NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

The Geelong Clinic

St Albans Park, Victoria

Organisation Code: 220997
Health Service Facility ID: 101047
Assessment Date: 22/10/2019 to 23/10/2019

Accreditation Cycle: 1

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 ongoing 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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Preamble

How to Use this Assessment Report
The ACHS assessment report provides an overview of quality and performance and should be used to:
1. provide feedback to staff
2. identify where action is required to meet the requirements of the NSQHS Standards
3. compare the organisation's performance over time
4. evaluate existing quality management procedures
5. assist risk management monitoring
6. highlight strengths and opportunities for improvement
7. demonstrate evidence of achievement to stakeholders.

The Ratings:
Each **Action** within a Standard is rated by the Assessment Team.

A rating report is provided for each health service facility.

The report will identify actions that have **recommendations** and/or comments for each health service facility.

The rating scale is in accordance with the Australian Commission on Safety and Quality in Health Care's Fact Sheet 4: Rating Scale for Assessment:

Assessor Rating	Definition
Met	All requirements of an action are fully met.
Met with Recommendations	The requirements of an action are largely met across the health service organisation, with the exception of a minor part of the action in a specific service or location in the organisation, where additional implementation is required.
Not Met	Part or all of the requirements of the action have not been met.
Not Applicable	The action is not relevant in the health service context being assessed.

Suggestions for Improvement
The Assessment Team may provide suggestions for improvement for the health service to consider implementing. They are not required to be implemented for an action to achieve a met rating. Suggestions for improvement are documented under the criterion level.

Recommendations
Not Met/Met with Recommendation rating/s have a recommendation to address in order for the action to be rated fully met. An assessor's comment is also provided for each Not Met/Met with Recommendation rating.

Risk ratings are applied to actions where recommendations are given to show the level of risk associated with the particular action. A risk comment is included if the risk is rated greater than low.
Risk ratings are:
1. E: **extreme (significant)** risk; immediate action required.
2. H: **high** risk; senior management attention needed.
3. M: **moderate** risk; management responsibility must be specified.
4. L: low risk; manage by routine procedures

Executive Summary

Introduction

The Geelong Clinic underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 22/10/2019 to 23/10/2019. The NS2 OWA required 2 assessors for a period of 2 days.

The Geelong Clinic is a Private organisation. The Geelong Clinic was last assessed between 07/11/2016 – 09/11/2016. Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier
Geelong Clinic, The	101047

General Discussion

The Geelong Clinic (TGC) established in 1998 is part of the Healthscope Group who operate 43 private hospitals across Australia. The Healthscope Group has 12 mental health services across a number of Australian states with the Mental Health Committee actively networking via teleconferencing bi-monthly discussing both shared learnings and corporate policy review.

TGC is a standalone facility with 52 general psychiatric and specialty inpatient beds, extensive Day programs, a dedicated Outreach service, Electroconvulsive therapy (ECT) / Transcranial Magnetic Stimulation (TMS) Suites and private consulting suites for 33 TGC credentialed psychiatrists.

An expansion of the TGC occurred in 2018 with the additional growth of the General and Eating Disorders Program and a clinical restructure resulting in the formation of two separate units Sunnymead Unit (25 beds) and Fairhaven Unit (27 beds).

TGC also conducts onsite an approved Department of Veteran Affairs (DVA) Trauma Recovery Programme (TRP) for Veterans and Emergency Workers (first responders) also participate in the program.

TGC has an approved future investment commitment for a new Brownfields project. Stage 1- a net gain of 21 beds, seven additional consulting rooms, a kitchen expansion, and further expansion of clinical and support areas. Stage 2- a 27 inpatient bed extension resulting in an increase in TGC's bed capacity to 100 beds.

TGC continues to expand recognising market growth, is well managed and attracts consultant psychiatrists, well qualified and experienced staff, and places the importance of providing a well-appointed, safe and secure environment for its patients, staff and visitors.

Summary of Results

The Geelong Clinic achieved a met rating for all **applicable** actions in all standards that were assessed and has achieved Accreditation (3 Years).

The Geelong Clinic achieved a met rating for all facilities in all actions and therefore there is no requirement for a follow up assessment.

Further details and specific performance to all of the actions within the standards is provided over the following pages.

The Geelong Clinic

Sites for Assessment

Sites for Assessment – The Geelong Clinic

Geelong Clinic, The HSF ID:101047	
Address: 98 Townsend Road ST ALBANS PARK VIC 3219	Visited: Yes

The Geelong Clinic

Reports for Each Standard

Standard 1 - Clinical Governance

Governance, leadership and culture

Action 1.1	
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.2	
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.3	
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.4	
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.5	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.6	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The Geelong Clinic (TGC) demonstrated good leadership and both with the overarching requirements of the Healthscope (HSP) Group and in belonging to a large group of Mental Health Services across Australia, the culture of safety and quality improvement is well embedded at TGC. There are high expectations and levels of reporting by the Healthscope group who set priorities and strategic directions for all HSP Mental Health Services including TGC.

All management and staff roles and responsibilities are clearly defined and there is a focus on actions to be or have been undertaken as a result of analysis of any TGC clinical incident/s.

TGC management supports all clinicians in the safety and quality roles they undertake and there is a strong commitment and support by the General Manager of the work clinicians undertake on a daily basis.

Patient safety and quality systems

Action 1.7	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.8	
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.9	
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.10	
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.11	
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework6 b. Monitors and acts to improve the effectiveness of open disclosure processes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.14	
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.15	
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.16	
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The Geelong Clinic (TGC) with oversight from the Healthscope (HSP) Group maintains a risk management approach in ensuring TGC policies, procedures and protocols are reviewed, evidenced and current.

Incident reporting and outcomes are discussed as to alignment and adherence to a policy or procedure as required. Reporting from TGC includes safety and quality with reports and outcomes provided to staff, psychiatrists and consumers as appropriate and relevant.

Organisational risks are identified and well monitored with TGC clinicians supported to recognise and report incidents enabling the information from an incident/s to be acted on to improve safety and quality at TGC if relevant.

The Open Disclosure process is actioned as required and relevant staff are trained in Open Disclosure.

Feedback from patients and their carers is sought and acknowledged about their inpatient or day patient treatment at TGC.

Complaint/s reporting is encouraged with all complaints entered into the risk management system to ensure ongoing review and analysis.

TGC does not have an electronic health care records system but all hard copy patient records are available at the point of care with 24/7hour access, with privacy and legislative requirements. TGC adheres to Advisory AS 18/11.

Clinical performance and effectiveness

Action 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.20	
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.21	
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.22	
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.23	
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.24	
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Action 1.28	
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The Healthscope (HSP) Group and The Geelong Clinic (TGC) place a strong focus on the importance of safe and quality healthcare within the teams or between clinicians and patients. Strategies are in place to manage workforce issues, with this managed well with the previous addition of beds. Planning is being considered and the ability to accommodate additional staff when the new additional consulting suites and beds are completed.

Credentialing is managed at a Corporate level with an audit process in place that ensures that all the appropriate clinicians are qualified to comply with their right to practice.

All staff complete an orientation program and attend mandatory and skills training.

Training is a combination of face-to-face, peer review, online learning modules, competency-based assessment as required and conferences and seminars.

Expectations are set for TGC employees with their performance monitored on an ongoing basis, or more focused in the event of unsatisfactory performance.

Safe environment for the delivery of care

Action 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.30	
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.32	
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

TGC has strategies in place to manage high risk unpredictable behaviours to minimise any risk to patients, carers and staff.

There are areas within TGC that provide calm and quiet environments for patients or when it is clinically required. TGC has an optimal physical environment that provides a therapeutic milieu for patients with spaces designed and monitored to prevent potential adverse events such as self-harm. Ligature points remain a high priority and are subject to ongoing monitoring.

The nursing stations are well positioned and at assessment there was no evidence of excessive noise that could be contributed to the environment.

Signage for patients and visitors to navigate the clinic was clear and appropriately placed.

A Psychiatric Environmental Risk Assessment Tool (PERT audit) is conducted 6/12 with the action plan reviewed every 3/12.

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action 2.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

HSP and TGC have maintained a commitment to the support and appropriate resourcing to partnering with consumers. TGC resourcing includes the paid position of an active and articulate Consumer Consultant who participates in the key committees such as the Heads of Department (HODs) Quality and Safety Committee meetings and other key consumer groups with ongoing availability to patients and carers as required.

TGC has embedded the partnering with consumers standard to the nature and context of TGC with no evidence of barriers to this partnership approach.

HSP and TGC have a number of policies in place that cover healthcare rights, shared decision-making, planning care and effective communication with patients, carers and families.

Partnering with patients in their own care

Action 2.3	
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights16 b. Easily accessible for patients, carers, families and consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.4	
The health service organisation ensures that its informed consent processes comply with legislation and best practice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.5	
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.6	
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.7	
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

Patients of TGC have access to the Australian Charter of Healthcare Rights in appropriate languages if required.

HSP has a policy on the Interpreter Service and regular community meetings at TGC supports consumer engagement and communication which is actively encouraged.

Patients are supported and guided in self-management principles with the clinician taking responsibility at times if the patient is unwell. Education in self-help principles are provided through the group programs and information on self-help and support groups in the area is provided prior to discharge.

Patients have the ability to access their own health record by application to TGC General Manager.

As a component of the pre-admission process in all Healthscope facilities, all patients and/or guardian are required to sign the Informed Financial Consent form. TGC complies with the Advisory AS 18/10 Informed Financial consent.

Health literacy

Action 2.8	
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.9	
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.10	
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

TGC has an awareness of the importance of ensuring that the environment is one that addresses health literacy. There is a focus on facilitating communication to enable effective partnerships with patients and families with an emphasis placed on encouraging all patients to make informed decisions about their care and to manage their own health wherever possible.

When a TGC patient is unwell or pre-discharge, clinicians support the patient to manage the health systems when required and assist in the navigation of other health facilities and organisations, they may be required to engage with in their ongoing care.

Partnering with consumers in organisational design and governance

Action 2.11	
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.12	
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	
Action 2.14	
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

TGC articulated the importance they place on including consumer input into the design, implementation and evaluation of policies, programs and services. The position of the Consumer Consultant acts as an advocate for consumer input and strengthens the base of partnering with consumers.

This approach operates to achieve mutually beneficial outcomes and are reflective of the diversity of patients and families who seek treatment at TGC and the local community.

Patient surveys are administered to seek feedback on many areas of TGC.

The levels of consumer engagement at TGC appeared to be appropriate for the size and complexity of the Clinic with consumer involvement sought and encouraged, where it is required.

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Action 3.1	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient’s information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.4	
The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that: a. Collects data on healthcare-associated infections and antimicrobial use relevant to the size and scope of the organisation b. Monitors, assesses and uses surveillance data to reduce the risks associated with healthcare-associated infections and support appropriate antimicrobial prescribing c. Reports surveillance data on healthcare-associated infections and antimicrobial use to the workforce, the governing body, consumers and other relevant groups	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

TGC demonstrated an awareness of the importance of reducing the adverse impact of antimicrobial use including antimicrobial resistance. The infection risk at TGC, although could be considered low, is well recognised and a basic risk management approach with the application of clinical principles in place. These principles are dependent on the complexity of the services delivered by TGC.

Antimicrobial prescribing is self-monitored by the consultant psychiatrists with oversight by the TGC clinical pharmacist.

Infection prevention and control systems

Action 3.5	
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.6	
Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs to manage infection risks d. The need to control the environment e. Precautions required when the patient is moved within the facility or to external services f. The need for additional environmental cleaning or disinfection g. Equipment requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.7	
The health service organisation has processes for communicating relevant details of a patient's infectious status whenever responsibility for care is transferred between clinicians or health service organisations	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.8	
The health service organisation has a hand hygiene program that: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.9	
The health service organisation has processes for aseptic technique that: a. Identify the procedures where aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.10	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare[18]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.11	
The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements – that: a. Respond to environmental risks b. Require cleaning and disinfection in line with recommended cleaning frequencies c. Include training in the appropriate use of specialised personal protective equipment for the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.12	
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings c. Handling, transporting and storing linen	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.13	
The health service organisation has a risk-based workforce immunisation program that: a. Is consistent with the current edition of the Australian Immunisation Handbook[19] b. Is consistent with jurisdictional requirements for vaccine-preventable diseases c. Addresses specific risks to the workforce and patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Patients are monitored as part of the initial and ongoing assessment process which commences at the pre-admission phase. When a patient requiring admission to TGC is assessed as having a pre-existing infection a clinical decision is made whether TGC is the suitable facility at that time or should the patient be treated at an external facility and then admitted to TGC.

If a patient acquires an infection during admission, accommodation needs are addressed to maintain control of the environment. On these occasions all infection prevention precautions are actioned, equipment requirements and the need for additional environmental cleaning or disinfection is addressed.

There is oversight and management by Healthcare Infection Control Management Resources (HICMR), the Healthscope groups Infection Prevention and Control consultants, with the onsite clinical staff ensuring the patients infectious state and the responsibility for care is well managed.

Reprocessing of reusable medical devices

Action 3.14	
Where reusable equipment, instruments and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There are no reusable medical devices used at TGC. All equipment are single use items as in the Electro Convulsive Therapy (ECT) Suite and items such as Blood pressure cuffs are subject to the normal cleaning regimes.

Antimicrobial stewardship

Action 3.15	
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard[20]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.16	
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

An antimicrobial stewardship policy is in place and consultant psychiatrists and all clinicians have access to the evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing.

Any inappropriate use is reported directly to the prescribing consultant psychiatrist by the clinical pharmacist and to the Medical Advisory Committee (MAC) if this is required.

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action 4.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.3	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.4	
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The Geelong Clinic has in place systems to ensure appropriate governance in relation to medication safety.

There are a range of policies available to guide practitioners. Healthscope corporate policies are reviewed and modified as required by a local medication safety committee. All policies are available to staff via the intranet and specific mental health policies are also available in hard copy for staff at a ward level.

Medication incidents are reported via the RiskMan system. Medication incidents are reviewed by the Medical Advisory Committee, the Medication Management Committee and the Heads of Department/ Quality and Safety Committee. Trended medication error reporting is available for review. Regular medication chart audits are undertaken with appropriate reporting.

A “shared learnings” report is distributed across the Healthscope hospitals that includes medication incidents and controls that may impact on medication incidents. This incident reporting and “shared learnings” are used to support both online and local educational activities.

The results of the Your Experience Survey are utilised to determine the consumer experience of medication management. In particular, the experience of shared decision making and discussion with staff of the effects of medication during the care planning process. Quality improvement activities related to medication management have included; enlargement of the Sunnymeade medication room and the inclusion of medication charts as part of a compendium of charts used as part of bedside handover. The display of medication dispensing times on treatment room doors aims to reduce distraction and prevent medication errors.

Documentation of patient information

Action 4.5	
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.6	
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.7	
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.8	
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.9	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Assessment Team Summary:

During the admission process nurses document the consumers current medication and their medication history. The PEAK Pharmacy service review consumer medication charts on a regular basis. Recently there has been an increase in available pharmacy hours to support these processes. There is a system in place to ensure more detailed medication reconciliation activities are undertaken as required.

There are systems in place to identify medicine allergies and adverse drug reactions. There are associated auditing processes and reporting. For example, red arm bands are used to alert staff to allergies and there is an associated arm band audit.

Continuity of medication management

Action 4.10	
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

During assessment it was observed that review of the medication chart was part of the bedside handover process. As part of the discharge planning process, the consumer's current medication are documented and reconciled against the current medication chart. TGC is committed to the patient being involved in the medication review process during this discharge planning process. A list of medication is provided to the patient and their GP on discharge.

Medication management processes

Action 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.14	
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.15	
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

TGC has in place systems to ensure that staff have access to medication decision support tools. These include a hard copy MIMS in each treatment room and access to electronic versions of a variety of resources. These include, the Australian Medicines Handbook and Therapeutic Guidelines Online eTG Complete.

TGC complies with the requirements of the storage of medications in the drug refrigerators situated in the two inpatient units and the Electro-Convulsive Therapy (ECT) Suite. Temperature checking with documentation is a component of the clinician's role in these three discrete areas.

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

Action 5.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.4	
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.5	
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.6	
Clinicians work collaboratively to plan and deliver comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There are a range of policies available to guide the delivery of comprehensive care. Local TGC activities in relation to the delivery of comprehensive care are supported by Healthscope corporate actions including the facilitation of a mental health specific meeting where the standard and associated actions are reviewed, gaps identified, and mitigation strategies developed. These strategies can include policy review, audit review and development, documentation changes including risk assessments. This mental health specific meeting includes input from someone with lived experience of mental illness.

Developing the comprehensive care plan

Action 5.7	
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.8	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.9	
Patients are supported to document clear advance care plans	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.10	
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Action 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.13	
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

TGC has documented exclusion criteria which includes; age, serious physical illness and involuntary legal status There is a suite of policies in place to guide the admission, assessment and care planning processes. As part of the pre-admission process all patients are screened for a variety of risks. These include; current Infection, previous Venous Thromboembolism, Falls, Skin Integrity, Self-harm, Aggression, Cognitive Deficits and Nutrition. The HoNOS and MHQ-14 are completed as part of the admission and discharge process.

As part of the admission process, a risk assessment tool is available to document risk of pressure injury, fall, aggression and vulnerability. This screening tool can prompt the use of more detailed assessments as required.

There is an established audit of the completion of risk assessments. Clinical incidents are reported via RiskMan and these incidents include, falls and pressure injuries. These audits and incidents are regularly reported at the Heads of Department/ Quality and safety and Medical Advisory Committee meetings.

A regular training needs analysis is undertaken; however, response rates are low. The use of a focus group approach to understanding training needs may be beneficial in this instance. AS 18/14 comprehensive care standard: screening and assessment of risk of harm. During assessment an action plan was identified that including activities aimed at meeting the intent of this Advisory. This included the completion of a gap analysis identifying risks facing the TGC population. This information was used to inform the review and development of a care plan and risk screening tool. A draft audit to monitor the effectiveness of this tool has also been developed. Testing and agreement on the introduction of this modified tool is progressing via Healthscope corporate processes.

As part of the pre-admission process ATSI status is gathered, an action plan has been developed to improve the quality of data collection in this area.

Internal national yearly documentation audits by Healthscope corporate monitors the quality of the documentation of comprehensive care. TGC complies with Advisory- AS 18/15.

Delivering comprehensive care

Action 5.14	
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.15	
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.16	
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	
Met	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Action 5.17	
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Met	
Met with Recommendations	

Not Met	
Not Applicable	All facilities under membership

Action 5.19	
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	
Met	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Action 5.20	
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

TGC uses a patient experience dashboard to track a variety of aspects of the patients stay. These include; their involvement in care planning activities, the involvement of family and friends in care planning and the respect for their individuality. A mental health care plan is started on admission, it is reviewed regularly, and goals are generated collaboratively with patient and carers (where applicable). These care plans are signed by the patients and there is a regular audit of patient involvement in care planning which averages approximately 70%.

TGC has developed specific systems to ensure the identification, prevention and management of pressure injuries, falls, nutritional deficits cognitive impairments including delirium, self-harm and aggression.

These systems are supported by documented policies, education and audit with reporting via the Heads of Department/ Quality and Safety and Medical Advisory Committee meetings.

Nutrition: anaphylaxis allergy sheet has been created. This will ensure that patients with food allergies are not exposed to allergens as part of ingredient selection and meal preparation process. Patients with allergies can order meals, these are highlighted on an orange order form, this brings to the attention of cooks and (Food Service Assistant) FSAs that the patient is on a special diet and is allergic to certain foods.

Patients would be transferred to appropriate facilities for end-of-life care. On assessment, staff were aware of the application of ‘reasonable force’ to ensure safety and security. Patients would not be restrained or secluded at TGC.

Minimising patient harm

Action 5.21	
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.22	
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Action 5.26	
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.28	
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.29	
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard47, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.30	
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.31	
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.32	
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.34	
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.36	
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

For Action 5.36 The Geelong Clinic is a private mental health facility and is not a gazetted public mental health facility and therefore is not legislated to provide seclusion.

All staff have access to two training modules on managing conflict and challenging behaviour training. WAVE (Workplace Aggression and Violence Education) One includes; the identification and reduction of risk, how to defuse, calm and resolve aggressive situations and personal safety and understanding personal safety and awareness. WAVE Two provides staff with access to training in ‘break-away’ techniques. On assessment, training records indicated near 100% completion of WAVE One and 90% completion of WAVE Two by staff.

Pressure injuries and falls are a component of the pre-admission assessment with ongoing monitoring and care planning of all patients. Whilst pressure injuries are rare, there are occasions where wound management may become a priority of care for a patient who may be admitted with a wound or it may be acquired during the admission phase.

The nutritional needs of all patients are well monitored. Specialised diets as required be they medical, religious or cultural are provided and with TGC's specialised program for eating disorders, nutritional needs are addressed as a component of the program.

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action 6.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.3	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.4	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There is a suite of policies available to guide staff in the delivery of effective clinical communication. During orientation staff receive training in the ISOBAR (identify–situation–observations–background–agreed plan–read back) tool to support clinical handover.

TGC has introduced communication boards into all patient rooms. These provide a range of information including; treating doctor, nursing staff on shift, personal goal setting and other timetable information, at a glance.

The patient experience dashboard is used to monitor a variety of patient experiences including “being treated with respect” and “feeling safe using the service”. Results are reported via the Heads of Department/ Quality and Safety and Medical Advisory Committee. Feedback on risks associated via clinical communication have been sought via a regularly held staff forum.

TGC has actively participated in the Healthscope, ‘Back to Bedside” quality improvement project which aims to re-focus staff to patient-centred care. This initiative is supported through a range of training modules which include, patient stories and modelling appropriate communication and patient rounding activities. Currently, 93% of staff have completed these training modules.

A training needs analysis informs education and training regarding communicating for safety. This process is supported by staff performance appraisals, where managers identify individual staff learning needs.

Correct identification and procedure matching

Action 6.5	
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.6	
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Patient identification and matching processes are supported by a range of policies which include processes for correctly matching patients to their care. Any policy changes are reported to staff monthly via email and are tabled at the Heads of Department/ Quality and Safety and Medical Advisory Committee.

TGC uses approved identifiers. TGC uses a single white band with approved identifiers which include, Name, Date of Birth and healthcare record number. There is a regular audit of identifiers in place, with an overall compliance of over 95%. There is an annual audit of MH timeout and clinical handover. Healthscope has a patient identification error rate key performance indicator, TGC is consistently well below the benchmark rate.

Communication at clinical handover

Action 6.7	
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.8	
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There are a range of policies available that guide staff in the information that should be shared as part of clinical handover. Patient rounding and bedside handover is monitored via the patient experience dashboard. These activities are also monitored via structured audits which are reported at the Heads of Department/Quality and Safety and Medical Advisory Committee. Changes have been made as a result of these audit processes. These have included the use of a trolley that enable notes to be transported to the bedside as well as additional training opportunities to rehearse clinical bedside handovers. These training opportunities are included as part of the induction/ orientation process for new staff.

The patient goals are identified on the communication board within each patient's room. During assessment, these goals were discussed as part of the bedside handover process. TGC uses the patient experience dashboard question "Development of a plan with you that considered all your needs" as a proxy indicator of discussion of patient goals. This is an innovative use of available information and it will be interesting to see if it adds value to the quality improvement process.

Communication of critical information

Action 6.9	
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.10	
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There are a variety of ways that critical information is communicated within TGC. These include; bedside handover, wards rounds, family meetings, and nursing discharge summaries. Nursing discharge summaries provide an opportunity to document a range of critical information including changes to medication, patient goals or information that requires follow up. Completion of these discharge summaries is monitored via the WebPAS-HRS report “NDS Submission and Discharge Analysis”. A trended report on assessment indicated above 80% completion rates.

Documentation of information

Action 6.11	
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There are a range of opportunities to document critical information including risk, alerts, change in patient condition and the outcomes of care. A national audit of documentation is undertaken annually by Healthscope corporate office. Overall, compliance with this audit has been above 90% with 2019 results still pending.

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action 7.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management	
Met	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Action 7.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management	
Met	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Action 7.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Assessment Team Summary:

Not Applicable

Prescribing and clinical use of blood and blood products

Action 7.4	
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks	
Met	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Action 7.5	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Met	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Action 7.6	
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	
Met	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Action 7.7	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Met	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Action 7.8	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Met	
Met with Recommendations	

Not Met	
Not Applicable	All facilities under membership

Assessment Team Summary:

Not Applicable

Managing the availability and safety of blood and blood products

Action 7.9	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer	
Met	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Action 7.10	
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage	
Met	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Assessment Team Summary:

Not Applicable

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action 8.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There are a variety of policies in place to support staff in recognising and responding to acute deterioration. All incidents are reviewed by the quality and General Manager/Director of Nursing. A critical systems review (CSR) is undertaken as required. There is an audit process of observation charts, calls regarding clinical deterioration and a documentation audit. Evidence on assessment indicated that these three audits contribute to TGC safety and quality plan. Results of these audits are reported at the Heads of Department/ Quality and Safety and Medical Advisory Committee. The consumer consultant is included in this process as required.

AS19/01 recognising and responding to acute deterioration standard: recognising deterioration in the persons mental state. During assessment there was evidence of an action plan that included the development of a Cognitive Impairment Risk Assessment Tool. This identified the modifiable and non-modifiable risk factors for the development of delirium. TGC has a system in place to ensure that families are involved in the escalation of care, this includes a carer information brochure.

Detecting and recognising acute deterioration, and escalating care

Action 8.4	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.5	
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.6	
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.7	
The health service organisation has processes for patients, carers or families to directly escalate care	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Action 8.8	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.9	
The workforce uses the recognition and response systems to escalate care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There are systems in place to support the identification of acute deterioration and the escalation of care.

This includes a variety of policies that are available to guide staff practice. Acute deterioration can also be recognised through regular recording of physical observations from daily to four times a day depending on the program (Alcohol and Drug, Eating Disorder or General Psychiatry) and patient need. A flow-chart provides guidance for staff. This identifies “white”, “yellow” and “red” zones of physical observations that require specific actions. For example, if in the “yellow” zone for longer than one hour the patient’s treating psychiatrist must be contacted. Mental state deterioration can also be recognised at the result of at least hourly patient rounding. Individualised care plans mean that the patients known early warning signs are used to identify and respond to acute deterioration. Training in Basic Life Support (BLS) on assessment sat at 96%. At least one member of nursing staff is trained in Advanced Life Support (ALS) during ECT procedures.

There is a system in place including duress alarms and emergency buzzers that are available to enable the emergency escalation of care. The senior nurse on duty takes the role of emergency controller who directs clinical staff as necessary.

Patients and their carers are provided with information on the process of escalating care if they have any concerns. This includes orientation to an emergency button placed in each patient’s room.

TGC complies with Advisory AS 19/01.

Responding to acute deterioration

Action 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Any deterioration in physical health or the development of an acute delirium results in transfer of care to a more appropriate setting. Mechanisms are in place to ensure that nursing staff can contact the patients treating psychiatrist to enable appropriate management as required. Acute deterioration in mental health requiring involuntary care results in transfer to a more secure setting. A checklist is used to ensure all appropriate documentation is available to the receiving team if the patient is transferred.

Training opportunities in the recognition and management of acute deterioration in physical and mental health are provided by the nurse educator. The completion of these training activities is monitored at the Heads of Department/ Quality and Safety Committee.

TGC has protocols, clear criteria and the appropriate expertise in place for the recognition and management of both the mental and physical state of a patient as required and therefore meets Advisory-AS 19/01.

National Standards for Mental Health Services

Assessment Overview

The Geelong Clinic (TGC) is one of a number of private mental health facilities owned and/or managed operated by the national Healthscope Group of hospitals. It is a mental health clinic situated in regional Victoria that continues to attract a group of consultant psychiatrists, a number of which have both a private and public profile. It conducts well recognized specialist programs such as the longstanding Eating Disorders program and the Trauma Recovery Program, as well as generalist mental health programs both inpatient and outpatient. It is a well-managed and appointed clinic with plans in place for further extensions and growth. The therapeutic milieu is consistent with optimal good mental health care and recovery.

The mental health standards were assessed with the National Standards and the Trauma Recovery Program Department of Veteran Affairs (DVA) standards who at this assessment required that these be undertaken until a decision is reached by the Commission and DVA.

All standards across these three current requirements have been met.

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.

Assessor Summary
Treatment in Least Restrictive Environment Patients of TGC are treated in a least restrictive environment, with all patients having a voluntary admission status. Policies are in place in the event that a patient's voluntary status changes and they require transfer to a public mental health unit.
Access to Staff of Own Gender While many nursing staff are female at TGC, male staff are available if requested. Historically there have been more requests for female staff, with staff gender mix a component of rostering considerations. Allied Health staff include a mix of genders and patient preferences are considered during their allocation both in groups and those patients requiring 1-1 counselling.
Advocacy & Support Provisions are made, and information is provided to patients at point of entry and during the patients stay regarding advocacy and support opportunities.

Criterion 1.8

The MHS upholds the right of the consumer to have their privacy and confidentiality recognised and maintained to the extent that it does not impose serious risk to the consumer or others.

Assessor's Rating	Met

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.

Assessor's Rating	Met

Criterion 1.13

The MHS upholds the right of consumers to have access to their own health records in accordance with relevant Commonwealth, state / territory legislation.

Assessor's Rating	Met

Criterion 1.15

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

Assessor's Rating	Met

Criterion 1.17

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

Assessor's Rating	Met

STANDARD 2 Safety

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

Assessor Summary
Protection from Abuse & Exploitation Risk assessments are regularly undertaken of patients and their vulnerability to intimidation or exploitation. There are policies in place to guide staff in the management of vulnerable patients.
Reduction/Elimination of Restraint & Seclusion TGC does not seclude or restrain patients. Policies are in place to ensure that consumers who are a danger to themselves or others receive appropriate care.
Compliance with Current National/State Safe Transport Principles Policies are in place to ensure patient transport complies with National and State safe transport principles. TGC does not provide any vehicles for patient transport. Patients who require transport to external appointments are transported via taxi and are always accompanied by a nurse. Any transport by police or ambulance are undertaken with the support of TGC staff, with the established Memorandum of Understanding (MOU) in place. TGC have a close relationship with Barwon Health (Public Mental Health service) and with the Consultants working via practices of a public/private mix, should a patient require Recommendation under the Victorian Mental Health Act 2014 this is implemented via established communication channels.

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.

Assessor's Rating	**Met**

Criterion 2.5

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

Assessor's Rating	**Met**

STANDARD 3 Consumer and Carer Participation

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

Assessor Summary
Consumers Right to Independent Representation At the point of entry, patients of TGC are asked to identify a support person or next of kin. It is identified to the degree to which they want these identified individuals involved in their care. Identified carers are involved in care planning processes to the extent the patient wishes. The care planning processes are regularly reviewed. Information is available on advocacy and support groups via the “Working Towards Recovery Resource Workbook”.
Consumer Representation to the MHS TGC has an active paid consumer consultant who undertakes a variety of advocacy and peer work activities over the week. This includes involvement in the development of policy and procedures and their implementation and attendance at the Heads of Department meetings and others.

Criterion 3.4

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

Assessor's Rating	**Met**

Criterion 3.6

Where the MHS employs consumers and carers, the MHS is responsible for ensuring mentoring and supervision is provided.

Assessor's Rating	**Met**

Criterion 3.7

The MHS has policies and procedures to assist consumers and carers to participate in the relevant committees, including payment (direct or in-kind) and / or reimbursement of expenses when formally engaged in activities undertaken for the MHS
.

Assessor'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.

Assessor Summary
MHS Identification of its Communities Diverse Population While a review of demographic information indicates that TGC does not service a large ATSI or CALD community this information is regularly reviewed and informs service development activities.
Utilisation of data to Review and Communicate to Staff TGC uses available data to understand the needs of the local community and the population under care. This information is used to inform clinical practice and service development. This data has informed cultural sensitivity training.
Engagement with Service Providers with Diversity Expertise TGC has developed strong links with other service providers such as Barwon Health to ensure that appropriate access to necessary resources can be gained when required.
Addressing Issues of Prejudice, Bias & Discrimination A Healthscope 'Reconciliation Plan' has been developed and distributed to all staff. TGC has delivered cultural safety training to clinicians and service managers. Cultural safety is a standing agenda item at the Heads of Department meetings with regular KPI reporting relating to incident, risk and complaints management used to benchmark performance.
Equitable Access to Services A range of polices are in place to guide the staff of TGC to ensure non-discriminatory practices are in place and there is an equitable distribution of resources. Regular patient meetings on the unit are an opportunity for patients to share their experience and give feedback to TGC on any perceived bias or discrimination.

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.

Assessor'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.

Assessor'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.

Assessor's Rating	**Met**

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.

Assessor Summary
Promotion/Prevention of Mental Health Problems & Illness TGC has undertaken a range of health promotion activities both at a corporate level (i.e. the Assessment and Review of Cape York Indigenous Youth) but also locally, through media appearances by clinicians and managers outlining protective factors that can prevent the development of mental health issues.
Consumers/Carers Activities to Promote Health & Wellbeing At the point of entry to TGC the patient assessment provides the chance for early intervention opportunities. Patients and their carers are central to the development of the patient's individual recovery plan. These plans include early identification of relapse and relapse prevention strategies.
Co-ordination of Promotion/Prevention Activities There is coordination of TGC prevention and promotion activities, via the DON/GM and the Executive Assistant. This includes promotion of mental health week and other activities along with the moderation of the TGC Facebook page.
Staff Education to Support Promotion/Prevention Principles TGC workforce is supported to undertake promotion and prevention activities through a variety of policies along with the prevention of education and training. Clinical supervision supports the inclusion of prevention and promotion activities as part of routine practice.

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.

Assessor'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.

Assessor'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.

Assessor'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.

Assessor's Rating	**Met**

Criterion 5.5

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

Assessor'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.

Assessor's Rating	**Met**

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.

Assessor Summary
Prompt Identification of Carers/Refusal to Nominate a Carer There is a system in place to ensure that the identification of carers is part of the entry into service through the completion of the 'nominated carer' form. If the patient refuses to complete the nominated carer form, then this decision is reviewed on a regular basis during the course of the admission.
Special Needs of Children and the Aged as Carers During entry into the service the special needs of the aged or children carers are identified. A social worker is available to meet those carers with special needs.
Provision of Information to Carers Written information about specialist support groups is available for carers. Specific groups in the Trauma Recovery program, Eating Disorders program and Drug and Alcohol program are undertaken for carers.
Active Identification of Carers in Relapse Prevention Plans Carers are involved, as much as possible, in the development of relapse prevention plans. This is reinforced on discharge which includes contact with the carer as part of the discharge planning process. Carers are actively involved in the Eating Disorders, Drug and Alcohol and Trauma Recovery programs including both individual and group activities.

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.

Assessor'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.

Assessor's Rating	**Met**

Criterion 7.5

The MHS considers the needs of carers in relation to Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, religious / spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age profile and socio-economic status.

Assessor'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.

Assessor's Rating	**Met**

Criterion 7.7

The MHS has documented policies and procedures for clinical practice in accordance with Commonwealth, state / territory privacy legislation and guidelines that address the issue of sharing confidential information with carers.

Assessor'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.

Assessor'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.

Assessor's Rating	**Met**

Criterion 7.11

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

Assessor's Rating	**Met**

Criterion 7.13

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

Assessor's Rating	**Met**

Criterion 7.14

The MHS actively seeks participation of carers in the policy development, planning, delivery and evaluation of services to optimise outcomes for consumers.

Assessor's Rating	**Met**

Criterion 7.15

The MHS provides ongoing training and support to carers who participate in representational and advocacy roles.

Assessor's Rating	**Met**

Criterion 7.17

The MHS has documented policies and procedures for working with carers.

Assessor's Rating	**Met**

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.

Assessor Summary
Promotion/Early Identification/ Prevention of Mental Health Illness TGC is actively involved in mental health month. TGC encourages access to the staff employee's assistance program (EAP) with staff performance reviews including a focus on an individual's health and wellbeing.
Position/s for Implementation of Promotion & Prevention Strategies The prevention, promotional and early intervention ethos is central to the TGC with the 'Working toward Recovery Resource and Workbook' identifying; early warning signs, strategies for relapse prevention and the identification of support networks.
Budget & Adequate Resource Planning Quarterly KPI and six monthly ACHS clinical indicators are reported to inform adequate budget and resource planning.

Criterion 8.1

The governance of the MHS ensures that its services are integrated and coordinated with other services to optimise continuity of effective care for its consumers and carers.

Assessor's Rating	**Met**

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.

Assessor's Rating	**Met**

Criterion 8.5

Identified resources are allocated to support the documented priorities of the MHS.

Assessor's Rating	**Met**

Criterion 8.8

The MHS has a policy and process to support staff during and after critical incidents.

Assessor's Rating	**Met**

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.

Assessor Summary
Facilitation of Care Co-ordination TGC has systems in place to ensure continuity of care with primary care providers. This includes information sharing on discharge via the nursing discharge summary. This information sharing is monitored via an audit process.
Interdisciplinary Care Teams There are a range of systems in place to ensure interdisciplinary care delivery. These arrangements vary by program (Eating Disorders, Trauma Recovery, Drug and Alcohol) but all include regular multidisciplinary team reviews. Some team reviews take the form of 'Professorial' reviews which involve Professor Michael Burke providing guidance and group supervision to reviews that include the multidisciplinary team and the patient as part of the process (Eating Disorders).
Inter-Agency, Intersectoral Links and Collaboration TGC has worked hard to ensure that interagency and intersectoral collaboration takes place. This is ensured by the identification of a visiting medical officer that takes primary responsibility for the coordination of care.

Criterion 9.4

The MHS establishes links with the consumers' nominated primary health care provider and has procedures to facilitate and review internal and external referral processes.

Assessor's Rating	**Met**

Criterion 9.5

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

Assessor's Rating	**Met**

STANDARD 10 Delivery of Care

Assessor Summary
Access/Prioritisation/Inclusion/Exclusion Criteria Entry into the service is coordinated through a central intake system. There are clear entry and exclusion criteria and a number of policies are available to guide the practice of staff in this respect.
Assessment/Risk Assessment A comprehensive assessment and risk assessment process along with appropriate documentation forms part of the admission process. As part of TGC's commitment to continuous quality improvement these documents are currently under review through a process of clinical consultation.
Informed Consent TGC has systems in place to ensure that informed consent is obtained prior to any procedure such as ECT or the sharing of information between service providers. Regular audits of these processes are undertaken and reported.
Active Promotion of Recovery Oriented Values/Principles TGC activity promotes recovery orientated practice through the use of the 'Working towards Recovery Resource and Workbook". Recovery orientated practice is the "golden thread" through the education and training calendar offered in the organisation.
MHS Knowledge of Community Services/Referral to Community Services TGC has developed information packs that outline the available community resources. Brochures outlining available resources are prominently displayed within the organisation to provide patients with access to the material.
Re-entry to the MHS- Facilitation/Ease of Access On discharge patients and as necessary their carers are provided with information on how to gain access to additional support as required or on how to re-enter the service if necessary.
Post-Discharge Follow-up Systems are in place to ensure that appropriate follow up is provided. The visiting medical officer takes responsibility for the co-ordination and follow up care provided on discharge form the TGC.

STANDARD 10.1 Supporting Recovery

The MHS incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery.

Criterion 10.1.1

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

Assessor'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.

Assessor's Rating	**Met**

Criterion 10.1.4

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

Assessor'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.

Assessor'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.

Assessor'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.

Assessor'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.

Assessor'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 10.2.3

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.

Assessor'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.

Assessor's Rating	**Met**

STANRARD 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.

Assessor'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.

Assessor'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.

Assessor'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.

Assessor's Rating	**Met**

Criterion 10.3.6

Where admission to an inpatient psychiatric service is required, the MHS makes every attempt to facilitate voluntary admission for the consumer and continue voluntary status for the duration of their stay.

Assessor'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.

Assessor'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 10.4.6

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).

Assessor'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.

Assessor'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.

Assessor'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.

Assessor's Rating	**Met**

Criterion 10.5.10

The MHS ensures that medication and / or other therapies when required, are only used as part of a documented continuum of treatment strategies.

Assessor'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.

Assessor'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.

Assessor'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.

Assessor'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.

Assessor's Rating	Met

Criterion 10.5.17

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

Assessor'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.

Assessor'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.

Assessor's Rating	Met

Criterion 10.6.6

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

Assessor'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.

Assessor'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.

Assessor's Rating	Met

Rating Summary

STANDARD 1	
1.8	Met
1.9	Met
1.13	Met
1.15	Met
1.17	Met

STANDARD 2	
2.1	Met
2.5	Met

STANDARD 3	
3.4	Met
3.6	Met
3.7	Met

STANDARD 4	
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

STANDARD 7	
7.1	Met
7.3	Met
7.5	Met
7.6	Met
7.7	Met
7.8	Met
7.9	Met
7.11	Met
7.13	Met
7.14	Met
7.15	Met
7.17	Met

STANDARD 8	
8.1	Met
8.2	Met
8.5	Met
8.8	Met

STANDARD 9	
9.4	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	
10.2.3	Met
10.2.4	Met

STANDARD 10.3	
10.3.1	Met
10.3.2	Met
10.3.4	Met
10.3.5	Met
10.3.6	Met
10.3.7	Met

STANDARD 10.4	
10.4.6	Met
10.4.7	Met

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

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

Recommendation from Current Assessment

Nil

Rating Summary

Geelong Clinic, The

Health Service Facility ID: 101047

Standard 1 - Clinical Governance

Governance, leadership and culture

Action	Assessment Team Rating
1.1	Met
1.2	Met
1.3	Met
1.4	Met
1.5	Met
1.6	Met

Patient safety and quality systems

Action	Assessment Team Rating
1.7	Met
1.8	Met
1.9	Met
1.10	Met
1.11	Met
1.12	Met
1.13	Met
1.14	Met
1.15	Met
1.16	Met
1.17	Met
1.18	Met

Clinical performance and effectiveness

Action	Assessment Team Rating
1.19	Met
1.20	Met
1.21	Met
1.22	Met
1.23	Met
1.24	Met
1.25	Met
1.26	Met
1.27	Met
1.28	Met

Safe environment for the delivery of care

Action	Assessment Team Rating
1.29	Met
1.30	Met
1.31	Met
1.32	Met
1.33	Met

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action	Assessment Team Rating
2.1	Met
2.2	Met

Partnering with patients in their own care

Action	Assessment Team Rating
2.3	Met
2.4	Met
2.5	Met
2.6	Met
2.7	Met

Health literacy

Action	Assessment Team Rating
2.8	Met
2.9	Met
2.10	Met

Partnering with consumers in organisational design and governance

Action	Assessment Team Rating
2.11	Met
2.12	Met
2.13	Met
2.14	Met

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Action	Assessment Team Rating
3.1	Met
3.2	Met
3.3	Met

Action	Assessment Team Rating
3.4	Met

Infection prevention and control systems

Action	Assessment Team Rating
3.5	Met
3.6	Met
3.7	Met
3.8	Met
3.9	Met
3.10	Met
3.11	Met
3.12	Met
3.13	Met

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Met

Antimicrobial stewardship

Action	Assessment Team Rating
3.15	Met
3.16	Met

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action	Assessment Team Rating
4.1	Met
4.2	Met
4.3	Met
4.4	Met

Documentation of patient information

Action	Assessment Team Rating
4.5	Met
4.6	Met
4.7	Met
4.8	Met
4.9	Met

Continuity of medication management

Action	Assessment Team Rating
4.10	Met
4.11	Met
4.12	Met

Medication management processes

Action	Assessment Team Rating
4.13	Met
4.14	Met
4.15	Met

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

Action	Assessment Team Rating
5.1	Met
5.2	Met
5.3	Met
5.4	Met
5.5	Met
5.6	Met

Developing the comprehensive care plan

Action	Assessment Team Rating
5.7	Met
5.8	Met
5.9	Met
5.10	Met
5.11	Met
5.12	Met
5.13	Met

Delivering comprehensive care

Action	Assessment Team Rating
5.14	Met
5.15	Met
5.16	Not Applicable
5.17	Met
5.18	Not Applicable
5.19	Not Applicable
5.20	Met

Minimising patient harm

Action	Assessment Team Rating
5.21	Met
5.22	Met
5.23	Met
5.24	Met
5.25	Met
5.26	Met
5.27	Met
5.28	Met
5.29	Met
5.30	Met
5.31	Met
5.32	Met
5.33	Met
5.34	Met
5.35	Met
5.36	Met

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action	Assessment Team Rating
6.1	Met
6.2	Met
6.3	Met
6.4	Met

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Not Applicable
7.2	Not Applicable
7.3	Not Applicable

Prescribing and clinical use of blood and blood products

Action	Assessment Team Rating
7.4	Not Applicable
7.5	Not Applicable
7.6	Not Applicable
7.7	Not Applicable
7.8	Not Applicable

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Not Applicable
7.10	Not Applicable

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

Action	Assessment Team Rating
8.4	Met
8.5	Met
8.6	Met
8.7	Met
8.8	Met
8.9	Met

Responding to acute deterioration

Action	Assessment Team Rating
8.10	Met
8.11	Met
8.12	Met
8.13	Met

Recommendations from Previous Assessment

Nil