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

Hobart Private Hospital &
St Helen's Private Hospital

Hobart, TAS

Organisation Code: 42 08 55

Survey Date: 20-22 June 2017

ACHS Accreditation Status: ACCREDITED

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About The Australian Council on Healthcare Standards

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

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

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

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

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

What is Accreditation?

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

How to Use this Survey Report

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

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

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

1 Survey Team Summary Report
2 Actions Rating Summary Report
3 Recommendations from Current Survey
4 Recommendations from Previous Survey
5 Standards Rating Summary Report

1 Survey Team Summary Report

Consists of the following:

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

Ratings

Each action within a Standard is rated by the organisation and the survey team with one of the following ratings. The survey team also provides an overall rating for the Standard. If one core action is Not Met the overall rating for that Standard is Not Met.

The report will identify individual actions that have recommendations and/or comments.

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

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

Action Recommendations

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

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

Risk ratings could be:

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular action.

Recommendations are structured as follows:

The action numbering relates to the Standard, Item and Action.

4 Recommendations from Previous Survey

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

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

5 Standards Rating Summary Report

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

Organisation: Hobart Private Hospital&St Helen's Private Hospital
Orgcode: 420855

Survey Report

Survey Overview

Hobart Private Hospital (HPH) is a 142-bed facility collocated with Royal Hobart Hospital (RHH) in the Hobart CBD and provides medical, surgical and obstetric services, a Coronary Care Unit and High Dependency Unit, and a 24/7 Emergency Department. St Helen's Private Hospital (SHPH) is located less than 2 km away and is a 47-bed mental health facility that includes adult beds and an eight-bed Mother and Baby Unit.

HPH and SHPH are owned and operated by Healthscope Ltd (HSP). The HSP National team provides support to the workforce through policies, guidelines and frameworks, and opportunities to participate in benchmarking with facilities in the HSP Group. In mid-2016 a 'Cluster" model was introduced for management of HPH and SHPH with a General Manager overseeing the operations of both hospitals and establishment of an integrated system of governance which includes peek committees supporting quality and safety activities across sites.

This Organisation-Wide Survey against the National Safety and Quality Health Service (NSQHS) Standards was undertaken on 20 to 22 June 2017 and included an on-site visit by three surveyors.

The organisation reported that there have been increased surgical and obstetric admissions at HPH, with the operating theatre utilisation consistently above 90% resulting in a consistent Saturday list and introduction of 'twilight' lists. In April 2017, a contract was established with the Department of Health and Human Services (DHHS) Tasmania and Healthscope (Hobart) for the management of RHH public surgical waiting lists in eight annexed beds at HPH. Activity in the SHPH Mother and Baby Unit has also increased in association with an increase in bed numbers from six to eight for the management of DHHS public patients.

The survey team was impressed with the progress made by the organisation in the implementation of the NSQHS Standards and the development of services since the previous survey in 2014. It is evident that the Executive and staff are continuing to strive for excellence in the standard of health care provided. A distinct focus is evident throughout the organisation on the engagement of the hospital's workforce to ensure safe and quality care is provided for consumers and in fostering partnerships with consumers and carers.

HPH and SHPH have achieved the following Met with Merit ratings:
3.5.1 - Workforce compliance with current national hand hygiene guidelines is regularly audited
3.5.2 - Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation; and
3.5.3 - Action is taken to address non-compliance, or the inability to comply, with the requirements of the current national hand hygiene guidelines.

All other Core and all the Developmental actions are assessed as Satisfactorily Met (SM). Core actions 3.10.1 and 9.6.1 are assessed as fully met.

The Executive and staff are congratulated on the enthusiasm demonstrated during the survey and their achievements in embedding the NSQHS Standards into the hospital's safety and quality program.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

Hobart Private Hospital (HPH) and St Helen's Private Hospital (SHPH) have an integrated system of governance that manages patient safety and quality. This is supported by the Healthscope Safety and Quality Plan Clinical Governance Framework and the HPH and SHPH Clinical Governance Framework and Safety and Quality Plan. Organisational and committee restructuring commenced mid-2016.

Management of both hospitals is now overseen by the General Manager. The HPH/SHPH Quality and Risk Committee is the peak committee and reports to the Executive. Organisation-wide committees report to the Quality and Risk Committee and include Infection Control, Antimicrobial Stewardship Program, Medications Safety, Clinical Deterioration, Education and Policy, Emergency Planning, Workplace Health and Safety, and Documentation. Separate Medical Advisory Committees continue to operate for each hospital and receive reports on the peak committee's quality and safety activities and the Clinical Committees (Surgical Clinical Review, Anaesthetic Services, Maternity Services, Psychiatric Services, TMS and ECT). All committees have documented Terms of Reference, and standing quality and safety agenda items. The survey team identified in the committee structure diagrams a need to more clearly illustrate the reporting lines of the various committees to the Quality and Risk Committee and the relationship of the Medical Advisory Committees. The organisation is encouraged to expedite the proposed amalgamation of the Medical Advisory Committees to further strengthen the integration of the governance structure and safety and quality activities across the hospitals.

The system for management of policies/procedures and clinical guidelines is well-established at both corporate and local levels and there is evidence of version control, ongoing review and currency of information. HSP, HPH and SHPH policies/procedures/clinical guidelines are available in electronic directories which are available on the intranet (HINT) and local drives, and are readily accessible by end-users. Processes are well-established for ensuring legislative compliance and alerts when legislative changes occur and for communicating new and revised policy documents to the workforce. Compliance with legislation occurs through a system of checks and balances at corporate and local levels.

Mechanisms for communicating new and revised policy documents to the workforce have been strengthened with the introduction of the ELMO (Electronic Learner Management Online) system which is being used for transmission of new and revised policies to the workforce. The introduction in 2016 of an Electronic Communication Platform by the HPH DON has enhanced communication of policies to the VMO workforce. Compliance with policies occurs via audits and incident monitoring. A comprehensive audit schedule is in use and incorporates audits relating to high-risk policies and NSQHS Standards audit requirements.

Consideration of patient safety and quality of care is evident in the HPH and SHPH Strategic, Safety and Quality and Operational plans which link to the Corporate Strategic and Safety and Quality Plans.

HPH/SHPH collect data on an extensive suite of safety and quality indicators which incorporate the requirements of the NSQHS Standards and risks identified in RiskMan, Healthscope 'never events,' and clinical indicators. Quarterly Safety and Quality reports are submitted to the Corporate clinical governance team and performance is measured against targets, trended and benchmarked across HSP hospitals. Reports show outliers which do not meet the specified performance targets and organisations are required to submit action plans within a target timeframe of one week to address areas below target. HPH/SHPH submit data to the ACHS clinical indicator program. Performance is monitored by the HPH/SHPH Executive and the various committees, and the HSP National Safety and Quality Committee, the Executive Management team and the Board. There is evidence of development and implementation of follow-up action plans for areas identified as requiring improvement.

Position descriptions indicate workforce responsibilities for safety and quality. HPH and SHPH organisation charts clearly outline reporting lines and responsibilities of staff. The organisation reported that there is a very low usage of agency staff. Orientation, mandatory and in-service education programs provide information related to safety and quality responsibilities of the workforce and are provided via face-to-face education sessions and eLearning. The workforce is provided with opportunities to participate in HSP Cluster activities and safety and quality programs.

Processes for orientation of staff are well developed and supported with educational resources. Very high levels of compliance with mandatory education requirements by nursing, midwifery and salaried medical staff are evident. Mandatory training programs address the requirements of the NSQHS Standards and include the required competencies and HSP Corporate requirements such as emergency procedures, manual handling, and MidSafe mandatory education by staff working in Healthscope Obstetric Units. The introduction of the new eLearning platform (ELMO) has been associated with substantial improvement in efficiency in the maintenance of records of workforce participation in education programs, improved accuracy of records and reporting of performance. Appropriate mechanisms are established for orientation of agency and locum workforce. The organisation's educational and staff development activities are very well supported with enthusiastic educators and quality unit staff.

The risk management system is overseen by the Executive and the Quality and Risk Manager and is supported with HSP policies which provide the framework for risk management across the organisation, the use of RiskMan, and availability of risk/quality manuals in all departments. Training on risk management is included in the induction program for all new employees, hospital-wide department based and one-to one education sessions. The risk register incorporates safety and quality risks and the integrated Risk Module has capacity to link risks to the 10 NSQHS Standards, Hospital Acquired Complications and Medibank Indicated Complications. There is evidence of risk rating, use of controls and risk mitigation activities, ongoing review and monitoring of outcomes. Time-based alerts are used to ensure compliance with all risk register review dates which is closely monitored by the National Risk Management team.

The survey team noted at SHPH psychiatric environment risk assessments were completed in 2015, 2016 and 2017 and the hazards identified which include ligature points (door handles, light and bathroom fittings) had been addressed. During the survey arrangements were made for replacement of handles of doors at the exit to an external smoking area located adjacent to Hampden Ward as these were observed by the survey team to be non-compliant with the required standard. The area where smoking is permitted was built in 2015 and is a balcony which appeared to have a wooden flooring and which is locked. Patients have to obtain permission to access, ensuring that staff are aware of who is in there.

The survey team was advised that a stub retainer for cigarette butts was provided and that a fire safety inspection has been completed by the fire authority. Given the nature of the permission to smoke unit including structure, site, access and constant use within the hospital, the organisation is encouraged to implement regular risk assessments and monitoring to ensure safety for all patients, staff and visitors/carers, and to ensure these are supported by a protocol and policy created on management including fire prevention, occupational health and safety including safe disposal of stubs/possible needles, and implementation of regular audits. Consideration should be given to the implementation of a strict no smoking hospital-wide policy overall aligning with current best practice for its introduction in mental health care facilities.

Clinical practice

Clinical guidelines and generic care plans are in use and are subject to ongoing review. Clinical pathways are in use in the Emergency Department and include acute asthma, adult sepsis, adult acquired pneumonia and geriatric trauma, and are subject to ongoing monitoring.

The models of care for patients include multidisciplinary assessments, goal setting, care planning and case reviews, and commencement of discharge planning at the beginning of the episode of care for all patients. The length of stay of patients and variances against expected ALOS, mortality and morbidity data and ACHS Clinical Indicator data are subject to regular review by the Executive, the Quality and Risk and Clinical Committees and Medical Advisory Committees. MET calls and unplanned transfers to higher levels of care are subject to review by the Clinical Deterioration Committee and the Medical Advisory Committee. The clinical indicator data for 2016 and 2017 shows a decreased trend in transfers to a higher level of care and unplanned overnight admissions, and a low incidence of unplanned transfers to a higher level of care at HPH. Patients requiring higher levels of care are discharged from HPH and SHPH and transferred to Royal Hobart Hospital (RHH). Intensivists from RHH provide consultancy services to HPH. The survey team was advised that the organisation is currently seeking approval from DHHS, Tasmania to establish a six-bed ICU in the current Coronary Care/High Dependency Unit.

A suite of HSP policies provides the framework by which the organisation identifies patients at increased risk of harm and includes an extensive suite of screening and assessment policies/procedures and tools developed by HSP Clinical Clusters and which are standardised across HSP hospitals. There are clear exclusion policies regarding patients who should not be admitted to HPH and SHPH. Exclusion criteria are included in the contract between Tasmanian Health Service and Healthscope (Tasmania) for the pre-and post-operative management of public

surgical/medical patients in the HPH designated annexed beds. Well-developed systems are established to monitor compliance and for ensuring admissions are in accordance with approved clinical services capability.

Risk assessment/screening tools are incorporated in pre-admission and admission processes. Risk assessments include falls, malnutrition, pressure injury, infection and cognitive status, allergies, VTE, medication and discharge risk. Mental health patients undertake robust risk assessments pre-admission and on admission, during the episode of care and prior to discharge/leave.

Alerts are documented in the patient clinical record, the electronic administration information system and in other communication tools. At-risk patients are discussed at handover meetings. Management plans are developed for patients identified at risk. An electronic leave register is used to manage leaves of mental health patients and assists in the follow-up of patients.

There is evidence of the strengthening of risk assessment processes, including improved timeliness of completion of assessment and screening tools and Emergency Department observations. Implementation of track and trigger observation charts has resulted in the earlier clinical review of patients. Audit results show good compliance with completion of risk assessments and implementation of appropriate management plans.

An effective system for escalating care is established and is discussed more fully in Standard 9.

The survey team was impressed with the suite of policies that is both relevant and appropriate to ensuring accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care. The policies include ones for FOI processing, the protection of privacy and confidentiality, transport and storage. The hospitals are noted to be in a relatively early stage of a comprehensive e-record development but there are some significant areas (as described by the organisation) already completed and maintained supporting integration and availability; for example, in WebPas. There is a national forms committee (commenced February 2016) which has initiated forms review. It is noted that Healthscope clinical clusters and document controllers coordinate revision and development of clinical record pro formas. Standardisation is being achieved across Clusters. The survey team examined a sample of records and was impressed at the layout of the documentation and files clearly supporting systematic auditing. Good compliance with documentation in the progress notes was noted by surveyors. Through audit, noted as an outlier, the VMOs have been requested to include their designation each time. A system is in place to ensure health information audit results and quality in action plans are fed back to all clinicians and clinician managers; for example, through the MACs.

Performance and skills management

HSP By-Laws provide the framework for credentialing and approval of the scope of practice of medical officers which is overseen by the HPH and SHPH Medical Advisory Credentialing Committees. Applicants are required to provide evidence of credentials, referees, verification of insurance, details of the scope of practice sought and a copy of a CV. An electronic database and hard copy personnel files are used to maintain medical officers' records and scope of practice. With regard to re-accreditation, the HPH and SHPH Medical Advisory Credentialing Committees consider patient outcomes, adverse events, complaints, participation in quality assurance activities and continuing professional development. An e-credentialing system (C-Governance) was introduced in 2015 and results of annual audits conducted by HSP show 100% compliance. The survey team noted that the contract between Tasmanian Health Service and Healthscope (Tasmania) for pre-and post-operative management of public surgical patients indicates that Royal Hobart Hospital credentialed Medical Officers are to provide medical care of patients in the designated annexed beds.

Medical, nursing and allied health registrations are subject to online currency checks via AHPRA. Appropriate processes for defining and monitoring the scope of practice of nursing and allied health workforce are in use and include position descriptions and monitoring of performance. Mechanisms for clinical supervision of Salaried Medical Officers, nurses and allied health workforce and students are well developed. The appointment of a Senior Emergency Medical Officer in 2016 was reported to have improved clinical supervision in the Emergency Department.

Appropriate processes are established for the safe introduction of new interventional procedures and for monitoring of outcomes and are overseen by the Medical Advisory Committees and the Executive.

Performance appraisal systems for nursing, allied health and support staff are well-developed. High compliance levels with annual appraisals were evident.

Feedback from the workforce on their understanding and use of safety and quality systems occurs via their evaluation of education sessions and workforce surveys. Education is tailored to meet training needs identified in performance and development reviews, through training needs analysis, audits, and incident trends. Evidence provided included results of training needs analysis, workforce surveys and reviewed education programs. The survey team observed that the clinical and non-clinical workforce demonstrated good understanding and application of safety and quality.

Incident and complaints management

The systems for management of incidents and complaints are well-developed, and supported by HSP and HPH/SHPH policies/procedures, use of RiskMan and staff education. The RisKMan system includes extensions requiring controls to be completed for NSQHS Standards, maintenance of registers of incidents/near misses and complaints, categorisation and risk rating of incidents and complaints according to severity. Management of incidents and complaints is overseen by the Directors of Nursing and the Quality Manager.

The RiskMan reporting system includes automatic notification of all incidents and feedback to the Healthscope and local Executives. Mechanisms are established for notification of the Executive, the HSP National Risk Manager and DHHS, Tasmania, when a sentinel event occurs. Critical System Reviews are conducted on DHHS reportable incidents, Sentinel and Medibank identified complication (MIC) events to analyse contributing factors. At HPH critical system reviews involve specifically convened committees which include a WMO from the specialty, MAC Chair or Deputy, and the Director of Nursing (DON) or Quality Manager. The HSP National Risk Manager provides support as required. There is evidence of good compliance by the hospitals with the submission of reports related to investigations/follow-up action for sentinel events to the Corporate level within the HSP target time frames. Notification of sentinel events to the DHHS occurs within the required time frame, however, the HPH Director of Nursing advised that there was an occasion when there was a delay in notification when the death of her mother occurred. Evidence was sighted showing results of Critical Systems Reviews, recommendations and implementation of follow-up actions, and copies of reports provided to the DHHS by the HPH Director of Nursing and are prepared following consultation with Clinical Committees and the Medical Advisory Committee. The survey team noted that delays in closing sentinel events are closely monitored by the HSP National Risk Manager and DHHS. Delays in finalisation of HPH reports may occur in relation to the quarterly scheduling of the Medical Advisory Committee meetings. To reduce the incidence of delays in the finalisation of reports the organisation could consider review and establishment of mechanisms for earlier finalisation of critical system reviews by the HPH Medical Advisory Committee.

Incidents are communicated to the workforce once confirmation and an initial investigation have occurred. Healthscope sentinel events report summaries (Shared Learning Reports) are disseminated to the workforce by the Executive. These are signed off quarterly for compliance with recommendations relevant to HPH/SHPH by GM and DONs as well as managers of relevant specialty services such as obstetrics, theatre and mental health managers.

Data on trends of incidents and complaints are reported to the Quality and Risk Committee, Medical Advisory and Clinical Committees. Quarterly Quality and Safety Reports submitted to HSP show 100% compliance by HPH and SHPH in meeting HSP target time frame KPIs for complaints acknowledgement and response.

Application of the National Open Disclosure Standard is undertaken in association with the investigation of incidents/complaints. Open Disclosure events are entered into RiskMan and clinical records. Evidence showed very high levels of compliance with the completion of mandatory eLearning open disclosure education by clinical staff in 2016 at HPH (98%) and SHPH (92%); HSP KPI is 92%. VMO open disclosure education is included in VMO induction and via MAC and Clinical Committee meetings and access to eLearning programs. Open disclosure educational material is available on the intranet.

Patient rights and engagement

A Patient Charter of Rights and Responsibilities consistent with the National Standard is in use. Information regarding this Charter is provided to patients on admission, in patient information compendiums, and is present in patient care areas and website. Translation of information is available via access to multicultural brochures and interpreter services. Assessment of patient understanding of their rights and responsibilities is undertaken via patient satisfaction surveys, with 2016 results showing 96% for HPH and 97% for SHPH.

Results of 2016 patient satisfaction surveys show patients indicated they were involved in making decisions about their care. There is provision for the signing of care plans by the patient. Bedside patient care boards are in use in all

clinical areas and clinical handover activities facilitate communication and partnering with patients and carers.

Systems for management of consent are well-established and are subject to ongoing monitoring and audit. Separate consent forms are used for surgical/medical procedures, transfusion of blood products, and ECT, TMS procedures. A wound care plan incorporates provision for patient consent by the patient for photography of a wound. Documentation audits show very high compliance with consent documentation and improved documentation of financial consent.

Information is provided to patients regarding completion of advance care directives and includes a comprehensive HSP brochure. Mechanisms are established for incorporation of alerts when patients present with an advance care directive and when treatment-limiting orders are established during a patient's episode of care. Advance care directives are not completed by the HPH/SHPH workforce.

It is evident that a focus has been made and maintained on implementing procedures that protect the confidentiality of patient clinical records without compromising appropriate clinical workforce access to patient clinical information. Transport and storage issues described previously have seen excellent improvements. A risk assessment has been done and an action plan implemented to address the clinical risk to the patient and merge the day program files with patients' hospital medical records. Merging is continuing. A date for completion of the merger is suggested cognisant that this is a rolling merger and development of the record has significant relevance. The surveyors noted the initiatives for improvement such as requests for information being in writing, checklists and tracking. Secure record transport bags have been introduced. Access to all electronic information systems by staff is via restricted password protected procedures. Policies include one on social media and professionals. A particularly important one is the security of information and IT. It is essential that IT/media policies and procedures are continuously reviewed and up-to-date, potential breaches are planned for and actioned, and regular audits done. It is suggested that each hospital manager regularly confirm that their organisation is fully part of the corporate IT monitoring and audit processes and initiatives particularly in relation to inappropriate access to and dissemination of patient clinical information. At survey, such were not sighted and/or not available to surveyors.

Data collected from patient satisfaction surveys, HSP patient-centred care experience surveys, complaints and compliments are used to gain feedback from patient experiences at HPH and SHPH and action plans are developed and improvements implemented as required. Examples of improvements made as a result of feedback from patients include adjustments to menus and meal presentations and bedside clinical handover practices, and implementation of strategies to reduce noise in clinical areas. Results of patient satisfaction surveys show high levels of overall satisfaction at both hospitals.

NSQHSS Survey

Organisation: Hobart Private Hospital&St Helen's Private Hospital
Orgcode: 420855

Governance and quality improvement systems

Ratings

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

Clinical practice

Ratings

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

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM
1.10.3	SM	SM
1.10.4	SM	SM

1.10.5	SM	SM
1.11.1	SM	SM
1.11.2	SM	SM
1.12.1	SM	SM
1.13.1	SM	SM
1.13.2	SM	SM

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

The governance arrangements occur within the framework of the HSP Partnering with Consumers Policy and the HPH/SHPH Quality and Safety Clinical Governance Plans, and are supported by two consumer consultants. Recruitment of additional consumer representatives is in progress. A consumer consultant regularly attends the Quality and Risk Committee and participates in HSP consumer consultant teleconferences. The consumer consultants not only provide a conduit for information and communication between the community and the hospital but have been proactive in identifying areas for future improvements in health services.

The consumer consultants have a clearly documented position description and arrangements are established for their participation in orientation programs, HSP consumer consultant activities and strategic planning activities.

Mechanisms are well-developed for communicating the activities of the consumer representatives to the workforce, patients and carers and include regular meetings with the Executive and the Quality Manager, participation in staff meetings and display of information within the hospitals.

Evidence was available demonstrating that consumer consultants have been consulted on the development and revision of publications/patient information materials and that feedback has been incorporated in the documentation. A HSP logo, which has been developed in consultation with consumers, is used to indicate a Consumer Approved Publication and applied when an organisation demonstrates that required criteria are met. The work undertaken by consumer consultants in reviewing materials provided to patients on admission to hospital has resulted in a reduction in a number of materials issued.

Consumer partnership in designing care

Mechanisms for the participation of consumers in designing and redesigning care are established and have included consultation on the development of the Emergency Department and pathology service waiting areas.

Patient-centred care education is incorporated in orientation, mandatory eLearning and in-service education programs provided for the workforce. Records show participation in the eLearning program at the time of survey was 87% at HPH and 97% at SHPH.

Consumer consultants provide education to the workforce through contributions to the orientation program and meetings with the workforce. These incorporate roles of the consumer consultants and feedback on patient surveys and quality activities. A HSP Clinical Handover video developed in consultation with consumers is used in workforce training. The organisation is encouraged to consider the use of DVDs which include the use of patient stories.

Consumer partnership in service measurement and evaluation

Mechanisms are established for providing the community and consumers with information on the safety and quality performance of the organisation and include the display of information on the My Healthscope website and throughout HPH and SHPH, and inclusion of information in newsletters.

There is evidence of consumer consultant participation in measurement and evaluation of services and safety and quality performance, and in quality activities which include visiting and surveying patients to obtain feedback on care and hospital activities. Examples of participation in quality activities include evaluation of content used on patient bedside communication boards, bedside clinical handover activities, and patient satisfaction regarding education on medications on discharge. Outcomes include improved currency of information on bedside communication boards, improved confidentiality in patient shared rooms during clinical handover, and improved management of discharge medications. HPH has participated in a HSP mystery shopper pilot and plans are in place for further implementation across the hospital and SHPH. A Carer Journey Tool has been developed and is to be implemented in hospitals in the near future. The organisation is encouraged to evaluate the findings in collaboration with consumer representatives.

NSQHSS Survey

Organisation: Hobart Private Hospital&St Helen's Private Hospital
Orgcode: 420855

Consumer partnership in service planning

Ratings

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

Consumer partnership in designing care

Ratings

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

Consumer partnership in service measurement and evaluation

Ratings

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

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

The governance system for Infection Prevention and Control is well managed and is overseen at Hobart Private Hospital (HPH) and St Helen's Private Hospital (SHPH) utilising the HICMR infection and control policies, Healthscope Corporate (HSP) and local policies. The hospitals are supported by a (0.8) part time infection control coordinator.

HSP, HICMR and local policies and procedures are available via the intranet and hard copy, and show evidence of ongoing review and currency. There are documented Infection Control Plans and well-developed audit and surveillance plans. Performance monitoring and review are undertaken by the Infection Control Committee and Medical Advisory Committee (MAC) and via the organisation's Quality and Safety reports which are submitted quarterly to Healthscope Corporate for benchmarking with peer hospitals. ACHS clinical indicators are submitted bi-annually and performance is discussed at the appropriate committee structures. All Staphylococcus Aureus Bacteraemia (SAB) infections are reported in RisKMan and to HSP and DHHS, Tasmania and a critical systems review is undertaken. Evidence provided showed the incidence of hospital-acquired infections (HAIs) is consistently low. Results of internal infection control audits show high levels of compliance, and there is evidence of follow-up actions for areas identified as requiring improvement. Risk management activities are addressed and reported in RiskMan with actions included in quarterly action plans. An Aseptic Non-Touch Technique (ANTT) program and hand hygiene audits are in place. Infection control orientation to new staff includes hand hygiene and ANTT. Workforce mandatory education and monitoring of outcomes are well documented.

Infection prevention and control strategies

The hand hygiene program is well embedded in the culture of HPH and SHPH. Hand washing basins, hand rub solutions and hand hygiene posters are readily available throughout the hospitals. Results of audits show the overall compliance rate has been consistently above the benchmark for the period 2015 – 2017. A compliance rate of 92.3% for HPH and 91.7% for SHPH for period 1, 2017 across the clinical, non-clinical and medical officers was reported. Hand hygiene education and competency assessments and audits were evident and are supported with 14 Gold Standard auditors. Results are reported to HSP and relevant committees at HPH and SHPH and improvement opportunities are disseminated to the relevant clinical departments. Results are published on My Healthscope and My Hospital websites.

There is evidence of substantial work being undertaken to ensure the HPH and SHPH immunisation program complies with the national guidelines. Rigorous processes are established for pre-employment screening and for the collection of data on the information status of all employees and maintenance of records. There are five nurse immunisers available to assist with immunising the staff. Evidence provided shows, following implementation of serology testing and provision of vaccines to 90% of the workforce, high-risk areas such as the perioperative staff had evidence of 100% vaccination to Hepatitis and immunity by March 2017. Evidence provided also shows continuous improvement in the workforce uptake of influenza vaccinations since 2014, with 70% achieved in 2017.

The documentation of the systems for prevention and management of occupational exposures and management of invasive devices was evident. These include the availability of personal protective equipment (PPE) and staff education programs. Blood exposure packs were seen in the clinical areas, with flow charts giving clear instructions to the workforce. The Hospital Coordinators manage exposure incidents for staff. HSP corporate product evaluation and procurement processes are in place and invasive devices have corporate contracts. Staff who are required to perform procedures with invasive devices and aseptic technique participate in competency education-based programs. Healthscope has moved to the Australian AT training module and is available to staff on the eLearning platform. Training records show that at the time of survey 100% of all nursing staff have completed the ANTT training in 2017. Action 3.10.1 is assessed as fully met.

Managing patients with infections or colonisations

HPH and SHPH have policies and procedures for managing patients with infections and colonisations and are available for all clinical and non-clinical staff. Staff training and monitoring of compliance with both standard and transmission-based precautions were evident. Audit results show high compliance. The risk assessment of patients' infectious status is well managed and includes pre-admission screening, to ensure that patients with an infection or colonisation are identified and appropriate patient placement occurs on admission. Information is documented as a clinical alert in the medical record and in the electronic information system. Processes are well developed for communicating a patient's infectious status whenever responsibility of care is transferred between service providers and facilities on discharge.

Antimicrobial stewardship

The antimicrobial stewardship program is overseen by the HPH Antimicrobial Stewardship (AMS) Committee which meets quarterly and reports to the MAC. The committee is chaired by the Hospital Chief Medical Officer. An Infectious Diseases Consultant is available on call for advice. Healthscope and HICMR policies and therapeutic guidelines are available in all clinical areas. There are surgical prophylaxis guidelines in poster format at the appropriate point of care. The infection control coordinator and clinical pharmacist monitor antibiotic usage, appropriateness of antibiotic prescribing and resistance. Evidence provided showed regular reports are submitted to the clinical committees and MAC. HPH participates in the National Antimicrobial Utilisation Surveillance Program (NAUSP) and the National Antibiotic Prescribing Surveys (NAPS). Recent audits conducted on surgical prophylaxis have had favourable results with product, dose and time of administration. Any outlier usage is reported to the AMS Committee and the MAC takes any action deemed appropriate. The survey team noted that in 2016 HPH was named as Champion Site in Tasmania for NAUSP and congratulates the organisation on this achievement.

Cleaning, disinfection and sterilisation

HICMR, Healthscope, HPH and SHPH policies and procedures provide the framework to ensure the principles of infection prevention and control are practised in environmental cleaning and linen management. Environmental cleaning schedules are used in all areas of the hospital, including the kitchen. Cleaning protocols with toolkits were available for MROs post inpatient stay, and material safety data sheets were sighted in the clinical areas, cleaners' rooms and appropriate areas. An annual schedule of environmental audits is documented for the hospitals and results show high levels of compliance. Linen and waste management is undertaken by external contractors and is very well managed.

The CSSD and the Endoscopy Suite have defined workflows for instrument cleaning, decontamination, reprocessing, sterilisation, and storage of instruments and equipment. A paper-based tracking and traceability system is in place for tracking reusable items, medical devices and endoscopes. There was compliance regarding storage and the integrity of sterile stock. There was a suitably trained workforce in the Central Sterilising Department and evidence shown of all competencies was sighted.

A gap analysis for compliance with AS4187:2014 has been completed and a plan to complete any remaining gaps has been developed. To ensure compliance, installation of a reverse osmosis water unit at HPH occurred in 2016 and upgrading of the IVF theatre at SHPH has occurred in 2017. This includes installation of a Trophon EPR in the IVF theatre for high-level disinfection of ultrasound probes, upgrading of the sterile stock area, and replacement of operating theatre doors. Replacement of the floor in the decontamination area adjacent to the theatre is scheduled to occur during reduced activity time December 2017/January 2018.

Communicating with patients and carers

My Healthscope website provides consumer specific information on the reduction of healthcare associated infections and HPH and SHPH performance data. Infection prevention and control information is also provided in brochure format and specific information is given to patients in the pre-admission clinic or as an inpatient if required.

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

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

Action 3.5.1 Core

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

Surveyor Comment:

Evidence provided showed that Hobart Private Hospital and St Helen's Private Hospital workforce compliance with the national hand hygiene guidelines had been audited as per the HSP Hand Hygiene Policy and the national hand hygiene initiative requirements and that the overall compliance rate has been consistently above the national benchmark for the period 2015 - 2017. There was a compliance rate of 92.3% at HPH and 91.7% at SHPH, audit period 1 2017 across the clinical and non-clinical workforce, including medical officers. The surveyors agree there is a sustained approach to compliance auditing and the action is rated MM.

Surveyor's Recommendation:

No recommendation

Action 3.5.2 Core

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

Surveyor Comment:

Evidence provided showed that Hobart Private Hospital and St Helen's Private Hospital hand hygiene rates are reported monthly to the HPH and SHPH Quality and Safety Committee and quarterly to HSP Corporate where performance is monitored against HSP targets, benchmarked with other HSP hospitals and reviewed by the National Safety and Quality Committee. The current HSP National Benchmark target is 85%. HPH and SHPH have consistently performed above the HSP targets which are above the National Benchmark and reviewed annually. The surveyors agree there is evidence of a sustained approach to reporting and review of hand hygiene compliance rates at the HPH, SHPH and HSP Corporate levels and the action to be rated MM.

Surveyor's Recommendation:

No recommendation

Action 3.5.3 Core

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

Surveyor Comment:

There is a very well established and comprehensive organisation-wide approach to improving compliance with hand hygiene and for minimisation of risks to patient safety and quality of care. This includes risk management plans, very high levels of participation in mandatory hand hygiene education by the workforce, widespread availability of hand gels and display of posters and information on workforce hand hygiene rates throughout the organisation. The organisation- wide compliance performance in hand hygiene demonstrates continuous improvement and is supported with the achievement of very high compliance rates and low levels of infection. The surveyors agree that there is a very well developed organisation-wide system which is subject to ongoing review and strengthening for improving and maintaining workforce compliance with the national hand hygiene guidelines. The action is rated MM.

Surveyor's Recommendation:

No recommendation

Action 3.10.1 Core

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

Surveyor Comment:

Training records show that 100% nursing staff have completed aseptic technique training in 2017. The action is fully met.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

Action	Organisation	Surveyor
3.11.1	SM	SM
3.11.2	SM	SM
3.11.3	SM	SM
3.11.4	SM	SM
3.11.5	SM	SM
3.12.1	SM	SM
3.13.1	SM	SM
3.13.2	SM	SM

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

Action	Organisation	Surveyor
3.15.1	SM	SM
3.15.2	SM	SM
3.15.3	SM	SM
3.16.1	SM	SM
3.17.1	SM	SM
3.18.1	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

Healthscope and both hospitals have systems and structures in place which support the development, implementation and maintenance of organisation-wide medication safety. The HPH/SHPH Medication Safety Committee meets bimonthly. This committee includes a NUM representative from each hospital, DON, Quality Manager (QM), educator and clinical pharmacist. The SHPH representative joined the committee in 2016. The chair/QM reports to the MAC at each site. DON and NUMs report to NUMs and department Standard 4 representatives. The QM reports to the QuaRM and Staff Development Coordinator reports to the Education Committee. Second monthly via teleconference the QM and a NUM attend the Healthscope Medication Safety Cluster. An agreement with HSP provides 35 hours clinical pharmacy at HPH and 10 at SHPH and there is a private pharmacy on site at HPH. There is evidence that clinical pharmacy services have strongly supported and improved the clinical governance of Medication Safety at both hospitals and a discussion was held at survey around opportunities to strengthen clinical pharmacy across both hospitals. The organisation advises, for example, of nurse educators being trained recently in regard to Best Possible Medication History by a clinical pharmacist.

There are KPI's for some key medication safety components. Audits followed by QIAs (quality in action plans) for outliers and where necessary focal reviews are embedded providing evidence that the medication management system is regularly assessed and action taken to reduce the risks identified. An example was given of hospital-wide signing of telephone orders by VMOs being an outlier and now has become a current hospital-wide QIA project. Medication Management Plan (MMP) completion was also an outlier across both sites and is a current QIA project between pharmacy and both hospitals. A general comment in regard to the variable compliance within audits across sites is necessary and work to achieve standardisation and across organisation achievements is noted.

Action taken to increase the effectiveness of the medication authority system is evident. In a further bid to increase effectiveness some health services provide a current credentialed/privileges list of VMOs and salaried medical officers regularly to the chief pharmacist, and in discussion with the medical practitioners an authorised signature list is retained by the pharmacists for identification, cross-referencing and audit purposes. The organisation may want to consider this.

There was evidence of a strong organisation-wide system of reporting, investigating and managing change to respond to medication incidents. These are reported through RiskMan and a system for managing medication errors is in place. For example, the introduction of individual staff education for repeated errors or any relating to high risk drugs was noted. They may be asked to repeat medication competency and/or Reflective Practice Tool.

ELMO sourced Mandatory Training Trend Data presented on the first day of survey recorded improvement. The Med-Safe eLearning program has been developed over 2015/2016 and implemented from mid-2016 onward. Med-Safe training of acute medical/surgical staff showed a compliance of 88% an improvement from December 16. Given paediatric admissions it is suggested that specific paediatric medication safety education be clarified as to where required, implemented and continuously audited. The organisation did advise it has had a focus on paediatric dose calculating recently.

Documentation of patient information

Policies and procedures are available to support the clinical workforce in documenting accurate patient medication records. NIMC and MSSA audits are reviewed. An audits and events schedule is in place. There are quarterly KPIs to be achieved. Auditing is in place to monitor ADR documentation and statistics presented by the organisation under 4.7.1. Action is taken to reduce the risk of adverse reactions with, for example, alert sheets remaining at the front of the bedside medical history, and brought to the front of the record and revised/added to at each admission. ADRs and TGA notifications are reported on RiskMan. Medication profiles are provided for all DVA patients and any with complex medication regimes, and clinical staff and VMOs can initiate a request for one. A QIA (2016/2017) which is part of a handover project has been reviewing the effectiveness of the nursing discharge summary and documentation of medications discharged with patients on this summary. The organisation advises NDSs "include medication as relevant. These are faxed to the community or referring GP". As a result of another QIA the Patient

Services Centre asks patients to have an updated medication list from the GP for day of admission and the pre-admission clinic will refer patients to the HSP pharmacy, if a patient is in need of a medication history. In summary, there is evidence of improvements across both hospitals with obtaining best medication history documentation and continuing auditing and monitoring of the clinical workforce, taking an accurate medication history early and then available at the point of care.

Medication management processes

Electronic and hard copy references are available to support medication practice. HSP pharmacy staff support the medical and nursing workforce, assisting with education in response to particular needs as well as in the provision of ongoing programs as part of the contract arrangements. Storage and distribution systems are generally well-managed. Work to improve appropriate storage of high risk and temperature-sensitive drugs and disposal of unwanted, unused and expired medications is evidenced. However, at survey and also reported through audits there was inconsistent checking compliance levels with the temperatures of fridges holding temperature-sensitive medication. The organisation reassured the survey team of its focus on rectifying this, presenting a policy document/flow chart for immediate circulation. This refers to standardisation to mandatory twice daily temperature checking, 365 days per year and what to do when out of range. This is to be monitored and compliance audited. This needs risk assessment and registering. Vaccine fridges have their own monitoring checks and audit.

Although previous reporting recorded management of APINCH medications being supported with posters and TallMan lettering, at survey the team was a little concerned at the perceived limited use seen. Although KCL has been moved to CCU the only storage appeared to be in a portable container on a workbench in the medication room in CCU (without alert); the DON was informed and urgent review of this was sought. She advised she would follow up. The safe storage and administration of Potassium Chloride (KCl) is outlined in the HSP policy and there is a current policy document on Medication Safety, High-Risk Drugs. Cytotoxics are utilised at HPH but not frequently which drew the surveyors' attention to the need for clarification of use, where and ensuring cytotoxic management and safety systems are in place and what education and training is provided. The organisation presented the team with a QIA plan at end of survey to ensure cytotoxic management safety and training systems are implemented for both hospitals where required, including the extent of use. Currently, management is perceived to be around individual prescription management. mainly oral cytotoxics and bladder washouts.

It is believed that enhanced clinical pharmacy services would support medication management processes and continuity of medication management further across both hospitals and, for example, in emergency and critical care, paediatrics, mothers and babies, perioperative and mental health.

Continuity of medication management

A suite of policies from Healthscope is in place, eg Best Possible Medication History, Medication Management Plan, Alerts (documentation and management), Admission of Patient (mental health and acute patients). The consumer consultant audits on patient understanding of information given on new medications is recorded as 83-100% HPH and 93.8% SHPH. Both hospitals have implemented a handover project and monitoring that medication charts are checked at handover. Compliance with creating medication profiles is studied and reported to VMOs. A QIA has been looking at MMP and improved compliance from pharmacy staff (all first floor/pharmacy staff). Outliers are being addressed in improving pharmacy compliance. Nursing discharge summaries are sent to GPs and patients are being asked to bring in an updated medication list from their GP at pre-admission.

A visit to the HSP pharmacy was kindly arranged. The "central" fridge was noted to have a manual paper sensitive temperature system which logs how long the temperature may be out of range. Temperature checking is not online and 24 hours a day, and breaches to the temperature compliance parameters are by manual checking. The fridge may not be checked daily when no pharmacy staff are on site. There is not a 24 hour "call back to base alarm system" on breaches or power outages. Routine liaison meetings between the DON/CEO and chief pharmacist with a view to risk assessing and monitoring breaches, security, cold chain, cytotoxic therapy, OH&S and fire safety areas of mutual responsibility are encouraged. The team was reassured of follow-up by the DON and CEO on matters raised with the organisation.

Communicating with patients and carers

Medication management plans are developed in consultation with patients. Nursing discharge summaries which are forwarded to GPs have information regarding medications given to the patient on discharge, and it was advised that

patients are encouraged to sign these as well (not sighted at survey). Consumer medication information sheets can be printed by nursing staff. Where a clinical pharmacist is accessible, for example from November 2016 at SHPH, an increase was noted in medication management planning in partnership with patients and carers. Clinical pharmacists can provide patients with specific medication education, documentation and counselling information on medications. Patient-centred survey results show evidence of improvement in the provision of medication management and information to patients and action is taken in response to patient feedback to improve medicines information distribution by the health service organisation to patients. Appointed consumer consultants monitor these audits and surveys. They also meet with patients and are empowered to feed back to the organisation and health professionals.

NSQHSS Survey

Organisation: Hobart Private Hospital&St Helen's Private Hospital
Orgcode: 420855

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

4.11.1	SM	SM
4.11.2	SM	SM

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

Organisation: Hobart Private Hospital&St Helen's Private Hospital
Orgcode: 420855

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

The organisation-wide patient identification system is overseen by the Quality and Risk Committee and supported by HSP, HPH and SHPH policies/procedures and forms which provide the framework for the standardisation of the organisation-wide identification process. These are designed to ensure the consistent and correct identification of a patient at any point and time during an admission/registration or course of treatment and include the use of four core identifiers (Unit Record Number, name, date of birth and gender). The patient identification bands meet the national specifications. A white patient identification (ID) band with four identifiers is used to identify a patient. The WebPas Patient Information Management System prints standardised labels with four identifiers. When an allergy alert condition exists the white ID band is replaced by a red iID band. Two identification bands are worn by neonates and patients undergoing ECT. Patient photographs and identification bands are used in the SHPH mental health services. Monitoring of compliance occurs via audits and the incident management system. Results of annual patient identification audits for the period 2015-2017 show an average compliance rate of 99% organisation-wide at HPH and improved compliance at SHPH. In 2017 SHPH demonstrated compliance of 94% following 85% compliance in 2016. This occurred following an increased focus on educating patients and daily checking of ID bands in the adult mental health ward (Hampden). Sustained high levels of compliance are reported in the Mother and Baby Unit. Low levels of patient identification incidents were reported for both hospitals.

Processes to transfer care

HSP and local policies provide the framework for identification of patients when a transfer of care occurs. Identity is confirmed using four patient identifiers when transferring responsibility of care. Implementation of a policy and training of hospital orderlies at HPH has strengthened processes when patients are transferred to internal and external services. Observation of the clinical handover process demonstrated effective use of the identification band. A very low level of incidents related to transfer of patients was reported.

Processes to match patients and their care

Events that require patient procedure matching are clearly identified within HSP policy, procedure and protocol and are used to guide practice in ensuring patients are matched to their intended procedure, treatment or investigation. This policy applies to all invasive diagnostic and treatment procedures. Surgical Safety, TMS, ECT and EBM checklists are in use. Results of observation and checklists/time-out audits show high levels of compliance. A very low level of mismatching errors was reported.

NSQHSS Survey

Organisation: Hobart Private Hospital&St Helen's Private Hospital
Orgcode: 420855

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

Organisation: Hobart Private Hospital&St Helen's Private Hospital
Orgcode: 420855

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Clinical handover is overseen by the HSP/SHPH Quality and Risk Committee and is supported by HSP and HPH/SHPH policies/procedures, guidelines and tools, and participation in the HSP Discharge Planning Cluster. Monitoring of compliance occurs via audits and the incident management system. Evidence shows strengthening of clinical handover practices and includes the appointment of a clinical champion, standardisation of approaches to workforce clinical handover education which occurs via eLearning and face-face presentations, use of the HSP clinical handover video which has been developed in consultation with consumers, standardisation of organisation-wide clinical handover practices, implementation of revised HSP clinical handover and discharge audit tools, implementation of HPH/SHPH generic nursing care plans, and increased participation of patients in bedside clinical handover. Training records show high levels of workforce participation in education programs. Observation and medical record documentation audits are targeted at all stages in the episode of care where clinical handover between health service providers is required to occur. Results show improved clinical handover practices and medical record documentation, and follow-up of areas identified as requiring improvement. The organisation reported a low-level of clinical handover incidents.

Clinical handover processes

Processes and procedures are in place for the implementation of a structured clinical handover between shifts, and when transferring between units and medical officers and are supported with the use of the ISOBAR tool. Mechanisms are well developed for handover of patients to other health providers when patients are discharged or transferred to other facilities. Handover tools have been incorporated into PACU and Emergency Nursing Record and a paediatric post anaesthetic care handover tool has been developed and implemented at HPH. Audit results show there are very high levels of compliance in clinical handover at both hospitals. Evidence provided shows there has been an increased focus on improved discharge documentation in the medical record by VMOs and timeliness of issue of nursing discharge summaries. Nursing discharges are sent to ongoing providers within 48 hours of discharge and good compliance with the HSP KPI target is evident. Evidence provided shows high compliance with completion of follow-up phone calls to day surgery, DVA and BUPA patients. Incidents relating to sub-optimal clinical handover are reported, investigated and monitored by the Executive and the Quality and Risk Committee. The organisation reported a low-level of clinical handover incidents.

Patient and carer involvement in clinical handover

There are mechanisms to facilitate the involvement of patients and/or carers in clinical handover, such as the use of bedside patient whiteboards and the provision of written patient information on handover. The surveyors observed occasions of clinical handover at HPH and SHPH and noted that these were undertaken in a professional manner. There was good interaction with patients, in that they were included in the discussion about their current and ongoing care. Reconciliation of identification and medicines occurred at this time. Results of patient satisfaction surveys show very high levels of satisfaction regarding the bedside handover processes.

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

Organisation: Hobart Private Hospital&St Helen's Private Hospital
Orgcode: 420855

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

The survey team was advised that no blood transfusions and/or blood products are utilised at SHPH. This summary refers to HPH.

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

A suite of policies provides the framework to support safe transfusion practices and management of storage and transport of blood and blood products. The organisation advises the policies are referenced to relevant national and state authorities and guidelines The Corporate Transfusion Cluster coordinates NSQHS Standard 7 across Healthscope. The QM is a member of this cluster. The meetings are held bimonthly. Compliance with policies is audited at least six-monthly it is advised.

There is evidence of a broad range of required audits in place and required monitoring done with quality in action plans, and refocus and re-audit where necessary. Appropriateness audits have been conducted annually since 2014. There is a Transfusion Documentation audit (including consent) and Blood Wastage audits monthly since July 2016. Results are reviewed by the local committee. This HPH Blood and Blood Products (HPH B and BP) Committee includes, since 2016, a haematologist and a medical representative. It is comprised of an excellent multidisciplinary team appropriate for such a committee. It currently has pathologists from both pathology providers (two), an intensivist, a haematologist and nursing staff (NUM representatives, theatre and emergency nursing staff, DON and QM). The committee reports through to the MAC and the chair is on the MAC. Systems are in place for audits as and when required. Clarification, however, is required on where reported standard annual audits may not operationally be at least six-monthly. In the documentation provided, for example, the results of the annual blood fridge audits are mentioned.

Incidents are reported through RiskMan and the risk register includes Blood and Blood Products components. Shared learning reports are available. RCAs are done if there were a sentinel event.

The organisation is congratulated on its quality improvement activities including discussions with the MAC and VMOs, surgical services committee, anaesthetic services and QuARM committee, which have been initiated and developed from 2015, 2016 and 2017 audits and policy review. Some are ongoing including systems for implementation of HMR 10.8 (blood and blood products prescription and transfusion record); the consent for blood transfusion/blood product administration forms and consent documentation, pre-transfusion history and appropriateness indicators and wastage minimisation. The Bloodstar program has been implemented. Such are monitored by the HPH Blood and Blood Products Committee and MAC.

Documenting patient information

Ongoing quality activities and audits scheduled are described and outliers reported and managed appropriately. The surveyors were advised a recent spot audit in relation to nursing documentation under 7.5.2, ie the patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed showed a compliance rate of 95%. There is a suite of relevant HSP policies and procedures in place and some under review. It is noted that the paediatric and neonatal blood transfusion management policy was due for release in March of this year. Although stated in documentation provided this was not sighted at survey so a reminder is in order for the Blood and Blood Products Committee to audit and review whether and where paediatric and neonatal blood transfusions may occur at HPH and with the policy's release confirm there is an appropriate HPH admission policy review; and education plan in place with upskilling on HPH's management (which may include transfer to higher care) of same for VMOs and clinical staff.

There is evidence of tools to ensure and monitor the best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record. Systems are in place to document adverse reactions and evidence of systems to reduce the risk of adverse events from administering blood or blood products.

Managing blood and blood product safety

Systems are established for safe management, transport and storage of blood and blood products and monitoring of wastage. HPH participates now in Bloodstar. Pre-transfusion work-up quality improvement activities have been carried out and appropriateness audits scheduled with resultant quality improvement activities. The expertise within the HPH Blood and Blood Products Committee including the two pathology providers strongly supports the managing of blood and blood products safety. Healthscope annual blood fridge audit results show compliance rates were: 2015 - 97.3%; 2016 and 2017 - 100%. The blood fridge comes under the responsibility and checking of theatre nursing staff. It is in a side room with access from a corridor which requires staff swipe access to enter. There is a blood register next to the fridge. In-house training of orderlies who access and transport blood and blood products is maintained by the hospital nurse coordinator. Compliance with blood safe eLearning for orderlies was 83% at March 2017 and is being followed up to ensure 100%. The register is audited monthly. Clinical patient identified details are recorded in the register.

Education and upskilling are evident. The ELMO mandatory training trend data that was presented at survey includes the clinical staff (and salaried medical staff) a figure of 87% - blood safe program improvement from December '16 again though recent upskilling is evident, thus it is important to continue ongoing monitoring of this by department. Such is now facilitated with this software. Cool bags have been implemented to transport blood products.

Clarification is sought on the frequency of blood fridge audits done by HPH and also where they include compliance with maintenance checks scheduling and alarming system monitoring checks, and what is done and required by Healthscope. The Blood and Blood Products Committee is encouraged to review.

There is a suite of policies relevant to the management of blood and blood product safety including blood fridge management and unused blood products.

Communicating with patients and carers

Healthscope has consumer consultants appointed and there is a Community Cluster corporate group. HSP advises that they are currently reviewing in partnership a blood transfusion care plan to implement as a corporate document. The HPH B and BP reviewed all forms available in 2015 and 2016 and advise it has implemented the National Blood Authority form, My Guide to Blood Transfusions. Patient education is an agenda item on this committee. A satisfaction survey regarding transfusion has been implemented. Results were not sighted at survey but there are mechanisms for feedback to the organisation and review by appointed consumer consultants. A lot of work is evidenced in regard to blood transfusion consent acquisition and documentation and improving on outliers in biannual transfusion audits. MAC is aware and leading in investigating and seeking the engagement of the VMOs in a partnership to improve joint agreement on practice and documentation within HPH. To improve the partnership and extend HPH clinical quality in action plans further, it is suggested that further advice and direction from the Blood Cluster and Chief Medical Officer be sought as added value to achieving HPH and its VMOs acknowledgement and excellent efforts on quality improvement.

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

Ratings

Action	Organisation	Surveyor
7.1.1	SM	SM
7.1.2	SM	SM
7.1.3	SM	SM
7.2.1	SM	SM
7.2.2	SM	SM
7.3.1	SM	SM
7.3.2	SM	SM
7.3.3	SM	SM
7.4.1	SM	SM

Documenting patient information

Ratings

Action	Organisation	Surveyor
7.5.1	SM	SM
7.5.2	SM	SM
7.5.3	SM	SM
7.6.1	SM	SM
7.6.2	SM	SM
7.6.3	SM	SM

Managing blood and blood product safety

Ratings

Action	Organisation	Surveyor
7.7.1	SM	SM
7.7.2	SM	SM
7.8.1	SM	SM
7.8.2	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
7.9.1	SM	SM
7.9.2	SM	SM
7.10.1	SM	SM
7.11.1	SM	SM

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

Hobart Private Hospital (HPH) and St Helen's Private Hospital (SHPH) have policies and procedures in place using best practice corporate and local guidelines and Healthscope (HSP) assessment tools. The HSP policy was developed by the HSP Pressure Injury Working Party referencing the Pan Pacific Clinical Practice Guidelines. Reports are provided to the national benchmark safety and quality committee Healthscope division. Feedback mechanisms are in place through the Quality and Risk Committee and multidisciplinary ward meetings.

Wound and pressure injury screening and assessment are in line with the Pan Pacific guidelines. Any pre-existing or acquired pressure injuries (PI) are recorded on the RiskMan extension with the integrated Risk Register including controls and actions to manage any identified risk/s. Equipment and devices are available to prevent PI in the patient population in all areas including the operating theatres.

Audit schedules are evident with several audits being conducted. The HPH pressure injury rate for stage 2 and above is 0.01% at both HPH and SHPH. Consent for wound photography is taken on admission for a patient who has a pressure injury stage 3 or 4 and placed in the medical record.

Preventing pressure injuries

All patients at HPH and SHPH are screened on admission using the HSP screening tool with monitoring actions in use to maximise the number of patients screened for PI on presentation. Patient purposeful rounding is used for monitoring skin integrity (utilising the Waterlow risk assessment tool) and turning of patients. Malnutrition identified as a key contributor to the deterioration of a patient's skin condition is monitored and a referral to a dietician is made for high-risk patients. A plan to implement the Malnutrition Screening Tool (MST) on pre-admission or admission to the clinical area is due for implementation in July 2017.

A plan to implement skin assessment for babies is actioned for July 2017.

Manual handling education is conducted for equipment and pressure relieving devices and an equipment register is kept in all clinical areas. A visual assessment of skin integrity is monitored at the bedside clinical handover.

HPH incidents of hospital acquired PI stage 2 and above are reported to HSP quarterly and performance is benchmarked. ACHS Clinical Indicator data for hospital-acquired PI stage 2 and above is submitted six-monthly and benchmarked. Results show incident rates are below the HSP KPI and Clinical Indicator PI rates are substantially below national industry rates and ACHS benchmarks. Performance is reported on the My Healthscope website. There have been no incidents of pressure injuries at SHPH in the past three years.

Managing pressure injuries

If a pressure injury is identified the use of a Wound Chart is put into place for use by the clinicians. Pre-admission risk screening facilitates advice to the wards of high-risk patients prior to admission and nursing discharge summaries include skin integrity status reporting. The perioperative care plan has a section that requires documentation of the strategies and equipment used in theatre for positioning of the patient. The Healthscope Wound Assessment and Plan chart was implemented in June 2015, to guide nursing practice with regard to pressure injury management.

Pressure relieving mattresses are used for patients that have been classified as medium risk and air mattresses can be hired for patients who are classified as high risk.

Education on wound dressings and pressure injury prevention is included on the eLearning modules and in-service is performed by company representatives and wound champions in the clinical areas; attendance is recorded on the education database.

Communicating with patients and carers

HPH and SHPH have a ‘Time to Move’ brochure which is informative, given to patients and families on admission and has had consumer input to ensure that the information is meaningful to the patient cohort. Any plans and actions that are in place are discussed with the patient and family if appropriate during the bedside handover. If required, information on the prevention of PI risk is included on the whiteboards in patient rooms.

NSQHSS Survey

Organisation: Hobart Private Hospital&St Helen's Private Hospital
Orgcode: 420855

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

NSQHSS Survey

Organisation: Hobart Private Hospital&St Helen's Private Hospital
Orgcode: 420855

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

There is evidence of strong organisation-wide (HSP, HPH and SHPH) communication and coordination addressing Standard 9 through HSP Cluster meetings, clinical deterioration meetings and the intranet. Through the intranet (HINT) there are Healthscope relevant and related policies accessible to staff. There is also a bank of standardised Healthscope forms such as track and trigger observation charts for adults, and those for paediatric age groups. There is an emergency response data collection tool (ERDC). HPH/SHPH policies/procedures and forms are also available to support management of clinical deterioration. There is a schedule of appropriate audits to monitor compliance.

The Clinical Deterioration Committee reports to the Quality and Risk Committee and MAC. Clinical indicators are utilised. Sentinel Event Shared Learning reports are available on HINT. There is regular auditing. Incident reporting (related to this standard) and investigations are managed through RiskMan. Case reviews are undertaken. A MET call system is in place at HPH and observed at survey to be both effective and efficient. At SHPH a low threshold is maintained for transfers out for clinical deteriorating patients.

There is an all deaths review system in place. At HPH review of all unexpected deaths and cardiac arrests is undertaken by the DON and an intensivist who is the Chair of the MAC and the Clinical Deterioration Committee. The Clinical Deterioration Committee reviews unexpected deaths, cardiac arrests and medical deaths. Surgical and maternity deaths are reviewed by the Surgical and Maternity Committees and deaths in operating theatre are reviewed by the Surgical and Anaesthetic Committees. A Mortality Review register is maintained and is overseen by the DON and the Quality and Risk Manager. Reports on all mortality reviews and cardiac arrests are provided to the Clinical Deterioration Committee and MAC and are prepared by the Quality and Risk Manager in consultation with the DON and MAC Chair. All deaths are reported quarterly to DHHS, Tasmania and include mortality review reports using the DHHS Mortality Review Form.

At SHPH mechanisms are in place for death reviews to be conducted in collaboration with the DON, Quality Manager and VMOs, and for reports to be tabled at the Psychiatric Services Committee and the MAC. Nil deaths are reported to have occurred for the period 20015-2017.

Overall evidence was provided and sighted of action being taken to improve the responsiveness and effectiveness of the recognition and response systems including where paediatric patients are admitted.

Recognising clinical deterioration and escalating care

There is evidence of ongoing improvements in implementing mechanisms for recording physiological observations that incorporate triggers to escalate care when deterioration occurs. For example, the suite of HSP track and trigger observation charts includes adult general, standard paediatric, neonatal and maternity charts. There is ongoing Healthscope processing of charts and plans to implement CEC charts in 2017. A broad range of appropriate audits, case and incident reviews is in place with QIAs (Quality in Action plans) widely utilised and reported on. They are changed/refocused where required over time. The survey team was impressed with such a practical business tool. NUM's evaluate all clinical deterioration incidents and associated emergency response data, and education requirements are analysed. MET calls and transfers out to higher levels of care owing to clinical deterioration are reviewed by the Clinical Deterioration Committee, Clinical Committees and MAC.

Responding to clinical deterioration

Education and training continue to be a focus of the organisation. An audit was done in 2017 and results showed 96% of perioperative staff had completed eLearning for advanced life support. The survey team is unsure as to whether this refers to HPH only and should be clarified. At SHPH during theatre lists for ECT and IVF at least one clinician will be onsite who has practice in advanced life support. For the rest of the hospital SHPH response to the deteriorating patient, and particularly code blue, is a referral to the paramedics/evacuation. Theatre at SHPH would still call the ambulance as per emergency procedure for the site. A GP is on site three days per week. VMO psychiatrists have an after hours roster.

Maternity unit staff at HPH have completed the 'resus for kids' (97%) training program while 100% is the compliance figure given for PACU and anaesthetic nursing staff. All paediatric patients are admitted via the maternity unit to theatre and then transferred via PACU to the maternity unit post op. There is a one-to-one model of care for paediatric patients and in theatre an extra staff member is reported. There is a paediatric emergency trolley in the Maternity Unit. Staff basic life support compliance with training figures for June 2017 shows HPH compliance of 95% and SHPH 89% respectively. Action 9.6.1 is assessed as fully met. Being co-located with RHH, HPH has access to on-call paediatricians and NETS as well. Mock arrest situations have occurred at Hampden SHPH. A paediatric emergency trolley is available in the Mother and Baby Unit. The organisation is encouraged to conduct routine mock code blues where there are babies and paediatric patients to clarify and familiarise any necessary additional training, equipment and resources that may be required and/or available to emergency external responders. Access to the deteriorating patient for responders should be audited across the hospitals where there are confined spaces/refurbished areas/smoking permitted areas at SHPH.

Communicating with patients and carers

Medication Orders on Life Sustaining Treatment Charts have been implemented from December 2014 with criteria relating to patients' advance care directives and wishes in regard to limitations of treatment. Advance care directives and treatment-limiting orders are audited annually within a Healthscope documentation audit. A Healthscope brochure on advance care planning was noted.

There is good evidence that systems are established to include patients, families and carers in escalation of care. They are informed of recognition and response systems; and can contribute to the processes of escalating care. On admission patients and carers are supported in raising concerns in regard to the deteriorating patient. Signage throughout the hospitals also assists in prompting carers, families and patients not to hesitate to report their concerns. Consumer consultants are involved in monitoring family escalation of care feedback from patients.

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Action 9.6.1 Core

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

Surveyor Comment:

A trending data chart (18 June 2017) was presented showing overall compliance of 89% with Healthscope basic life support program by clinical staff (including salaried doctors). There is evidence of an education focus over the last few months but an improvement overall from December 2016. Further figures were given for June 2017 with HPH compliance of 95% and SHPH 89% respectively. Clarification improvement and real time reporting of rolling data has

become increasingly more effective and efficient with the software introduction - ELMO. Local managers now have quicker access to their own unit data and stats while executive can sight an overview. Given that the KPI is greater than 92% for both hospitals; compliance with BLS training is reported monthly at educator/policy committee meetings and quarterly to GM/QM for KPI report. The organisation is in a good position to maintain a focus on this essential component of training and education. Action 9.6.1 is fully met.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

Hobart Private Hospital and St Helen's Private Hospital have policies and procedures in place for falls prevention and management. The policies on falls prevention and management have been developed and monitored by the HSP Falls Prevention Cluster.

A falls prevention resource folder is available in all clinical areas. HPH and SHPH falls are reported on RiskMan and submitted to HSP Corporate quarterly. All falls are reviewed by Nurse Unit Managers. All patient falls are reported to the Quality and Risk Management Committee and are a standing agenda item on the Medical Advisory Committees. The ACHS clinical indicator for total falls and those resulting in fracture or a closed head injury are reported six-monthly for benchmarking. Any fall with harm is reported to the DHHS, Tasmania and the HSP National Clinical Risk Manager and Chief Medical Officer. Evidence provided shows a reduction in the incidence of falls since 2014 and low levels occurring in 2015 and 2016, and a very low rate of injury from falls. ACHS indicator data show rates are substantially below the ACHS benchmark. HPH performance is reported on the My Healthscope website.

Screening tools are available for identification of at-risk patients. The Patient Health Questionnaire has a preliminary falls screen and the Falls Risk Assessment Tool (FRAT) directs clinical staff to a comprehensive assessment of patients that includes physical and psychological factors. All preoperative and maternity patients are risk assessed appropriately.

There is evidence that compliance audits of the medical record and FRAT are conducted regularly and Quality Action Plans that include improvement activities and outcomes achieved are developed. Audit results show improved compliance with the completion of risk assessments. Falls prevention equipment such as high-low beds and other falls prevention aids are available and distributed by the physiotherapy team with education on their use managed by this team.

Screening and assessing risks of falls and harm from falling

The FRAT is based on preventing falls and harm from falls in the older peoples' best practice guidelines. This tool is used at HPH in the Emergency Department, Pre-admission Clinic and at SHPH on admission to the clinical areas. A modified FRAT is used for maternity and day surgery patients. Falls are reviewed following surgery, changes in physical condition, post fall and ward transfer. Patients are reviewed hourly using the Purposeful Rounding Tool and at bedside handover.

The morning multidisciplinary meetings, which include Nurse Unit Manager, Medical Officer and Physiotherapist, discuss each patient and ensure appropriate physiotherapy referral and treatment plan for each patient. Patient rooms have an identifier on each door to ensure that all staff know that a patient is a 'high falls risk'.

The level of compliance with initial falls assessments is 100% at HPH and 72.5% at SHPH. Work has been undertaken to re-focus staff attention on risk assessment at SHPH.

Preventing falls and harm from falling

HPH and SHPH have evidence of documentation of strategies and interventions recorded in the FRAT and the patient care plans in the medical record. There is a multidisciplinary approach to falls management, with clear processes for appropriate referrals of patients being at risk to physiotherapists.

There are numerous resources and tools utilised by the patient and staff to minimise the risk of falling. These include coloured slides on the patient rooms and call for assistance signs on the patient whiteboard to remind patients not to get out of bed unassisted. Grip socks are also used for patients at high risk.

Staff are educated in the appropriate preventative strategies run by the physiotherapy team, eLearning, discussion at handover and multidisciplinary team meetings.

Patients falls risk status and preventative strategies are handed over whenever a patient is discharged, including a summary to General Practitioners.

Communicating with patients and carers

Communicating with patients and carers is a component of falls management at HPH and SHPH. Consumers are involved in the development and review of the Healthscope brochures used at both hospitals. All patients assessed at risk and carers are provided with the ‘Falls can be prevented’ booklet published by the Australian Government Department of Health and Ageing, and the Healthscope ‘Keeping a step ahead of falls’ brochure.

A consumer survey was conducted in February 2017 and the results showed that patients and carers preferred to receive the brochures given to them in the pre-admission clinic or on admission. Patients and families participate in the clinical handover process and sign the nursing discharge form to acknowledge that falls prevention strategies have been discussed and understood.

Governance and systems for the prevention of falls

Ratings

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

Screening and assessing risks of falls and harm from falling

Ratings

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

Preventing falls and harm from falling

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation: Hobart Private Hospital&St Helen's Private Hospital
Orgcode: 420855

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

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

Clinical practice

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

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

Performance and skills management

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

Incident and complaints management

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

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

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

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

2.4.1	Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)	SM	SM
2.4.2	Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients	SM	SM

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

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

3.10.1	The clinical workforce is trained in aseptic technique	SM	SM
3.10.2	Compliance with aseptic technique is regularly audited	SM	SM
3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	SM

Managing patients with infections or colonisations

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

Antimicrobial stewardship

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

Cleaning, disinfection and sterilisation

Action	Description	Organisation's self-rating	Surveyor Rating
3.15.1	Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including: • maintenance of building facilities • cleaning resources and services • risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved	SM	SM

	• waste management within the clinical environment • laundry and linen transportation, cleaning and storage • appropriate use of personal protective equipment		
3.15.2	Policies, procedures and/or protocols for environmental cleaning are regularly reviewed	SM	SM
3.15.3	An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly	SM	SM
3.16.1	Compliance with relevant national or international standards and manufacturer's instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored	SM	SM
3.17.1	A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place	SM	SM
3.18.1	Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices	SM	SM

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

4.5.2	Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use	SM	SM

Documentation of patient information

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

Medication management processes

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

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Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	SM	SM
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM
4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

Action	Description	Organisation's self-rating	Surveyor Rating
5.5.1	A documented process to match patients and their intended treatment is in use	SM	SM
5.5.2	The process to match patients to any intended procedure, treatment or investigation is regularly monitored	SM	SM
5.5.3	Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	SM	SM

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

6.4.2	Action is taken to reduce the risk of adverse clinical handover incidents	SM	SM

Patient and carer involvement in clinical handover

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

Blood and Blood Products

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

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

Documenting patient information

Action	Description	Organisation's self-rating	Surveyor Rating
7.5.1	A best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record	SM	SM
7.5.2	The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed	SM	SM
7.5.3	Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record	SM	SM
7.6.1	Adverse reactions to blood or blood products are documented in the patient clinical record	SM	SM
7.6.2	Action is taken to reduce the risk of adverse events from administering blood or blood products	SM	SM

7.6.3	Adverse events are reported internally to the appropriate governance level and externally to the pathology service provider, blood service or product manufacturer whenever appropriate	SM	SM

Managing blood and blood product safety

Action	Description	Organisation's self-rating	Surveyor Rating
7.7.1	Regular review of the risks associated with receipt, storage, collection and transport of blood and blood products is undertaken	SM	SM
7.7.2	Action is taken to reduce the risk of incidents arising from the use of blood and blood product control systems	SM	SM
7.8.1	Blood and blood product wastage is regularly monitored	SM	SM
7.8.2	Action is taken to minimise wastage of blood and blood products	SM	SM

Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

8.4.1	Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries	SM	SM

Preventing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.5.1	An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury	SM	SM
8.5.2	The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation	SM	SM
8.5.3	Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation	SM	SM
8.6.1	Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries	SM	SM
8.6.2	Patient clinical records, transfer and discharge documentation are periodically audited to identify at-risk patients with documented skin assessments	SM	SM
8.6.3	Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries	SM	SM
8.7.1	Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record	SM	SM
8.7.2	The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed	SM	SM
8.7.3	Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan	SM	SM
8.7.4	Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan	SM	SM

Managing pressure injuries

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

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Communicating with patients and carers

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

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

Action	Description	Organisation's self-rating	Surveyor Rating
9.1.1	Governance arrangements are in place to support the development, implementation, and maintenance of organisation-wide recognition and response systems	SM	SM
9.1.2	Policies, procedures and/or protocols for the organisation are implemented in areas such as: • measurement and documentation of observations • escalation of care • establishment of a rapid response system • communication about clinical deterioration	SM	SM
9.2.1	Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems	SM	SM
9.2.2	Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as not for resuscitation or do not resuscitate) are reviewed to identify the use of the recognition and response systems, and any failures in these systems	SM	SM
9.2.3	Data collected about recognition and response systems are provided to the clinical workforce as soon as practicable	SM	SM
9.2.4	Action is taken to improve the responsiveness and effectiveness of the recognition and response systems	SM	SM

Recognising clinical deterioration and escalating care

Action	Description	Organisation's self-rating	Surveyor Rating
9.3.1	When using a general observation chart, ensure that it: • is designed according to human factors principles • includes the capacity to record information about respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness graphically over time • includes thresholds for each physiological parameter or combination of parameters that indicate abnormality • specifies the physiological abnormalities and other factors that trigger the escalation of care • includes actions required when care is escalated	SM	SM
9.3.2	Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan	SM	SM

9.3.3	Action is taken to increase the proportion of patients with complete sets of recorded observations, as specified in the patient's monitoring plan	SM	SM
9.4.1	Mechanisms are in place to escalate care and call for emergency assistance	SM	SM
9.4.2	Use of escalation processes, including failure to act on triggers for seeking emergency assistance, are regularly audited	SM	SM
9.4.3	Action is taken to maximise the appropriate use of escalation processes	SM	SM

Responding to clinical deterioration

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

Communicating with patients and carers

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

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Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

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

Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

10.8.1	Discharge planning includes referral to appropriate services, where available	SM	SM

Communicating with patients and carers

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

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Recommendations from Current Survey

Not applicable

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Recommendations from Previous Survey

Not applicable

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Standards Rating Summary

Organisation - NSQHSS V01

Core

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

Developmental

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

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Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**209**	**0**	**209**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	11	0	11
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	3	0	3
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**47**	**0**	**47**

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Combined

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

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	15	0	15	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**256**	**0**	**256**	**Met**

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Surveyor - NSQHSS V01

Core

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

Developmental

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

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	36	3	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**206**	**3**	**209**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	11	0	11
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	3	0	3
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**47**	**0**	**47**

NSQHSS Survey

Organisation: Hobart Private Hospital&St Helen's Private Hospital
Orgcode: 420855

Combined

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

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	15	0	15	Met
Standard 3	38	3	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**253**	**3**	**256**	**Met**