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

The Sydney Clinic

Bronte, NSW

Organisation Code: 12 06 16

Survey Date: 01-02 March 2017

ACHS Accreditation Status: ACCREDITED

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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.

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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
4 Recommendations from Previous Survey
5 Standards Rating Summary Report

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.

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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.

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Survey Report

Survey Overview

The Sydney Clinic (TSC) is a 44-bed private mental health hospital situated in the eastern suburb of Bronte in Sydney. It is a purpose-built two-storey facility providing a comprehensive range of general and speciality services consisting of both inpatient and day program services.

TSC maintains partnerships with the University of Western Sydney, Notre Dame University, Sydney University, UTAS and University of Central Queensland.

TSC provides Substance Withdrawal and Rehabilitation on both an inpatient and day patient program basis and also provides Electro Convulsive Therapy (ECT) three times a week. It was recognised that there was a gap in supporting patients with social issues so in 2016 a Social Worker was contracted to assist patients with housing, Centrelink and other social issues.

The facility has undergone a major refurbishment in the administration and admissions area resulting in a more private area for the admission of a patient with the relocation of the Registrar, the Intake Clinician and the Continuum of Care Planner to this new area.

There have been some changes in senior and executive staff over the past three years and resultant demonstrated improvements in service efficiency, staff and patient satisfaction.

TSC has in place effective systems for the management of infection prevention and control to ensure there is minimal risk of healthcare associated infections to both patients and staff.

Surveillance systems appropriate to TSC are in place; these are monitored and reported to the Quality and Risk Committee and the Medical Advisory Committee as required.

The continuing engagement by Healthscope (HSP) of the ‘Healthcare Infection Control Management Resources’ group (HICMR) to guide its infection control processes across all HSP hospitals, including TSC, provides ongoing support to the clinical staff. There is the full range of HICMR infection control policies, procedures, risk assessments (including ECT invasive devices), with planned audit programs in place to deliver an effective infection control system. Infection control is also included in the TSC organisational quality, safety, WHS and Infection Control Management Plan.

There are well-established and consistent systems to manage patient identification validated by regular audit, improving clinical handover with revision of its bedside handover process and its shift-to-shift patient information electronic ‘white board’.

TSC continues to be innovative and although operating on a site with limited opportunities for expansion it is providing excellent services in a well-appointed facility to a population of patients and clients seeking treatment for mental health and substance use issues who are requiring either an inpatient admission or admission to a day patient program.

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STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

TSC Clinical Governance system adheres to HSP governance principles with systems in place to minimise harm and risk for all patients with managers and clinicians having shared responsibilities for the TSC safety and quality system. Work Health and Safety (WHS) and Infection Prevention & Control (IPC) plans focus at all times on promoting safer outcomes. These plans are integral to all TSC processes and are supported by robust monitoring mechanisms with oversight by the TSC Executive.

New Quality Plans and improvement initiatives are based on the annual development of the Quality Plan, the evaluation of achievements from the previous twelve months and any new initiatives that are planned via targeted activities, improvement strategies projects and quality activities.

Clinical risk management, adverse event reporting and management, escalation of quality concerns and open disclosure are all described in either HSP or TSC policies, procedures or protocols.

Credentialing and scope of practice are monitored by TSC with oversight provided by HSP.

There is a strong focus at TSC on the collection and review of performance data; these include the analysis of reported incidents, performance development, regular clinical audits and ensuring compliance with legislative requirements. TSC ensures that orientation and ongoing training programs continue to provide TSC workforce with the skills and knowledge required to fulfil the quality and safety roles of all TSC clinical and non-clinical staff.

Clinical practice

TSC has agreed clinical guidelines, policies and procedures in place and available at the point of care, with audits and performance measures tracking any variance against these; for example, an analysis of an incident where it is demonstrated that an agreed clinical guideline has not been adhered to.

TSC clinicians have access to Therapeutic Guidelines online, links to key references, library reviews, the Australian Prescriber (including Medicines Safety Update). TSC has mechanisms to enable identification of patients at risk of harm via screening tools and close observation with early actions implemented for any 'at-risk' patient, and systems in place for the escalation of care when an unexpected deterioration takes place.

Integrated clinical records are available at the point of care with the design allowing systematic documentation auditing.

Performance and skills management

TSC has systems in place that define and monitor the scope of practice for all TSC clinicians with a clinicians' scope of practice linked to their role/s within TSC. Verification and re-verification of each clinician's credentials is closely monitored and managed both at TSC and HSP Corporate levels. Supervision is available for clinicians if required. All Position Descriptions (PD) denote the scope of practice with annual reviews of the PD during the appraisal process. Recruitment to vacancies adhering to the required minimum staff/patient ratios occurs promptly but if a suitable applicant is not found the position is re-advertised. TSC has the Kronos rostering system in place that ensures an appropriate skill mix and staff ratios are in place at TSC at all times.

Clinical and non-clinical staff have access to, and opportunities for, education and training and adequate investment is provided by TSC for this purpose.

Incident and complaints management

Any TSC incident is reported through RiskMan with policies including critical systems review, sentinel events management, complaints management and open disclosure. All clinicians are trained in the use of RiskMan with RiskMan eBulletins available via the intranet.

Shared learnings based on sentinel events are reported on RiskMan and shared with staff as appropriate.

All incidents are trended and presented at TSC Quality Committee meetings and to the Medical Advisory Committee (MAC). Data is also available on the MyHealthscope website with benchmarking occurring within HSP and via ACHS Clinical Indicators.

TSC complaints are made via the available Comments and Complaints form with locked feedback boxes available in the reception area and the clinical units. The General Manager(GM) is the designated TSC Complaints Officer and is available for consultation with consumers and carers.

Complaints/Compliments feedback is provided to staff and the Quality Committee has a standing agenda item - review of Complaints Feedback.

Patient rights and engagement

TSC displayed Charter of Patient Rights is consistent with the National Charter of Patient Rights. Patients, clients and carers are partners in their treatment with mechanisms in place to ensure that all the information being provided is aligned to their capacity to understand. Legislative requirements and HSP policy are adhered to in regard to obtaining consent to treatment; for example, ECT. Protocols are in place for the monitoring of consent via handover checklists, eg prior to ECT and documentation auditing.

Patients are encouraged to voice any complaints on their rights not being adhered to directly to a senior clinician via patient meetings, consumer satisfaction surveys or meetings with the Consumer Consultant.

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Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.1.1	SM	SM
1.1.2	SM	SM
1.2.1	SM	SM
1.2.2	SM	SM
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

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	SM
1.8.3	SM	SM
1.9.1	SM	SM
1.9.2	SM	SM

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

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STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

TSC has established mechanisms in place for engaging consumers in the governance of the clinic, with TSC adhering to the HSP consumer policy. A Consumer Consultant (CC) is employed by TSC who is newly appointed due to the resignation of the previous incumbent. Consumer surveys are conducted on a regular basis with a consumer participation audit conducted on an annual basis. The CC report is a standing agenda item on the TSC Quality Committee agenda. Consumer focus groups are conducted in the Day Patient Program, and patient-centred care ensures that partnerships with consumers via the clinical bedside handover continue to provide an opportunity for patients who do not usually provide feedback to the service.

Consumer partnership in designing care

The CC is a member of the Quality Committee and advises, when appropriate, the General Manager (GM) and Director of Clinical Services (DCS) on operational requirements. The CC position is included on the TSC organisational chart with the CC participating in staff education/orientation and having a role in the review of brochures and printed material.

Consumer partnership in service measurement and evaluation

The MyHealthscope website includes data on hand hygiene, HoNOS and falls with a number of brochures for consumers available on the escalation of care, clinical handover and the role of official visitors. Displayed throughout the clinic is information on how to make a complaint and how to make contact with the official visitors.

The CC participates in the review of all incident data and complaints to provide input for solution/s or any actions from a consumer perspective that may be implemented. The CC also conducts inpatient satisfaction surveys and is involved in a number of focus groups.

Consumer partnership in service planning

Ratings

Action	Organisation	Surveyor
2.1.1	SM	SM
2.1.2	SM	MM
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 2.1.2 Developmental

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

Surveyor Comment:

TSC has a focus on understanding and providing services that both support and provide an understanding of the range of backgrounds of their patients. Of particular note is the link with Jewish House which provides a Step Up/Down service of 12 beds with professional support including medical, psychology and cultural input during a patient's transition from inpatient care to the community. There is also an established relationship with a Social Worker who can see referred patients on an outpatient basis whilst awaiting a bed, during inpatient and post discharge phases to assist with social issues, including housing and understanding Centrelink entitlements. TSC is congratulated on this initiative as this support is often not available in private mental health services.

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

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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

TSC engages the 'Healthcare Infection Control Management Resources' group (HICMR) to guide its infection control process, as does Healthscope generally. Consequently, there is the full range of infection control policies, procedures, risk assessments (including ECT invasive devices), and audits required to deliver an effective infection control system. Infection control is also included in the TSC organisational quality, safety, WHS, and Infection Control Management Plan.

Infection Prevention & Control (IPC) audits include hand hygiene, antibiotic use, transmission risk, environmental, cleaning, PPE, and invasive devices. Audits indicate 75% to 100% compliance with requirements.

Infection control is included in the Healthscope Safety and Quality Plan 2016/17, supported by the Healthscope Infection Control Cluster with IPC governance at TSC through the Quality and Medical Advisory Committees. Many of the HICMR policies expired in 2016 while HICMR waited the outcome of revised National Infection Prevention & Control Guidelines, however HICMR has now commenced updating its IPC policies; this temporary expiration of policies poses little risk to TSC.

The effectiveness of the IPC program is shown by low levels of infection control incidents and no recent outbreaks.

The current TSC Food Authority audit is rated 'A'.

Infection prevention and control strategies

Of particular note is the 31% to 82% rise in hand hygiene compliance over the past year following a specific quality improvement strategy with mandatory education for infection control currently at 100%, which includes antiseptic technique and hand hygiene.

TSC's staff immunisation program on commencement of employment is 100% compliant, and was also the subject of a recent quality improvement strategy.

Managing patients with infections or colonisations

At risk TSC consumers are identified through the pre-admission process.

TSC has pandemic packs available across the site and there have been no recent reported outbreaks at TSC

Antimicrobial stewardship

Antimicrobial (AMS) prescription is monitored by the Chief Pharmacist and is included in the Healthscope Infection Control Key Performance Indicators (KPIs).

Antimicrobial use at TSC is reviewed at the TSC Quality, Medical Advisory and Drug Committees and also by the IPC Consultants HICMR. Therapeutic Guidelines are available online and accessible by medical staff at all times.

Audits of TSC antimicrobial prescription data sighted by the survey team demonstrate appropriate use across TSC.

Cleaning, disinfection and sterilisation

There is no use of sterilisation or disinfection across TSC. There are no invasive devices in use and the Electro Convulsive Therapy Suite has available single use items only.

Current monthly cleaning and environmental audits show respectively 96% and 92% compliance with the requirements of the schedules in place.

Communicating with patients and carers

There is infection control information posted in patient and staff key areas around the whole of TSC site.

Facts sheets are also available for the common infections with clinicians available to respond to any questions from either patients/carers or families.

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

Action 3.10.1 Core

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

Surveyor Comment:

Aseptic technique training is 100% compliant. This action is fully met.

Surveyor's Recommendation:

No recommendation

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	SM
3.18.1	SM	SM

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Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

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STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

TSC has policies, procedures and protocols in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines for the management of TSC's medication management system. The relevant TSC and HSP credentialing and Scope of Practice systems ensure that clinicians have the medication authorities in place to ensure all prescribing and administration of medications remain safe and are regularly monitored.

Medication incidents are reported on RiskMan and investigated with any reported outcomes aligned to action to ensure that the risk of the same adverse medication incident does not re-occur.

The HSP Medication Safety Cluster conducts medication policy reviews and both intranet and hard copies of medication policies are available to TSC clinicians. The Clinical Pharmacist (CP) is on-site at TSC two days a week to support clinicians and patients, and contribute to the monitoring of TSC's Medication Management System.

TSC's Quality and Safety Plan includes NSQHS Standard 4 for guidance and monitoring, with TSC participating in the National Inpatient Medication Chart (NIMC) National Audit in 2016 for the third year. An Enrolled Nurse (EN) register is available to identify ENs who have a medication administration authority as a component of their Scope of Practice. All clinical staff undergo medication competency and education at orientation.

Antimicrobial Stewardship (AMS) is managed via the Quality and Safety and IPC Committees.

Documentation of patient information

A Medication Management Plan (MMP) has been introduced with all patients having a medication history documented at admission. The MMP commenced at admission is monitored throughout the patient's inpatient stay by the Nurse Unit Manager (NUM) with the MMP forming part of the NIMC annual audit.

All known medication allergies and adverse drug reactions are documented in the clinical file on an alert sheet which is kept at the point of care. All patients who have an allergy or have had an adverse drug reaction wear a red arm band to aid in risk identification for clinical staff.

Medication management processes

TSC ensures that current medicines information is available for clinicians including MIMS online and Therapeutic Guidelines. Medication safety is a discussion point at TSC MAC meetings and Medication Management Tools and a Medication Competency for completion is available on the Medsafe ELMO e-learning platform.

TSC participates in the 6/12 ACHS Medication Clinical Indicator program with no outliers reported. Tall man lettering, drug auditing, the redesign of a medication room with close monitoring of safe and secure storage are all in place at TSC

Contraband is part of a room search process if required at TSC; this can include un-prescribed medication.

Continuity of medication management

Any changes to the medication regime of an inpatient are documented on the NIMC and communicated to the patient by either the Registrar, the Consultant Psychiatrist, the medication administering nurse, or a combination of all on occasions if the patient is concerned.

Any medication change is a component of all clinical handovers and is given in a documented and/or verbal form.

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Communicating with patients and carers

Clinicians, including the treating Consultant Psychiatrist and/or Registrar, provide patients with information on the benefits, options and associated risks of their prescribed medication/s. Printed patient medication information is available via the CP or clinicians as required, in a format that is easily understood with patients given the opportunity to seek clarification should they require it. In a mental health unit this is often done at medication administration times between the administering nurse and the inpatient who may be seeking further information at that time.

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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

TSC has well-established consistent systems in place to manage patient identification, with the effectiveness of these systems validated by regular audit, which currently as sighted shows 100% compliance with requirements.

TSC patient identification is framed by Healthscope policy and exceeds the three patient identifier requirement by one identifier, with a total of four identifiers in use. The patient's clinical file also includes a photograph of each patient as an additional identifier.

TSC has recently changed its wrist bands to a more durable product and one that now includes a bar code in preparation for electronic medication management.

The recently introduced electronic leave system prompts staff to reapply identification bands to a patient following their return from patient leave.

There is a clear incident management process that escalates to TSC's risk register, and overseen by the Quality and Medical Advisory Committees if an identified incident is the result of an incident or near miss involving patient identification and procedure matching.

Completion of the patient ‘alerts’ sheet has been variable in the recent past, however is now currently 100% following a recent quality improvement strategy. There is a clear process for the identification of alerts and transcription to appropriate documents, such as the medication chart. Identification of a person with an alert is enhanced by a coloured wrist band.

Processes to transfer care

Patient identification is included in handover from the unit to the ECT suite and on the patient's return to the unit, is documented in the ECT checklist, and audited as part of the Healthscope documentation audit with a resultant 100% compliance.

This same patient identification system is used across both TSC inpatient and outpatient services.

Communication with the referring General Practitioner (GP) within 24 hours via a nursing discharge summary and audit results is currently 97% compliance.

Processes to match patients and their care

ECT consent and patient identification is governed by the Healthscope Consent Policy and structured via the ECT administration and clinical packs.

There is currently 100% compliance with the ECT ‘time out’ noted through audit.

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	MM

Action 5.3.1 Core

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

Surveyor Comment:

TSC patient identification is framed by Healthscope policy and exceeds the three patient identifier requirement by one identifier.

The clinical file also includes a photograph of each patient as an additional identifier.

The revised patient wrist band includes a bar code, which will further enhance patient identification for medication and pathology once electronic management systems are in place.

Surveyor's Recommendation:

No recommendation

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

Clinical handover is framed by Healthscope policy and driven by the Healthscope Mental Health Cluster and local TSC initiatives with TSC currently improving clinical handover with revision of its bedside handover process and its shift-to-shift patient information electronic 'white board'.

Clinical handover, time out, and discharge summary audits are tabled at both the TSC Quality and Medical Advisory Committees.

There is a clear incident management process at TSC that escalates to TSC's risk register, and overseen by the Quality and Medical Advisory Committees; no incidents related to clinical handover are noted in recent reports.

Clinical handover processes

Revision of the 'white board' in clinical areas will allow the ISOBAR structure to be integrated into the board; clinical handover is currently framed by the ISOBAR structure but is currently paper-based.

Observational audits of shift-to-shift handover have been undertaken, noting an 80% compliance with requirements, and this will form a base to build the program improvement described above.

Handover from Unit to ECT and back is noted in ECT reporting and is audited as a component of the documentation audit/s, with 100% compliance.

TSC ensures fast information handover with the GP through a nursing discharge summary sent to the GP within 24 hours, followed by the VMO discharge summary at a later date. Consequently, communication of the discharge information to the GP within 24 hours now sits at 97%.

A current vulnerability with clinical handover processes noted by clinical staff is with the transfer of information from the referrer via the intake and assessment team to the inpatient unit. This vulnerability will be addressed through the newly planned multidisciplinary 'assessment centre' where a clinician will complete all the admission assessment requirements.

Patient and carer involvement in clinical handover

The well-established process of bedside handover will move to a multidisciplinary team approach in response to consumer feedback. The bedside handover process is well-described in the consumer brochure enabling patient education on TSC's handover process they will experience and be part of.

NSQHSS Survey

Organisation: Sydney Clinic, The
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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

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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

NSQHSS Survey

Organisation: Sydney Clinic, The
Orgcode: 120616

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

Organisation: Sydney Clinic, The
Orgcode: 120616

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

TSC adheres to the HSP policy - Pressure Injury (PI) Prevention Identification and Management of Pressure Injuries - which is consistent with best practice guidelines and incorporates the use of screening and assessment tools.

TSC Quality and Safety meeting has an agenda item related to PI Prevention with a PI Champion acting as a resource for all clinical staff. PI assessment completion is a component of the ongoing audit process and quarterly KPIs with all PIs pre-existing or hospital acquired reported on RiskMan

Preventing pressure injuries

The majority of the patients at TSC are ambulant and therefore not liable to develop a pressure injury whilst undergoing treatment.

The pressure relieving equipment, such as mattresses or sheepskins, is available for hire; should this be required this is identified at the initial assessment when the patient's risk assessment/management plan is completed. The admission of a patient with a PI is dependent on their medical condition and TSC exclusion criteria in place, ie "does not require specialist medical care in a mental health setting".

Managing pressure injuries

Whilst the ambulant patient population at TSC may not need PI management the possibility for wound management may still be required in this setting. This management, whether in consultation with a Wound Management Consultant or adherence to the nursing management plan, would be consistent with best practice and all interventions and care documented in the patient's clinical record.

Communicating with patients and carers

A patient at risk of developing a pressure injury following a risk assessment is informed in a format that is easily understood and meaningful.

NSQHSS Survey

Organisation: Sydney Clinic, The
Orgcode: 120616

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

NSQHSS Survey

Organisation: Sydney Clinic, The
Orgcode: 120616

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

THS response to patient deterioration is guided by Healthscope policy and supported by a standard observation chart with the effectiveness of the patient deterioration process and any associated incidents reviewed at the Quality and Medical Advisory Committees.

TSC has an effective system in place to identify "at-risk" patients pre-admission, which will be enhanced by the establishment of a multidisciplinary 'assessment centre' where a nurse and a Registrar will conduct a full physical assessment of the consumer at the point of admission; this process will also enhance the consistency of metabolic screening of all TSC patients, which has been recently commenced.

Advance care directives will be identified as part of the admission process once the Admission Centre is operational; this was planned to commence following the ACHS survey.

Recognising clinical deterioration and escalating care

Appropriate response to patient deterioration is audited through the Healthscope documentation chart audit and is currently 100% compliant.

Alcohol Withdrawal Scales (AWS) further enhance the recognition of deteriorating patients with drug and alcohol problems and TSC also considers deterioration in the mental state along with physical health status in the bed-side and shift-to-shift handover processes.

Responding to clinical deterioration

TSC staff members are 100% compliant with annual Basic Life Support training with an effective and tested 'Code Blue' response in place across TSC. The 'Code Blue' response will be further enhanced by Digital Enhanced Cordless Technology (DECT) phones shortly. More regular Code Blue drills will enhance staff familiarity with the Code Blue process and further are planned in the near future.

Selected staff members are Advanced Life Support (ALS) trained, with plans to train more staff to ensure a more consistent cover.

Communicating with patients and carers

The escalation procedure is well-described in a Carer's brochure available in each patient's room which carers and families are encouraged to read and seek further information should they require it.

NSQHSS Survey

Organisation: Sydney Clinic, The
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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

Action 9.6.1 Core

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

Surveyor Comment:

Basic life support training is 100% compliant. This action is fully met.

Surveyor's Recommendation:

No recommendation

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

TSC adheres to the HSP Falls Prevention and Management policies available to the clinical workforce. All patients admitted to TSC are assessed for falls risk, including a further assessment if there is a change in their condition or on transfer from TSC as this forms part of the clinical handover to the receiving clinician.

All falls are recorded on RiskMan and reported at the TSC Quality Committee meeting, the Medical Advisory Committee (MAC), and quarterly as a component of TSC Key Performance Indicators (KPI). TSC website also has information displayed on patient falls rates.

Day program patients are risk assessed on admission and a patient assessed as a medium or high falls risk has this documented in their care plan.

Screening and assessing risks of falls and harm from falling

The Falls Risk Assessment Tool (FRAT) is in place at TSC and Falls Risk auditing monitors the usage of FRAT ensuring that ongoing compliance with screening, assessment and implemented strategy/strategies is completed.

High risk patients are referred to the Occupational Therapist (OT) for further assessment.

Preventing falls and harm from falling

TSC has a focus on the prevention of falls in all at risk groups which can include patients who are withdrawing from alcohol and other drugs. The "Keeping On Your Feet" patient education material is available in the units and is given to appropriate patients as an education tool. Patients are encouraged to use the lift and not the stairs during their early admission to TSC and this is clearly signed. A falls risk patient is identified at clinical handover and on transfer out of TSC if required.

Communicating with patients and carers

Falls brochures are provided to patients who are at risk of a fall and this is documented in their care plans which are signed by the patient. Both patients and carers where appropriate are encouraged to be involved in the development of care plans.

NSQHSS Survey

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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

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Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation: Sydney Clinic, The
Orgcode: 120616

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	SM
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	SM
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	SM

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 reported complaints	SM	SM
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	SM
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	MM
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 distribution to patients)	SM	SM
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	SM	SM

	• surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases • 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 protocols	SM	SM

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	SM	SM

- waste management within the clinical environment
- laundry and linen transportation, cleaning and storage
- appropriate use of personal protective equipment

3.15.2	Policies, procedures and/or protocols for environmental cleaning are regularly reviewed	SM	SM
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	SM
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

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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 patient and/or carer when concluding an episode of care	SM	SM
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	MM

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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

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 of blood and blood product control systems	N/A	N/A
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 screened for pressure injury on presentation	SM	SM
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: • measurement and documentation of observations • escalation of care • establishment of a rapid response system • communication about clinical deterioration	SM	SM
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	SM	SM

	sets of observations recorded in agreement with their monitoring plan		
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 advanced life support	SM	SM

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

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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

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

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Recommendations from Current Survey

Not applicable

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Recommendations from Previous Survey

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Governance and quality improvement systems
Action: 1.5.2 Actions are taken to minimise risks to patient safety and quality of care

Recommendation: NSQHSS Survey 0414.1.5.2

Recommendation:

Sydney Clinic considers the manning of the reception area during evening and weekend program times to further enhance the safety of patients and staff.

Action:

The Saturday groups held at TSC have been disbanded.

The Reception area is now staffed until 18:00 Monday - Thursday to facilitate safe entry into the clinic for Outpatients attending evening groups. No Pm groups are held on Friday.

Completion Due By: 01/05/2014

Responsibility: GM

Organisation Completed: Yes

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

The Sydney Clinic (TSC) now has in place extended reception hours that ensure increased safety by the monitoring of clients entering TSC for evening groups.

There are no day patient groups held on the weekend at TSC.

The intent of this recommendation has been met and the recommendation is now closed.

NSQHSS Survey

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Standards Rating Summary

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**

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**

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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**

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**

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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**

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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	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**

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	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	8	1	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	**188**	**1**	**189**

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**

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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	14	1	15	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	8	1	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	**231**	**2**	**233**	**Met**