission the consumer is identified as posing a severe risk to themselves or others they are referred to a public mental health facility. **1.15 The rights of the consumer to access advocacy and support services.** There are three consumer consultants positions within the service. All three attend a team's meetings, meet with consumers on a one to one basis as required and also facilitate a group meeting with other consumers. Referral to services not readily available with TGC are provided either by Geelong Private, public mental health facilities or NGOs. **1.17 The rights of the consumer to access a staff member of their own gender.** Staff rosters are built with a mix of gender staff available wherever possible. There are also male and female psychiatrists on staff. As a private hospital only admitting voluntary patients, all patients have the right to choose their treating practitioner. The organisation's observation policy states that whilst nursing staff can increase the level of observation provided if there are concerns for consume or other resident safety. Only a psychiatrist can "lower" the level of observation to be provided.

Criterion 1.9

The MHS upholds the right of the consumer to be treated in the least restrictive environment to the extent that it does not impose serious risk to the consumer or others.

Surveyor's Rating	Met

Criterion 1.15

The MHS upholds the right of the consumer to access advocacy and support services.

Surveyor's Rating	Met

National Standards for Mental Health Services (Unmapped Criteria) to NSQHS Standards

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

Criterion 1.17
The MHS upholds the right of the consumer, wherever possible, to access a staff member of their own gender.

Surveyor's Rating	Met

National Standards for Mental Health Services (Unmapped Criteria) to NSQHS Standards

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

STANDARD 2 Safety

The activities and environment of the MHS are safe for consumers, carers, families, visitors, staff and its community.

Surveyor Summary
2.1 The MHS promotes optimal consumer safety and ensures all consumers are protected from abuse and exploitation. There are vigilant systems to promote optimum safety and wellbeing of consumers. Stringent risk assessments are conducted at the point of admission. Daily vulnerability assessments are completed. Patients are not permitted to visit each other in their bedrooms. Hourly rounding is performed. **2.2 The MHS reduces and where possible eliminates the use of restraint and seclusion.** Restraint and seclusion is not used in this organisation. There is a local policy which confirms "No Restraint". **2.5 The MHS complies with relevant commonwealth/state/territory transport guidelines including current national safe transport principles.** In the event of patient transport there is a local policy which underpins mode of patient transport. If clinically appropriate, a patient may be transported by taxi with staff escort, otherwise ambulance service will be arranged. There is a "no restraint " policy. A policy which prohibits patients from visiting each other in their bedrooms contributes to optimal safety and wellbeing.

Criterion 2.1

The MHS promotes the optimal safety and wellbeing of the consumer in all mental health settings and ensures that the consumer is protected from abuse and exploitation.

Surveyor's Rating	Met

Criterion 2.2

The MHS reduces and where possible eliminates the use of restraint and seclusion within all MHS settings.

Surveyor's Rating	Met

National Standards for Mental Health Services (Unmapped Criteria) to NSQHS Standards

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

Criterion 2.5

The MHS complies with relevant Commonwealth and state / territory transport policies and guidelines, including the current National Safe Transport Principles.

Surveyor's Rating	Met

STANDARD 3 Consumer and carer participation

Consumers and carers are actively involved in the development, planning, delivery and evaluation of services.

Surveyor Summary
3.4 Consumers/carers have the right to determine who represents their views to the MHS Consumer consultants are available within the clinic and regularly meet with the patients. Each patient has an identified lead psychiatrist, but other psychiatrists may be involved in the treating team. Patients are able to identify who their Primary Carer is and what level of information is shared. They are able to change this at any stage. There is a variety of ways by which carer perspectives can be expressed. They may attend clinical handovers. Some services invite carers to case reviews and ward rounds. The Post Traumatic Stress Disorder program has dedicated times throughout the length of the program which includes carer participation.

Criterion 3.4

Consumers and carers have the right to independently determine who will represent their views to the MHS.

Surveyor's Rating	Met

STANDARD 4 Diversity responsiveness

The MHS delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care.

Surveyor Summary
4.1, 4.2 The MHS defines diverse groups who access the service and review the needs of its community and communicates this to staff. The organisation has a low admission rate of patients identifying as ATSI and CALD. Examples were given of organisational learning from the rare occasion an indigenous patient was admitted. Healthscope is investigating the use of "Rainbow" Accreditation to ensure culturally and sensitive approaches GBLTI patients. **4.4, 4.5, 4.6 The MHS demonstrates engagement with other diverse groups service providers and that non-discriminatory practices are in place.** There are policies which cover Code of Conduct, Diversity and Grievance Management - all of which contribute to ensuring the diverse needs of the community are met by staff. TGC is a participant in the Healthscope workplace gender equality project ("Rainbow accreditation")

Criterion 4.1

The MHS identifies the diverse groups (Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD), religious / spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status) that access the service.

Surveyor's Rating	Met

Criterion 4.2

The MHS whenever possible utilises available and reliable data on identified diverse groups to document and regularly review the needs of its community and communicates this information to staff.

Surveyor's Rating	Met

Criterion 4.4

The MHS has demonstrated knowledge of and engagement with other service providers or organisations with diversity expertise / programs relevant to the unique needs of its community.

Surveyor's Rating	Met

Criterion 4.5

Staff are trained to access information and resources to provide services that are appropriate to the diverse needs of its consumers.

Surveyor's Rating	Met

Criterion 4.6

The MHS addresses issues associated with prejudice, bias and discrimination in regards to its own staff to ensure non-discriminatory practices and equitable access to services.

Surveyor's Rating	Met

National Standards for Mental Health Services (Unmapped Criteria) to NSQHS Standards

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

STANDARD 5 Promotion and prevention

The MHS works in partnership with its community to promote mental health and address prevention of mental health problems and / or mental illness.

Surveyor Summary
5.1, 5.2, 5.3 The MHS promotes mental health to the community, addresses early identification and prevention and ensures consumers/carers are included in developing these strategies and activities. TGC has well established linkages with health and when appropriate works with organisations such as ARAFMI, Eating Disorders Vic and National Carers. The organisation was active in sponsoring Mental Health Week and a video of staff talking about their roles and responsibilities was launched. Staff from TGC participated in the Healthscope Cape York "Djarragun" project which was designed to promote health with the indigenous community. The Business Manager based at Geelong Private is accountable for developing and promoting prevention activities for both Geelong Private and Geelong Clinic. This includes management of a Facebook page, placing advertisements s in newspapers, use of radio advertising and arranging for billboards in shopping centres. LInkages have been created with Alcoholics Anonymous and Narcotics Anonymous and other local groups associated with addictive behaviours. Advice regarding management of eating disorders and personality disorders is provided to the Directors of Nursing of acute care hospitals when indicated. **5.4, 5.5, 5.6 The MH demonstrates it evaluates strategies and activities with its service provider partners and ensures its workforce is adequately trained in rights and responsibilities.** R&R is reinforced at staff Orientation and included in the staff handbook. There is a service FB page which the organisation uses to promote mental health initiatives. Mental Health competency training is provided by eLearning programs with particular emphasis on high risk learning. Staff are supported to attend mental health conferences and there is an active research program. Clinical case reviews are attended by Professor Michael Berk, Director of Professorial Unit, The Geelong CliniC, who provide opportunities of expert advice and learning for colleagues.

Criterion 5.1

The MHS develops strategies appropriate to the needs of its community to promote mental health and address early identification and prevention of mental health problems and / or mental illness that are responsive to the needs of its community, by establishing and sustaining partnerships with consumers, carers, other service providers and relevant stakeholders.

Surveyor's Rating	Met

Criterion 5.2
The MHS develops implementation plans to undertake promotion and prevention activities, which include the prioritisation of the needs of its community and the identification of resources required for implementation, in consultation with their partners.

Surveyor's Rating	Met

Criterion 5.3
The MHS, in partnership with other sectors and settings supports the inclusion of mental health consumers and carers in strategies and activities that aim to promote health and wellbeing.

Surveyor's Rating	Met

Criterion 5.4
The MHS evaluates strategies, implementation plans, sustainability of partnerships and individual activities in consultation with their partners. Regular progress reports on achievements are provided to consumers, carers, other service providers and relevant stakeholders.

Surveyor's Rating	Met

Criterion 5.5
The MHS identifies a person who is accountable for developing, implementing and evaluating promotion and prevention activities.

Surveyor's Rating	Met

Criterion 5.6
The MHS ensures that their workforce is adequately trained in the principles of mental health promotion and prevention and their applicability to the specialised mental health service context with appropriate support provided to implement mental health promotion and prevention activities.

Surveyor's Rating	Met

National Standards for Mental Health Services (Unmapped Criteria) to NSQHS Standards

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

STANDARD 7 Carers

The MHS recognises, respects, values and supports the importance of carers to the wellbeing, treatment, and recovery of people with a mental illness.

Surveyor Summary
7.1, 7.2, 7.3 The MHS can identify carers, implements and maintains ongoing engagement with carers as partners in the delivery of care soon as possible and a policy is in place where a consumer refuses to name a carer. Identified carers and next of kin are identified at Intake and confirmed on admission. This is a mandatory field in the admission database. If a patient refuses to identify a carer this matter is revisited after symptomology has improved. Care is taken to identify the level of information which can be provided to carers or family. There are several groups provided within TGC and family and carers are invited to attend, Friends and Carers of Addiction. The TRP service invites carers to the first assessment, or inpatient day and a special group during week three of the special program. After lunch family and participants of the program participate in an interpersonal effectiveness group to share experiences. **7.6, 7.8 The MHS has a policy that identifies the special needs of children or aged persons as carers and carers are identified in the health record.** At Geelong Clinic when appropriate children of patients can be referred for support from the COPMI services (public mental health). **7.9, 7.11, 7.13 Evidence that the MHS is providing carers with non-personal information, involving carers in relapse prevention plans and providing information on access to other services as required.** Consumers nominate what level of information is shared with family members as part of the admission process. Identification of Next of Kin is a mandatory field in the e- admission. Information packs are given to carers on Intake and made available at discharge. Carers are invited to contribute (if appropriate) in discharge planning. The twelve-week Trauma Response Programme has specific sessions scheduled which incorporate carer participation; these include family lunches and participation in an interpersonal effectiveness group.

Criterion 7.1

The MHS has clear policies and service delivery protocols to enable staff to effectively identify carers as soon as possible in all episodes of care, and this is recorded and prominently displayed within the consumer's health record.

Surveyor's Rating	Met

Criterion 7.2
The MHS implements and maintains ongoing engagement with carers as partners in the delivery of care as soon as possible in all episodes of care.

Surveyor's Rating	Met

Criterion 7.3
In circumstances where a consumer refuses to nominate their carer(s), the MHS reviews this status at regular intervals during the episode of care in accordance with Commonwealth and state / territory jurisdictional and legislative requirements.

Surveyor's Rating	Met

Criterion 7.6
The MHS considers the special needs of children and aged persons as carers and makes appropriate arrangements for their support.

Surveyor's Rating	Met

Criterion 7.8
The MHS ensures information regarding identified carers is accurately recorded in the consumer's health record and reviewed on a regular basis.

Surveyor's Rating	Met

Criterion 7.9
The MHS provides carers with non-personal information about the consumer's mental health condition, treatment, ongoing care and if applicable, rehabilitation.

Surveyor's Rating	Met

Criterion 7.11

The MHS actively encourages routine identification of carers in the development of relapse prevention plans.

Surveyor's Rating	Met

Criterion 7.13

The MHS provides information about and facilitates access to services that maximise the wellbeing of carers.

Surveyor's Rating	Met

National Standards for Mental Health Services (Unmapped Criteria) to NSQHS Standards

Organisation : Geelong Clinic, The
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STANDARD 8 Governance, leadership and management

The MHS is governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services.

Surveyor Summary
8.2 The MHS ensures strategies for the promotion, early identification and prevention of mental health illness. All consumers complete a discharge planning workbook during their admission and discussion on discharge planning occurs on admission in the context of goal setting. Brochures are readily available and information sheets can be downloaded from TGC's website.

Criterion 8.2

The MHS has processes to ensure accountability for developing strategies to promote mental health and address early identification and prevention of mental health problems and / or mental illness.

Surveyor's Rating	Met

National Standards for Mental Health Services (Unmapped Criteria) to NSQHS Standards

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

STANDARD 9 Integration

The MHS collaborates with and develops partnerships within in its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and carers.

Surveyor Summary
9.1, 9.2, 9.5 The MHS ensures a designated person is available for care coordination, interdisciplinary care teams are supported and formal processes are in place to develop and collaborate with interagency and inter-sectoral links. At Geelong Clinic the treating psychiatrist is the designated person responsible for care coordination. Consultants are available 24/7. There are multidisciplinary case review meetings which provide for comprehensive review of clinical care for each individual. Supervision is readily available for allied health staff. The organisation demonstrated linkages with appropriate external agencies including public and private local hospitals as well as NGOs.

Criterion 9.1

The MHS ensures that a person responsible for the coordination of care is available to facilitate coordinated and integrated services throughout all stages of care for consumers and carers.

Surveyor's Rating	Met

Criterion 9.2

The MHS has formal processes to support and sustain interdisciplinary care teams.

Surveyor's Rating	Met

Criterion 9.5

The MHS has formal processes to develop inter-agency and inter-sectoral links and collaboration.

Surveyor's Rating	Met

National Standards for Mental Health Services (Unmapped Criteria) to NSQHS Standards

Organisation : Geelong Clinic, The
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STANDARD 10 Delivery of Care

Surveyor Summary

10.1 Supporting Recovery
10.1.1, 10.1.3, 10.1.4, 10.1.5, 10.1.7, 10.1.9, .10.1.10 The MHS supports and promotes recovery principles, recognises the lived experience of consumers, promotes the enhancement of social connections and has a comprehensive knowledge of community resources.

The organisation reinforces the concept of recovery. This is evidenced by encouraging patients to identify goals at the time of admission. Patients are encouraged to set their own course of care and consideration is given to encourage them to reflect on what has worked in the past to promote mental health. Patients are encouraged to identify problems at the point of admission. Patients are encouraged to pursue their goals through participation in group work as one of the therapeutic interventions, to maximise learnings from other consumers. Language used in promotional material eg brochures and information on the intranet is recovery orientated.

10.2 Access
10.2.1, 10.2.2, 10.2.3, 10.2.4 The MHS demonstrates access and available services to address the needs of its community in a timely manner.

Whilst the organisation does not provide 24-hour admission service, outside of business hours, consumers in crisis will be referred to Barwon Mental Health Service. There are close relations with this service as some staff work between both services. As a private facility Geelong Clinic is unable to provide treatment to the whole range of mental health disorders - particularly those which would result in a non-voluntary admission. A clearly defined exclusion admission / referral document is promoted eg all patients must be capable of self-care.

10.3 Entry
10.3.1, 10.3.2, 10.3.3, 10.3.4, 10.3.5, 10.3.7, 10.3.8 the MHS demonstrates entry inclusion and exclusion criteria, has a documented system for prioritising risk, service specific entry points and policies for involuntary admissions.

There are policies underpinning entry processes to the Geelong Clinic. Exclusion criteria clearly defined. The entry process includes telephone triage by a senior nurse. Anyone presenting with high acuity is referred to public mental health services for initial treatment and support. TGC does not admit any involuntary patients. After symptom resolution it is possible for the patient to transfer to TGC.

10.4 Assessment/Review
10.4.2, 10.4.4, 10.4.6, 10.4.7, 10.4.8 the MHS conducts assessment/review of treatment, care and recovery plans for voluntary and involuntary at least every 3/12 (by qualified staff) and where appropriate with the consumer/carer and has a procedure in place for patients who decline follow up.

Care plans are written on admission and signed off by the consumer and a copy of this is kept in their room. These are reviewed by the treating team (multidisciplinary review) every week. The care plan includes issues that the consumer would like to work on during their admission. The assessment process also includes identification of potential risk and nominated levels of observation required.

10.5 Treatment/Support
10.5.4, 10.5.5 Informed consent is obtained for participation in clinical trials or experimental treatments and the MHS Provides the least restrictive environment, consideration given to a consumer's needs, availability and support and safety of all involved.

There are currently no clinical trials occurring. There have been in the past. Ethics approval for trials is managed through the Healthscope Melbourne Clinic Ethics Committee.

10.5.12, 10.5.13, 10.5.14, 10.5.15, 10.5.16, 10.5.17 The MHS demonstrates it facilitates access to appropriate agencies to meet consumers' needs for recreation, education, work, accommodation and self-care programs.

Generally, the patient mix consists of those that are functioning reasonably well in the community (ie Work and accommodation issues are not prevalent problems). Patient information provides guidance on supportive NGOs which is distributed to consumers and carers on admission and discharge. Patients at TGC have access to a social worker at Geelong Private if required.

10.6 Exit / Re-entry
10.6.1, 10.6.2, 10.6.3, 10.6.5, 10.6.6, 10.6.7, 10.6.8 The MHS demonstrates the consumer has access to services that promote recovery, commences an exit plan on consumers access to the service, ease of access for re-entry and follow up within 7 days.

The organisation has a written admission policy which also articulates exclusion criterion. There is an admission flow chart and a system to ensure telephone follow-up for those on a waiting list for admission. It was clear that "recovery" principles are supported during the treatment process. Goal setting, which occurs at time of admission includes enabling patients to consider what has, and has not worked in the past. It was noticed during clinical handovers that patients were encouraged to reflect on goals in the context of reviewing daily activities. There are clear processes which will facilitate re-entry to the service if required. Examples were given of some patients actually given re-admission dates prior to current discharge - (where this was clinically indicated). Some patients have a case manager within local public mental health service for follow up. There is an outreach service that provides support in the community by the staff of The Geelong Clinic for those patients for whom this is appropriate. Risk assessment occurs at time of admission and at least every 24 hours thereafter. The level of assessed risk will dictate the level and frequency of observations and leave options. The provision of the day hospital provides opportunities for discharged patients (with otherwise minimal options) to engage in social activities with others. TGC has flexible visiting hours and families are able to have meals with patients. Care plans are reviewed weekly. They are kept in the patient bedrooms and signed by patients. For those enrolled in the PTSD program, follow-up on completion of the program occurs according to the PHOENIX research and evaluation protocols. At time of this review, there was no active research involving patients. Approval for conducting any proposed research would be obtained through the Healthscope Melbourne Clinic Ethics Committee.

National Standards for Mental Health Services (Unmapped Criteria) to NSQHS Standards

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

STANDARD 10.1 Supporting recovery

Criterion 10.1.1

The MHS actively supports and promotes recovery oriented values and principles in its policies and practices.

Surveyor's Rating	Met

Criterion 10.1.3

The MHS recognises the lived experience of consumers and carers and supports their personal resourcefulness, individuality, strengths and abilities.

Surveyor's Rating	Met

Criterion 10.1.4

The MHS encourages and supports the self-determination and autonomy of consumers and carers.

Surveyor's Rating	Met

Criterion 10.1.5

The MHS promotes the social inclusion of consumers and advocates for their rights of citizenship and freedom from discrimination.

Surveyor's Rating	Met

Criterion 10.1.7

The MHS supports and promotes opportunities to enhance consumers' positive social connections with family, children, friends and their valued community.

Surveyor's Rating	Met

Criterion 10.1.9

The MHS has a comprehensive knowledge of community services and resources and collaborates with consumers and carers to assist them to identify and access relevant services.

Surveyor's Rating	Met

Criterion 10.1.10

The MHS provides access for consumers and their carer(s) to a range of carer-inclusive approaches to service delivery and support.

Surveyor's Rating	Met

STANDARD 10.2 Access

The MHS is accessible to the individual and meets the needs of its community in a timely manner.

Criterion 10.2.1

Access to available services meets the identified needs of its community in a timely manner.

Surveyor's Rating	Met

Criterion 10.2.2

The MHS informs its community about the availability, range of services and methods for establishing contact with its service.

Surveyor's Rating	Met

Criterion 10.2.3

The MHS makes provision for consumers to access acute services 24 hours per day by either providing the service itself or information about how to access such care from a 24/7 public mental health service or alternate mental health service.

Surveyor's Rating	Met

Criterion 10.2.4

The MHS, wherever possible, is located to provide ease of physical access with special attention being given to those people with physical disabilities and/or reliance on public transport.

Surveyor's Rating	Met

STANDARD 10.3 Entry

The entry process to the MHS meets the needs of its community and facilitates timeliness of entry and ongoing assessment.

Criterion 10.3.1

The MHS has a written description of its entry process, inclusion and exclusion criteria and means of facilitating access to alternative care for people not accepted by the service.

Surveyor's Rating	Met

Criterion 10.3.2

The MHS makes known its entry process, inclusion and exclusion criteria to consumers, carers, other service providers, and relevant stakeholders including police, ambulance services and emergency departments.

Surveyor's Rating	Met

Criterion 10.3.3

The MHS has a documented system for prioritising referrals according to risk, urgency, distress, dysfunction and disability with timely advice and / or response to all those referred, at the time of assessment.

Surveyor's Rating	Met

Criterion 10.3.4

The entry process to the MHS is a defined pathway with service specific entry points that meet the needs of the consumer, their carer(s) and its community that are complementary to any existing generic health or welfare intake systems.

Surveyor's Rating	Met

Criterion 10.3.5

Entry to the MHS minimises delay and the need for duplication in assessment, treatment, care and recovery planning and care delivery.

Surveyor's Rating	Met

Criterion 10.3.7

When the consumer requires involuntary admission to the MHS the transport occurs in the safest and most respectful manner possible and complies with relevant Commonwealth and state / territory policies and guidelines, including the National Safe Transportation Principles.

Surveyor's Rating	Met

Criterion 10.3.8

The MHS ensures that a consumer and their carer(s) are able to identify a nominated person responsible for coordinating their care and informing them about any changes in the care management.

Surveyor's Rating	Met

STANDARD 10.4 Assessment and review

Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carer(s).

Criterion 10.4.2

Assessments are conducted during the consumer's first contact with the MHS by appropriately qualified staff experienced and trained in assessing mental health problems, and where possible in a consumer's preferred setting with consideration of safety for all involved.

Surveyor's Rating	Met

Criterion 10.4.4

The MHS actively plans as early as possible in the course of psychiatric inpatient admission, for the discharge of the consumer from inpatient care.

Surveyor's Rating	Met

Criterion 10.4.6

The MHS conducts assessment and review of the consumer's treatment, care and recovery plan, whether involuntary or voluntary, at least every three months (if not previously required for reasons stated in criteria 10.4.5 above).

Surveyor's Rating	Met

Criterion 10.4.7

The MHS has a procedure for appropriate follow-up of those who decline to participate in an assessment.

Surveyor's Rating	Met

Criterion 10.4.8

There is a current individual interdisciplinary treatment, care and recovery plan, which is developed in consultation with and regularly reviewed with the consumer and with the consumer's informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them.

Surveyor's Rating	Met

STANDARD 10.5 Treatment and support

The MHS provides access to a range of evidence based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promotes their recovery.

Criterion 10.5.4

Any participation of the consumer in clinical trials and experimental treatments is subject to the informed consent of the consumer.

Surveyor's Rating	Met

Criterion 10.5.5

The MHS provides the least restrictive and most appropriate treatment and support possible. Consideration is given to the consumer's needs and preferences, the demands on carers, and the availability of support and safety of those involved.

Surveyor's Rating	Met

Criterion 10.5.12

The MHS facilitates access to an appropriate range of agencies, programs, and / or interventions to meet the consumer's needs for leisure, relationships, recreation, education, training, work, accommodation and employment in settings appropriate to the individual consumer.

Surveyor's Rating	Met

Criterion 10.5.13

The MHS supports and / or provides information regarding self-care programs that can enable the consumer to develop or re-develop the competence to meet their everyday living needs.

Surveyor's Rating	Met

Criterion 10.5.14

The setting for the learning or the re-learning of self-care activities is the most familiar and / or the most appropriate for the skills acquired.

Surveyor's Rating	Met

Criterion 10.5.15

Information on self-care programs or interventions is provided to consumers and their carer(s) in a way that is understandable to them.

Surveyor's Rating	Met

Criterion 10.5.16

The MHS endeavours to provide access to a range of accommodation and support options that meet the needs of the consumer and gives the consumer the opportunity to choose between these options.

Surveyor's Rating	Met

Criterion 10.5.17

The MHS promotes access to vocational support systems, education and employment programs.

Surveyor's Rating	Met

STANDARD 10.6 Exit and re-entry

The MHS assists consumers to exit the service and ensures re-entry according to the consumer's needs.

Criterion 10.6.1

The MHS ensures that on exiting the service the consumer has access to services that promote recovery and aim to minimise psychiatric disability and prevent relapse.

Surveyor's Rating	Met

Criterion 10.6.2

The consumer and their carer(s) are provided with understandable information on the range of relevant services and support available in the community.

Surveyor's Rating	Met

Criterion 10.6.3

The MHS has a process to commence development of an exit plan at the time the consumer enters the service.

Surveyor's Rating	Met

Criterion 10.6.5

The MHS provides consumers, their carers and other service providers involved in follow-up with information on the process for re-entering the MHS if required.

Surveyor's Rating	Met

Criterion 10.6.6

The MHS ensures ease of access for consumers re-entering the MHS.

Surveyor's Rating	Met

Criterion 10.6.7
Staff review the outcomes of treatment and support as well as ongoing follow-up arrangements for each consumer prior to their exit from the MHS.

Surveyor's Rating	Met

Criterion 10.6.8
The MHS, in conjunction with the treating clinician, has a procedure for appropriate follow-up of all consumers within 7 days after discharge from inpatient care wherever possible, and has a follow-up procedure for those consumers who do not keep the planned follow-up arrangements.

Surveyor's Rating	Met

National Standards for Mental Health Services (Unmapped Criteria) to NSQHS Standards

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

Rating Summary

STANDARD 1	
1.9	Met
1.15	Met
1.17	Met

STANDARD 2	
2.1	Met
2.2	Met
2.5	Met

STANDARD 3	
3.4	Met

STANDARD 4	
4.1	Met
4.2	Met
4.4	Met
4.5	Met
4.6	Met

STANDARD 5	
5.1	Met
5.2	Met
5.3	Met
5.4	Met
5.5	Met
5.6	Met

National Standards for Mental Health Services (Unmapped Criteria) to NSQHS Standards

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

STANDARD 7	
7.1	Met
7.2	Met
7.3	Met
7.6	Met
7.8	Met
7.9	Met
7.11	Met
7.13	Met

STANDARD 8	
8.2	Met

STANDARD 9	
9.1	Met
9.2	Met
9.5	Met

STANDARD 10	
STANDARD 10.1	
10.1.1	Met
10.1.3	Met
10.1.4	Met
10.1.5	Met
10.1.7	Met
10.1.9	Met
10.1.10	Met

STANDARD 10.2	
10.2.1	Met
10.2.2	Met
10.2.3	Met
10.2.4	Met

National Standards for Mental Health Services (Unmapped Criteria) to NSQHS Standards

Organisation : Geelong Clinic, The
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STANDARD 10.3	
10.3.1	Met
10.3.2	Met
10.3.3	Met
10.3.4	Met
10.3.5	Met
10.3.7	Met
10.3.8	Met

STANDARD 10.4	
10.4.2	Met
10.4.4	Met
10.4.6	Met
10.4.7	Met
10.4.8	Met

STANDARD 10.5	
10.5.4	Met
10.5.5	Met
10.5.12	Met
10.5.13	Met
10.5.14	Met
10.5.15	Met
10.5.16	Met
10.5.17	Met

STANDARD 10.6	
10.6.1	Met
10.6.2	Met
10.6.3	Met
10.6.5	Met
10.6.6	Met
10.6.7	Met
10.6.8	Met

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

Action	Description	Organisation's self-rating	Surveyor Rating
1.1.1	An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols	SM	SM
1.1.2	The impact on patient safety and quality of care is considered in business decision making	SM	MM
1.2.1	Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance	SM	SM
1.2.2	Action is taken to improve the safety and quality of patient care	SM	MM
1.3.1	Workforce are aware of their delegated safety and quality roles and responsibilities	SM	SM
1.3.2	Individuals with delegated responsibilities are supported to understand and perform their roles and responsibilities, in particular to meet the requirements of these Standards	SM	SM
1.3.3	Agency or locum workforce are aware of their designated roles and responsibilities	SM	SM
1.4.1	Orientation and ongoing training programs provide the workforce with the skill and information needed to fulfil their safety and quality roles and responsibilities	SM	SM
1.4.2	Annual mandatory training programs to meet the requirements of these Standards	SM	SM
1.4.3	Locum and agency workforce have the necessary information, training and orientation to the workplace to fulfil their safety and quality roles and responsibilities	SM	SM
1.4.4	Competency-based training is provided to the clinical workforce to improve safety and quality	SM	SM
1.5.1	An organisation-wide risk register is used and regularly monitored	SM	SM
1.5.2	Actions are taken to minimise risks to patient safety and quality of care	SM	SM
1.6.1	An organisation-wide quality management system is used and regularly monitored	SM	SM
1.6.2	Actions are taken to maximise patient quality of care	SM	SM

Clinical practice

Action	Description	Organisation's self-rating	Surveyor Rating
1.7.1	Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce	SM	SM
1.7.2	The use of agreed clinical guidelines by the clinical workforce is monitored	SM	SM
1.8.1	Mechanisms are in place to identify patients at increased risk of harm	SM	SM
1.8.2	Early action is taken to reduce the risks for at-risk patients	SM	MM

1.8.3	Systems exist to escalate the level of care when there is an unexpected deterioration in health status	SM	SM
1.9.1	Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care	SM	SM
1.9.2	The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards	SM	SM

Performance and skills management

Action	Description	Organisation's self-rating	Surveyor Rating
1.10.1	A system is in place to define and regularly review the scope of practice for the clinical workforce	SM	SM
1.10.2	Mechanisms are in place to monitor that the clinical workforce are working within their agreed scope of practice	SM	SM
1.10.3	Organisational clinical service capability, planning and scope of practice is directly linked to the clinical service roles of the organisation	SM	SM
1.10.4	The system for defining the scope of practice is used whenever a new clinical service, procedure or other technology is introduced	SM	SM
1.10.5	Supervision of the clinical workforce is provided whenever it is necessary for individuals to fulfil their designated role	SM	SM
1.11.1	A valid and reliable performance review process is in place for the clinical workforce	SM	SM
1.11.2	The clinical workforce participates in regular performance reviews that support individual development and improvement	SM	SM
1.12.1	The clinical and relevant non-clinical workforce have access to ongoing safety and quality education and training for identified professional and personal development	SM	SM
1.13.1	Analyse feedback from the workforce on their understanding and use of safety and quality systems	SM	SM
1.13.2	Action is taken to increase workforce understanding and use of safety and quality systems	SM	SM

Incident and complaints management

Action	Description	Organisation's self-rating	Surveyor Rating
1.14.1	Processes are in place to support the workforce recognition and reporting of incidents and near misses	SM	SM
1.14.2	Systems are in place to analyse and report on incidents	SM	SM
1.14.3	Feedback on the analysis of reported incidents is provided to the workforce	SM	SM
1.14.4	Action is taken to reduce risks to patients identified through the incident management system	SM	SM
1.14.5	Incidents and analysis of incidents are reviewed at the highest level of governance in the organisation	SM	SM
1.15.1	Processes are in place to support the workforce to recognise and report complaints	SM	SM
1.15.2	Systems are in place to analyse and implement improvements in response to complaints	SM	SM
1.15.3	Feedback is provided to the workforce on the analysis of	SM	SM

	reported complaints		
1.15.4	Patient feedback and complaints are reviewed at the highest level of governance in the organisation	SM	SM
1.16.1	An open disclosure program is in place and is consistent with the national open disclosure standard	SM	SM
1.16.2	The clinical workforce are trained in open disclosure processes	SM	SM

Patient rights and engagement

Action	Description	Organisation's self-rating	Surveyor Rating
1.17.1	The organisation has a charter of patient rights that is consistent with the current national charter of healthcare rights	SM	SM
1.17.2	Information on patient rights is provided and explained to patients and carers	SM	SM
1.17.3	Systems are in place to support patients who are at risk of not understanding their healthcare rights	SM	SM
1.18.1	Patients and carers are partners in the planning for their treatment	SM	SM
1.18.2	Mechanisms are in place to monitor and improve documentation of informed consent	SM	SM
1.18.3	Mechanisms are in place to align the information provided to patients with their capacity to understand	SM	SM
1.18.4	Patients and carers are supported to document clear advance care directives and/or treatment-limiting orders	SM	SM
1.19.1	Patient clinical records are available at the point of care	SM	SM
1.19.2	Systems are in place to restrict inappropriate access to and dissemination of patient clinical information	SM	SM
1.20.1	Data collected from patient feedback systems are used to measure and improve health services in the organisation	SM	SM

Partnering with Consumers

Consumer partnership in service planning

Action	Description	Organisation's self-rating	Surveyor Rating
2.1.1	Consumers and/or carers are involved in the governance of the health service organisation	SM	MM
2.1.2	Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback	SM	SM
2.2.1	The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation	SM	SM
2.2.2	Consumers and/or carers are actively involved in decision making about safety and quality	SM	SM
2.3.1	Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role	SM	SM
2.4.1	Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for	SM	SM

	distribution to patients)		
2.4.2	Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients	SM	SM

Consumer partnership in designing care

Action	Description	Organisation's self-rating	Surveyor Rating
2.5.1	Consumers and/or carers participate in the design and redesign of health services	SM	SM
2.6.1	Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care	SM	SM
2.6.2	Consumers and/or carers are involved in training the clinical workforce	SM	SM

Consumer partnership in service measurement and evaluation

Action	Description	Organisation's self-rating	Surveyor Rating
2.7.1	The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance	SM	SM
2.8.1	Consumers and/or carers participate in the analysis of organisational safety and quality performance	SM	SM
2.8.2	Consumers and/or carers participate in the planning and implementation of quality improvements	SM	SM
2.9.1	Consumers and/or carers participate in the evaluation of patient feedback data	SM	SM
2.9.2	Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data	SM	SM

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

Action	Description	Organisation's self-rating	Surveyor Rating
3.1.1	A risk management approach is taken when implementing policies, procedures and/or protocols for: • standard infection control precautions • transmission-based precautions • aseptic non-touch technique • safe handling and disposal of sharps • prevention and management of occupational exposure to blood and body substances • environmental cleaning and disinfection • antimicrobial prescribing • outbreaks or unusual clusters of communicable infection • processing of reusable medical devices • single-use devices • surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases	SM	SM

	• provision of risk assessment guidelines to workforce • exposure-prone procedures		
3.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
3.1.3	The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation	SM	SM
3.1.4	Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols	SM	SM
3.2.1	Surveillance systems for healthcare associated infections are in place	SM	SM
3.2.2	Healthcare associated infections surveillance data are regularly monitored by the delegated workforce and/or committees	SM	SM
3.3.1	Mechanisms to regularly assess the healthcare associated infection risks are in place	SM	SM
3.3.2	Action is taken to reduce the risks of healthcare associated infection	SM	SM
3.4.1	Quality improvement activities are implemented to reduce and prevent healthcare associated infections	SM	SM
3.4.2	Compliance with changes in practice are monitored	SM	SM
3.4.3	The effectiveness of changes to practice are evaluated	SM	SM

Infection prevention and control strategies

Action	Description	Organisation's self-rating	Surveyor Rating
3.5.1	Workforce compliance with current national hand hygiene guidelines is regularly audited	SM	SM
3.5.2	Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation	SM	SM
3.5.3	Action is taken to address non-compliance, or the inability to comply, with the requirements of the current national hand hygiene guidelines	SM	SM
3.6.1	A workforce immunisation program that complies with current national guidelines is in use	SM	SM
3.7.1	Infection prevention and control consultation related to occupational health and safety policies, procedures and/or protocols are implemented to address: • communicable disease status • occupational management and prophylaxis • work restrictions • personal protective equipment • assessment of risk to healthcare workers for occupational allergies • evaluation of new products and procedures	SM	SM
3.8.1	Compliance with the system for the use and management of invasive devices in monitored	SM	SM
3.9.1	Education and competency-based training in invasive devices protocols and use is provided for the workforce who perform procedures with invasive devices	SM	SM
3.10.1	The clinical workforce is trained in aseptic technique	SM	SM
3.10.2	Compliance with aseptic technique is regularly audited	SM	SM
3.10.3	Action is taken to increase compliance with the aseptic technique	SM	SM

	protocols

Managing patients with infections or colonisations

Action	Description	Organisation's self-rating	Surveyor Rating
3.11.1	Standard precautions and transmission-based precautions consistent with the current national guidelines are in use	SM	SM
3.11.2	Compliance with standard precautions is monitored	SM	SM
3.11.3	Action is taken to improve compliance with standard precautions	SM	SM
3.11.4	Compliance with transmission-based precautions is monitored	SM	SM
3.11.5	Action is taken to improve compliance with transmission-based precautions	SM	SM
3.12.1	A risk analysis is undertaken to consider the need for transmission-based precautions including: • accommodation based on the mode of transmission • environmental controls through air flow • transportation within and outside the facility • cleaning procedures • equipment requirements	SM	SM
3.13.1	Mechanisms are in use for checking for pre-existing healthcare associated infections or communicable disease on presentation for care	SM	SM
3.13.2	A process for communicating a patient's infectious status is in place whenever responsibility for care is transferred between service providers or facilities	SM	SM

Antimicrobial stewardship

Action	Description	Organisation's self-rating	Surveyor Rating
3.14.1	An antimicrobial stewardship program is in place	SM	SM
3.14.2	The clinical workforce prescribing antimicrobials have access to current endorsed therapeutic guidelines on antibiotic usage	SM	SM
3.14.3	Monitoring of antimicrobial usage and resistance is undertaken	SM	SM
3.14.4	Action is taken to improve the effectiveness of antimicrobial stewardship	SM	SM

Cleaning, disinfection and sterilisation

Action	Description	Organisation's self-rating	Surveyor Rating
3.15.1	Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including: • maintenance of building facilities • cleaning resources and services • risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved • waste management within the clinical environment • laundry and linen transportation, cleaning and storage • appropriate use of personal protective equipment	SM	SM
3.15.2	Policies, procedures and/or protocols for environmental cleaning are	SM	SM

	regularly reviewed		
3.15.3	An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly	SM	SM
3.16.1	Compliance with relevant national or international standards and manufacturer's instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored	SM	SM
3.17.1	A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place	SM	N/A
3.18.1	Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
3.19.1	Information on the organisation's corporate and clinical infection risks and initiatives implemented to minimise patient infection risks is provided to patients and/or carers	SM	SM
3.19.2	Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience	SM	SM

Medication Safety

Governance and systems for medication safety

Action	Description	Organisation's self-rating	Surveyor Rating
4.1.1	Governance arrangements are in place to support the development, implementation and maintenance of organisation-wide medication safety systems	SM	SM
4.1.2	Policies, procedures and/or protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines	SM	SM
4.2.1	The medication management system is regularly assessed	SM	SM
4.2.2	Action is taken to reduce the risks identified in the medication management system	SM	SM
4.3.1	A system is in place to verify that the clinical workforce have medication authorities appropriate to their scope of practice	SM	SM
4.3.2	The use of the medication authorisation system is regularly monitored	SM	SM
4.3.3	Action is taken to increase the effectiveness of the medication authority system	SM	SM
4.4.1	Medication incidents are regularly monitored, reported and investigated	SM	SM
4.4.2	Action is taken to reduce the risk of adverse medication incidents	SM	SM
4.5.1	The performance of the medication management system is regularly assessed	SM	SM
4.5.2	Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use	SM	SM

Documentation of patient information

Action	Description	Organisation's self-rating	Surveyor Rating
4.6.1	A best possible medication history is documented for each patient	SM	SM
4.6.2	The medication history and current clinical information is available at the point of care	SM	SM
4.7.1	Known medication allergies and adverse drug reactions are documented in the patient clinical record	SM	SM
4.7.2	Action is taken to reduce the risk of adverse reactions	SM	SM
4.7.3	Adverse drug reactions are reported within the organisation and to the Therapeutic Goods Administration	SM	SM
4.8.1	Current medicines are documented and reconciled at admission and transfer of care between healthcare settings	SM	SM

Medication management processes

Action	Description	Organisation's self-rating	Surveyor Rating
4.9.1	Information and decision support tools for medicines are available to the clinical workforce at the point of care	SM	SM
4.9.2	The use of information and decision support tools is regularly reviewed	SM	SM
4.9.3	Action is taken to improve the availability and effectiveness of information and decision support tools	SM	SM
4.10.1	Risks associated with secure storage and safe distribution of medicines are regularly reviewed	SM	SM
4.10.2	Action is taken to reduce the risks associated with storage and distribution of medicines	SM	SM
4.10.3	The storage of temperature-sensitive medicines is monitored	SM	SM
4.10.4	A system that is consistent with legislative and jurisdictional requirements for the disposal of unused, unwanted or expired medications is in place	SM	SM
4.10.5	The system for disposal of unused, unwanted or expired medications is regularly monitored	SM	SM
4.10.6	Action is taken to increase compliance with the system for storage, distribution and disposal of medications	SM	SM
4.11.1	The risks for storing, prescribing, dispensing and administration of high-risk medicines are regularly reviewed	SM	SM
4.11.2	Action is taken to reduce the risks of storing, prescribing, dispensing and administering high-risk medicines	SM	SM

Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	SM	SM
4.12.2	A current and comprehensive list of medicines is provided to the	SM	SM

	patient and/or carer when concluding an episode of care		
4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
4.13.1	The clinical workforce provides patients with patient specific medicine information, including medication treatment options, benefits and associated risks	SM	SM
4.13.2	Information that is designed for distribution to patients is readily available to the clinical workforce	SM	SM
4.14.1	An agreed medication management plan is documented and available in the patient's clinical record	SM	SM
4.15.1	Information on medicines is provided to patients and carers in a format that is understood and meaningful	SM	SM
4.15.2	Action is taken in response to patient feedback to improve medicines information distributed by the health service organisation to patients	SM	SM

Patient Identification and Procedure Matching

Identification of individual patients

Action	Description	Organisation's self-rating	Surveyor Rating
5.1.1	Use of an organisation-wide patient identification system is regularly monitored	SM	SM
5.1.2	Action is taken to improve compliance with the patient identification matching system	SM	SM
5.2.1	The system for reporting, investigating and analysis of patient care mismatching events is regularly monitored	SM	SM
5.2.2	Action is taken to reduce mismatching events	SM	SM
5.3.1	Inpatient bands are used that meet the national specifications for patient identification bands	SM	SM

Processes to transfer care

Action	Description	Organisation's self-rating	Surveyor Rating
5.4.1	A patient identification and matching system is implemented and regularly reviewed as part of structured clinical handover, transfer and discharge processes	SM	SM

Processes to match patients and their care

Action	Description	Organisation's self-rating	Surveyor Rating
5.5.1	A documented process to match patients and their intended treatment is in use	SM	SM

5.5.2	The process to match patients to any intended procedure, treatment or investigation is regularly monitored	SM	SM
5.5.3	Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	SM	SM

Clinical Handover

Governance and leadership for effective clinical handover

Action	Description	Organisation's self-rating	Surveyor Rating
6.1.1	Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored	SM	SM
6.1.2	Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols	SM	SM
6.1.3	Tools and guides are periodically reviewed	SM	SM

Clinical handover processes

Action	Description	Organisation's self-rating	Surveyor Rating
6.2.1	The workforce has access to documented structured processes for clinical handover that include: • preparing for handover, including setting the location and time while maintaining continuity of patient care • organising relevant workforce members to participate • being aware of the clinical context and patient needs • participating in effective handover resulting in transfer of responsibility and accountability for care	SM	SM
6.3.1	Regular evaluation and monitoring processes for clinical handover are in place	SM	SM
6.3.2	Local processes for clinical handover are reviewed in collaboration with clinicians, patients and carers	SM	SM
6.3.3	Action is taken to increase the effectiveness of clinical handover	SM	SM
6.3.4	The actions taken and the outcomes of local clinical handover reviews are reported to the executive level of governance	SM	SM
6.4.1	Regular reporting, investigating and monitoring of clinical handover incidents is in place	SM	SM
6.4.2	Action is taken to reduce the risk of adverse clinical handover incidents	SM	SM

Patient and carer involvement in clinical handover

Action	Description	Organisation's self-rating	Surveyor Rating
6.5.1	Mechanisms to involve a patient and, where relevant, their carer in clinical handover are in use	SM	SM

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Blood and Blood Products

Governance and systems for blood and blood product prescribing and clinical use

Action	Description	Organisation's self-rating	Surveyor Rating
7.1.1	Blood and blood product policies, procedures and/or protocols are consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products	N/A	N/A
7.1.2	The use of policies, procedures and/or protocols is regularly monitored	N/A	N/A
7.1.3	Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products	N/A	N/A
7.2.1	The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed	N/A	N/A
7.2.2	Action is taken to reduce the risks associated with transfusion practices and the clinical use of blood and blood products	N/A	N/A
7.3.1	Reporting on blood and blood product incidents is included in regular incident reports	N/A	N/A
7.3.2	Adverse blood and blood product incidents are reported to and reviewed by the highest level of governance in the health service organisation	N/A	N/A
7.3.3	Health service organisations participate in relevant haemovigilance activities conducted by the organisation or at state or national level	N/A	N/A
7.4.1	Quality improvement activities are undertaken to reduce the risks of patient harm from transfusion practices and the clinical use of blood and blood products	N/A	N/A

Documenting patient information

Action	Description	Organisation's self-rating	Surveyor Rating
7.5.1	A best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record	N/A	N/A
7.5.2	The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed	N/A	N/A
7.5.3	Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record	N/A	N/A
7.6.1	Adverse reactions to blood or blood products are documented in the patient clinical record	N/A	N/A
7.6.2	Action is taken to reduce the risk of adverse events from administering blood or blood products	N/A	N/A
7.6.3	Adverse events are reported internally to the appropriate governance level and externally to the pathology service provider, blood service or product manufacturer whenever appropriate	N/A	N/A

Managing blood and blood product safety

Action	Description	Organisation's self-rating	Surveyor Rating
7.7.1	Regular review of the risks associated with receipt, storage, collection and transport of blood and blood products is undertaken	N/A	N/A
7.7.2	Action is taken to reduce the risk of incidents arising from the use	N/A	N/A

	of blood and blood product control systems		
7.8.1	Blood and blood product wastage is regularly monitored	N/A	N/A
7.8.2	Action is taken to minimise wastage of blood and blood products	N/A	N/A

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
7.9.1	Patient information relating to blood and blood products, including risks, benefits and alternatives, is available for distribution by the clinical workforce	N/A	N/A
7.9.2	Plans for care that include the use of blood and blood products are developed in partnership with patients and carers	N/A	N/A
7.10.1	Information on blood and blood products is provided to patients and their carers in a format that is understood and meaningful	N/A	N/A
7.11.1	Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation	N/A	N/A

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines and incorporate screening and assessment tools	SM	SM
8.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
8.2.1	An organisation-wide system for reporting pressure injuries is in use	SM	SM
8.2.2	Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries	SM	SM
8.2.3	Information on pressure injuries is regularly reported to the highest level of governance in the health service organisation	SM	SM
8.2.4	Action is taken to reduce the frequency and severity of pressure injuries	SM	SM
8.3.1	Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries	SM	SM
8.4.1	Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries	SM	SM

Preventing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.5.1	An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury	SM	SM
8.5.2	The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation	SM	SM
8.5.3	Action is taken to maximise the proportion of patients who are	SM	SM

	screened for pressure injury on presentation		
8.6.1	Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries	SM	SM
8.6.2	Patient clinical records, transfer and discharge documentation are periodically audited to identify at-risk patients with documented skin assessments	SM	SM
8.6.3	Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries	SM	SM
8.7.1	Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record	SM	SM
8.7.2	The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed	SM	SM
8.7.3	Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan	SM	SM
8.7.4	Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan	SM	SM

Managing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.8.1	An evidence-based wound management system is in place within the health service organisation	SM	SM
8.8.2	Management plans for patients with pressure injuries are consistent with best practice and documented in the patient clinical record	SM	SM
8.8.3	Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans	SM	SM
8.8.4	Action is taken to increase compliance with evidence-based pressure injury management plans	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
8.9.1	Patient information on prevention and management of pressure injuries is provided to patients and carers in a format that is understood and is meaningful	SM	SM
8.10.1	Pressure injury management plans are developed in partnership with patients and carers	SM	SM

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

Action	Description	Organisation's self-rating	Surveyor Rating
9.1.1	Governance arrangements are in place to support the development, implementation, and maintenance of organisation-wide recognition and response systems	SM	SM
9.1.2	Policies, procedures and/or protocols for the organisation are implemented in areas such as:	SM	SM

	• measurement and documentation of observations • escalation of care • establishment of a rapid response system • communication about clinical deterioration		
9.2.1	Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems	SM	SM
9.2.2	Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as not for resuscitation or do not resuscitate) are reviewed to identify the use of the recognition and response systems, and any failures in these systems	SM	SM
9.2.3	Data collected about recognition and response systems are provided to the clinical workforce as soon as practicable	SM	SM
9.2.4	Action is taken to improve the responsiveness and effectiveness of the recognition and response systems	SM	SM

Recognising clinical deterioration and escalating care

Action	Description	Organisation's self-rating	Surveyor Rating
9.3.1	When using a general observation chart, ensure that it: • is designed according to human factors principles • includes the capacity to record information about respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness graphically over time • includes thresholds for each physiological parameter or combination of parameters that indicate abnormality • specifies the physiological abnormalities and other factors that trigger the escalation of care • includes actions required when care is escalated	SM	SM
9.3.2	Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan	SM	SM
9.3.3	Action is taken to increase the proportion of patients with complete sets of recorded observations, as specified in the patient's monitoring plan	SM	SM
9.4.1	Mechanisms are in place to escalate care and call for emergency assistance	SM	SM
9.4.2	Use of escalation processes, including failure to act on triggers for seeking emergency assistance, are regularly audited	SM	SM
9.4.3	Action is taken to maximise the appropriate use of escalation processes	SM	SM

Responding to clinical deterioration

Action	Description	Organisation's self-rating	Surveyor Rating
9.5.1	Criteria for triggering a call for emergency assistance are included in the escalation policies, procedures and/or protocols	SM	SM
9.5.2	The circumstances and outcome of calls for emergency assistance are regularly reviewed	SM	SM
9.6.1	The clinical workforce is trained and proficient in basic life support	SM	SM
9.6.2	A system is in place for ensuring access at all times to at least one clinician, either on-site or in close proximity, who can practise	SM	SM

	advanced life support

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
9.7.1	Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include: • the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce • local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration	SM	SM
9.8.1	A system is in place for preparing and/or receiving advance care plans in partnership with patients, families and carers	SM	SM
9.8.2	Advance care plans and other treatment-limiting orders are documented in the patient clinical record	SM	SM
9.9.1	Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response	SM	SM
9.9.2	Information about the system for family escalation of care is provided to patients, families and carers	SM	SM
9.9.3	The performance and effectiveness of the system for family escalation of care is periodically reviewed	SM	SM
9.9.4	Action is taken to improve the system performance for family escalation of care	SM	SM

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

Action	Description	Organisation's self-rating	Surveyor Rating
10.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools	SM	SM
10.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
10.2.1	Regular reporting, investigating and monitoring of falls incidents is in place	SM	SM
10.2.2	Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service organisation	SM	SM
10.2.3	Information on falls is reported to the highest level of governance in the health service organisation	SM	SM
10.2.4	Action is taken to reduce the frequency and severity of falls in the health service organisation	SM	SM
10.3.1	Quality improvement activities are undertaken to prevent falls and minimise patient harm	SM	SM
10.4.1	Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls	SM	SM

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Screening and assessing risks of falls and harm from falling

Action	Description	Organisation's self-rating	Surveyor Rating
10.5.1	A best practice screening tool is used by the clinical workforce to identify the risk of falls	SM	SM
10.5.2	Use of the screening tool is monitored to identify the proportion of at-risk patients that were screened for falls	SM	SM
10.5.3	Action is taken to increase the proportion of at-risk patients who are screened for falls upon presentation and during admission	SM	SM
10.6.1	A best practice assessment tool is used by the clinical workforce to assess patients at risk of falling	SM	SM
10.6.2	The use of the assessment tool is monitored to identify the proportion of at-risk patients with a completed falls assessment	SM	SM
10.6.3	Action is taken to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment	SM	SM

Preventing falls and harm from falling

Action	Description	Organisation's self-rating	Surveyor Rating
10.7.1	Use of best practice multifactorial falls prevention and harm minimisation plans is documented in the patient clinical record	SM	SM
10.7.2	The effectiveness and appropriateness of the falls prevention and harm minimisation plan are regularly monitored	SM	SM
10.7.3	Action is taken to reduce falls and minimise harm for at-risk patients	SM	SM
10.8.1	Discharge planning includes referral to appropriate services, where available	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
10.9.1	Patient information on falls risks and prevention strategies is provided to patients and their carers in a format that is understood and meaningful	SM	SM
10.10.1	Falls prevention plans are developed in partnership with patients and carers	SM	SM

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

Recommendations from Current Survey

Not applicable.

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

Recommendations from Previous Survey

Standard: Preventing and Controlling Healthcare Associated Infections
Criterion: Infection prevention and control strategies
Action: 3.5.1 Workforce compliance with current national hand hygiene guidelines is regularly audited

Recommendation: NSQHSS Survey 0214.3.5.1

Recommendation:

The Geelong Clinic continue to progress the Hand Hygiene auditing program to demonstrate a higher percentage of clinicians have been captured in the process.

Action:

Hand Hygiene auditing continues at The Geelong Clinic with a new Infection Control Provider (HICMR) appointed in December 2014.
All clinical staff allocated Hand Hygiene eLearning to complete.
Hand Hygiene policy available: Healthscope policy 8.10 Hand Hygiene
The Geelong Clinic staff are required to complete the hand hygiene training package using the tool provided by Hand Hygiene Australia.
Observational audits of hand hygiene are conducted throughout the year, based on the 5 moments of hand hygiene. The results are provided to clinical staff and the Heads of Department Committee.
Hand Hygiene auditing and education – Healthscope KPI
Gold Standard Auditor x2 onsite
MyHealthscope public reporting data on Infection Control and Hand Hygiene Infection control results reported to relevant committees as follows: MAC, HOD's & WH&S
Trial of Purell GoJo Hand Sanitiser foam implemented
Procurement Contracts - register of currently available National Products on the Healthscope HINT intranet site
Auditing of moments continues - Oct -Dec compliance rate; 67%. continue to work toward target of 75%

Completion Due by: 2016

Responsibility: L Sleeman

Organisation Completed: Yes

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

The Hand Hygiene program has continued with audit results showing considerable compliance improvement. The program is supported with two gold standard auditors, a requirement for the completion of the Hand Hygiene Australia online training package and the installation of additional hand hygiene stations throughout the facility.

Standard: Preventing and Controlling Healthcare Associated Infections
Criterion: Infection prevention and control strategies
Action: 3.10.2 Compliance with aseptic technique is regularly audited

Recommendation: NSQHSS Survey 0214.3.10.2

Recommendation:

The Geelong Clinic demonstrate that a higher percentage of staff have participated in the continuing aseptic technique audit program.

Action:

A new infection control consultant firm, HICMR, was appointed in December 2014 and an infection control consultant on site commenced in 2015
HICMR 9.3: Aseptic technique policy available
HSP Policy 8.38 Aseptic Technique
Practical competency for aseptic technique undertaken
Guidelines and procedures on as aseptic techniques are consistent with relevant policies and procedures.
The Geelong Clinic continues to audit clinicians who undertake aseptic procedures.
ANTT implementation budle purchased for audit tools and education.
Theory learning package allocated to all clinical staff.
Aseptic technique risk matrix undertaken in 2015.
Australasian College for Infection Prevention and Control Aseptic technique learning package implemented in 2016

Completion Due by: 2016

Responsibility: LSleeman

Organisation Completed: Yes

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

Records sighted during survey demonstrated a significant increase in the number and percentage of staff who have been trained and participated in aseptic technique auditing.

NSQHSS Survey

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

Standards Rating Summary Report

Organisation - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	39	0	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	0	20	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**189**	**20**	**209**

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	0	0	0
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**189**	**0**	**189**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	0	3	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**44**	**3**	**47**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	11	0	11
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	0	0	0
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**44**	**0**	**44**

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	0	15	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	0	23	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**0**	**233**	**23**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	15	0	15	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	0	0	0	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**233**	**0**	**233**	**Met**

NSQHSS Survey

Organisation : Geelong Clinic, The
Orgcode : 22 09 97

Surveyor - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	38	1	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	0	20	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**188**	**21**	**209**

Standard	SM	MM	Total
Standard 1	41	3	44
Standard 2	4	0	4
Standard 3	38	0	38
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	0	0	0
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**185**	**3**	**188**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	0	3	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**44**	**3**	**47**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	10	1	11
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	0	0	0
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**43**	**1**	**44**

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	0	15	0	15	Met
Standard 3	0	40	1	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	0	23	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**0**	**232**	**24**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	50	3	53	Met
Standard 2	14	1	15	Met
Standard 3	40	0	40	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	0	0	0	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**228**	**4**	**232**	**Met**